



Physician Assisted Suicide

Where's the Harm?

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Good Discussions Follow Good Definitions

Definitions:

Euthanasia, Active: The “intentional life-terminating action,”
by someone other than the person
concerned.

Voluntary: At the request of the person concerned.

Non-Voluntary: Without a request or consent being possible.

Involuntary: Despite a patient’s wishes to the contrary, or
no consent sought.

Assisted Suicide: Providing a lethal dose of medication or
making other means available,
for someone to end their own life,
without the direct participation of the provider.



CDC Definition

“Suicide:

Death caused by self-directed injurious behavior with an intent to die..”



Meyers vs. Schneiderman

Suicide has long been understood as “the act or an instance of taking one’s own life voluntarily and intentionally.” ...Black’s Law Dictionary defines “suicide” as “[t]he act of taking one’s own life,” and “assisted suicide” as “[t]he intentional act of providing a person with the medical means or the medical knowledge to commit suicide” (10th ed 2014). Aid-in-dying falls squarely within the ordinary meaning of the statutory prohibition on assisting a suicide.

Read more at: <http://www.nationalreview.com/corner/451145/ny-high-court-rejects-assisted-suicide-right>

Two Questions

Is Assisted Suicide a good thing for patients?

Should a Medical Society claim neutrality on Physician Assisted Suicide?



“Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.”

AMA CODE OF MEDICAL ETHICS 2.211



What are the Effects of the “Death with Dignity” Law?

on:

- Patients
- Physicians
- Society



Why not be supportive of laws permitting Physician Assisted Suicide?

Bad Public Policy:

Uncontrollable

Discriminatory

Incoherent restrictions

Unnecessary



Physician Assisted Suicide

- Places vulnerable patients at risk as “burdens”
- Distorts compassion, truncates the possibility of a good death
- Creates uncontrollable effects on public
- Causes damage to doctor-patient relationship and the profession



Europe Euthanasia/PAS

Euthanasia: **Prohibited** in 33 nations by statute, criminal code, and/or professional codes of ethics and opposed by World Medical Association

Netherlands: (2002) “Exempt from Criminal Liability”

Belgium: (2002) “Commits no criminal offense” when Euthanasia is done and guidelines are followed.

Assisted Suicide:

Prohibited by statute, criminal code and or/code of ethics in most European nations

Netherlands

Also “exempt from criminal liability”

Belgium

Not included in Act of Euthanasia

Switzerland

Allowed if “not driven by selfish motive”

Luxemburg/

Suicide not a criminal offense, so ‘accomplice’ not

Estonia

_____prosecuted either



Physician Guidelines

Netherlands Physician Only	Belgium Physician Only	Oregon Physician Only
<u>Patient Request</u> Voluntary and well considered	Voluntary & well considered, in writing. Repeated over reasonable period – 1 month	Voluntary written, 15-day delay Oregon Resident
<u>Patient's Condition</u> Lasting and unbearable suffering	Conscious* & competent, Medically futile, serious constant, unbearable physical or mental suffering	Terminal Competent
<u>Patient's Age</u> <ul style="list-style-type: none"> • 16 (If parents involved) • 12-16 (If parents agree) 	Majority	18
<u>Informed Consent</u> <ul style="list-style-type: none"> • Can be via Advance Directive • Patients believes “no other reasonable solution” 	*Yes	Yes
<u>Consultation</u> 2 nd Physician to examine and concur	SAME & Discuss with Nursing Team, Relatives, others Psychiatric if non-terminal	YES (Notify next of kin) Psychiatrist to determine no psychiatric disease causing impaired judgement
<u>Reporting</u> Municipal Coroner	Federal Commission	Specific form in Medical Record
<u>Review</u> Regional Committees	Federal Commission	Health Division Reviews Sample of Records; Annual Statistical Report



USA: Euthanasia/PAS

- Court Decisions support patient's right to accept/refuse LSMT (Quinlan 1975, Cruzan 1990) but find no constitutional right for PAS (Vacco v. Quill 1997)
- Legislation has **decriminalized suicide / attempted suicide**
- but all states outlaw euthanasia
- 5 states – OR, WA, VT, CA, CO (DC) – permit physician assisted suicide
- Court in 1 state has vacated laws (MT)
- Referenda/State Legislatures have rejected PAS repeatedly in at least 27 other states
- American Medical Association, American Nursing Association: REJECT PAS/Euthanasia



Some Outcomes

Netherlands:

- 60% of deaths unreported despite requirements
- Hundreds euthanized without a request
- 8% of infant death were euthanasia (1995)
- Gronigen Protocol for Pediatric Euthanasia (2004)

Belgium:

- Euthanasia of dementia patients proposed (2004)
- Euthanasia of infants and children reported (Provoust et al 0 Lancet, 2005)
- and legalized – (2014)
- “Euthanasia Kits” in Pharmacy – 60 Euros

Oregon: (U.S.A.)

- About 40 deaths/year, 250 by 2005\Typical patient: Elderly, white male with cancer.
Reason: Depression, fear of being a burden
- Only 2 psychiatric evaluations in 2005
- Use of morphine, palliative care increase
- 24% of involved physicians regretted their involvement



Effect on Patients:

- PAS requests not motivated by pain:
*Control, fear of being burdensome,
depression*
- 1% of Oregon patients get a psychiatric
evaluation, *but researchers found 25%
were depressed*



Oregon's "Death with Dignity Act"

I. No new rights for *patients*

II. Legal protection (civil and criminal) for physicians involved in medically-caused deaths

III. No independent verification or review

- What if they fail to treat depression?
 - What if the patient is not mentally competent?
 - What about influence of those with financial interest?
 - What about coercion of the patient by family?

No funding for state validation or enforcement



Assisted Suicide in Oregon: Truth -No Safeguards

- No requirement for mental health examination
- No requirement for family notification
- No mechanism for reporting pressure on patients
- or penalty for failure to report undue influence



Assisted Suicide in Oregon: Truth -No Oversight

- \$0 funding for governmental oversight
- Prescriptions counted by Department of Human Services (DHS)
- Data collected are kept secret
- Original reports destroyed after annual summary made public by the DHS
- *No provision for medical record review* to detect fraudulent reporting
- “Compassion and Choices” advocacy group is effectively the “Keeper of the Law” and controls the data



PAS: Ethical Implications- Other Transparency Issues?

Need to conceal:

- Euphemisms: PAS→PAD→DWD
- No “suicide” on death certificate
- No witness required at death

Only 22 of 272 PAS deaths had a physician present
C&C directly involved with 75%



Absence of Evidence

is not

Evidence of Safety

Assisted Suicide and the Vulnerable

The Case of Kate Cheney

d. 29 Aug 1999, age 85

A family struggle

Is Mom capable of choosing to die?

Kate Cheney says she wants assisted suicide, but doctors and therapists wonder if it's actually her vocal daughter's wish



“Kate’s choices may be influenced by her family’s wishes; and her daughter may be somewhat coercive.” — evaluating psychologist



PAS in Oregon

I. The vulnerable are at risk

- A. Patients with dementia: **Kate Cheney**
- B. Patients with Depression: **Michael Freeland**

II. Changing roles of doctors and nurses

- A. Doctors give lethal injection: **Clarietta Day**
- B. Nurses now getting involved: **Wendy Melcher**

III. It doesn't always work

- A. Waking up after 5 days: **David Pruitt**



PAS - Uncontrollable

- Creates no new rights for patients but only offers legal protection for doctors for prescribing lethal doses
- Defines causing death as a model *good*, a patient benefit
- Creates “safeguards or boundaries” that are logically inconsistent.

A Patient's Right?

TWO kinds of rights:

Negative - Non Interference

Positive - Claim on your actions



Autonomy-Based Justification & Restrictions are Contradictory

- Based on autonomy to allow and promote suicide, which results in the *ultimate loss of autonomy*
- Patients not allowed complete free choice, but a *discriminatory judgment* that only some categories of patients
 - (terminally ill, suffering unbearably) are “better off dead”

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The Law restricts Autonomy

- *Arbitrarily* restricts the autonomy of
- the “death benefit”
- **6 months** (why not 12 months, or *years*?)
- **Terminally ill**
(why not the chronically suffering?)
- Suicide not always physically possible.
- **Why not euthanasia?**
- Why not “benefit”
comatose,
dementia,
psychiatric and
pediatric patients?



Autonomy and Compassion as Justification

- All restrictions on Autonomy eventually appear arbitrary
- Compassion demands that this newly defined Good be offered to non-terminal cases, or those not fully autonomous
- Societal approval creates pressure for multiple reasons, including that *death is always cost-effective*

(“Cost Analysis of Assisted Dying in Canada” CMAJ 1/23/17

= \$ 35-138 Million in savings)



“Compassionate” Expansion of Indications Europe

Not *Terminal* but Chronic Disease or Suffering

- Anorexia Nervosa
- Autism
- Alcoholism
- Chronic Fatigue Syndrome
- Blindness (impending)
- Gender Dysphoria (post-op)
- Loss of Attractiveness
- Aging, Loneliness, depression
- Organ Donation?



Euthanasia/PAS for Psychiatric Disorders in Netherlands 2011-2014

- Case summaries available from regional review committees
- 70% women
- Personality disorders, socially isolated or lonely
- Depressive disorders most common
- Also:
psychoses, anxiety, eating disorders, prolonged grief

27% EAS by physician new to their care

11% No independent psychiatric input

24% Consultants disagreed about E/PAS



Society and PAS: *Other Suicides*

*How can we promote PAS
yet reduce other suicides?*

- Suicide kills more than traffic accidents
- Suicide is 2rd most frequent cause of adolescent death and for Medical Students!
- Phenomenon of “suicide contagion”
- Oregon: 40% increase in overall suicide rate since (PAS)?



Other Patients & PAS:

Increased Sense of Vulnerability *for non-suicidal*

- Physically Disabled
- Elderly
- Mentally disabled
- Depressed/Suicidal
- Traditionally underserved minorities



Physicians & PAS

- Fundamental challenge to the trust relationship between doctors and patient
- Confusion and conflict of interest in offering as goals of care: cure, palliation, or ...causing death
- Assisting suicide less difficult than EOL care
- Post-PAS depression reported by physicians (24%)
- Doctors instructed not to list “suicide” as cause of death
- *integrity* issue



Has the Medical Profession Devolved into Healers and Killers?

- How is it not killing to remove life sustaining medical treatment?
- Why should we not assist in causing death, if it's wanted by the patient?



Definitions

- **Killing**

an act creating a new lethal state with the intention of causing death

- **Allowing to die**

a. removing a life sustaining intervention (from a pre-existing lethal state)

OR

b. refraining from forestalling or ameliorating actions (for a pre-existing lethal state)

A Patient's Right?

TWO kinds of rights:

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The permissibility of actions that result in a patient's death relates to:

- **Autonomy** of the patient/surrogate
- **Intention** of the physician
- **Autonomy** of the physician



Killing vs. Allowing to Die

Distinction upheld by:

A. Hippocratic Tradition

B. AMA code of Medical Ethics

C. Court Decisions (eg. *Vacco v. Quill*)

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NY High Court

As to the right asserted here, the State pursues a legitimate purpose in guarding against the risks of mistake and abuse. The State may rationally seek to prevent the distribution of prescriptions for lethal dosages of drugs that could, upon fulfillment, be deliberately or accidentally misused.

Read more at: <http://www.nationalreview.com/corner/451145/ny-high-court-rejects-assisted-suicide-right>



Public Policy Follows the Traditional View

- All intentional killing is proscribed
- Allowing to die is usually permitted in the absence of any evidence of wrong intention
- Patient's refusals of interventions – Acceptable
- Patients requests for killing – not honored



Challenges to Traditional View

- **Physician Assisted Suicide**
(Physician Assisted Death)
("Death with Dignity")
- **Euthanasia**
- **Overturning the traditional doctor patient relationship, and the perspective of society, entails a radical social revolution**



- PAS laws *Unecessary*

- Suicide is already legal
- Compassion & Choices states that VSED is a good, painless option
- Doctors have reported doing this for selected without legal sanction



Non-transparent PAS/Euthanasia in US?

- In a survey of 3299 oncologists

10.8% had performed physician-assisted suicide on their patients.

3.7% had performed euthanasia

Oncologists who believed that they had received adequate training in end-of-life care were less likely to have performed euthanasia or physician-assisted suicide.

Those who reported not being able to obtain all the care that a dying patient needed were more likely to have performed euthanasia
($P= 0.001$)

Ann Intern Med. 200;133:527-532



New Sub-Specialty?

- 1% of Oregon doctors (109) prescribed suicide meds (over 7 year observation)
- 20 doctors accounted for 84% statewide
- 3 doctors wrote 23% of prescriptions

WHY should this be Medicalized?



Physician Role in PAS?

“If it is to be state policy to provide death on demand to its citizens, it is best to divorce physicians from any such proceeding. It is perhaps time for a modest proposal: should not the state set up a Termination Bureau, which would provide a comfortable death under pleasant circumstances to eligible, applicant citizens?”

Terminators would not have to be physicians; they could be veterinarians trained in putting animals to sleep, or perhaps vocationally retrained hangmen.”

*Hugh Gregory Gallagher – served on the board of
Compassion in Dying*



Contra PAS

- *Discriminatory* – defines some lives as not worth keeping alive
- *Elitist* – small number who want it would place larger society at risk
- *Uncontrollable* – lack of transparency
- *Unrestrictable* – defines death as a moral & medical good
- *Unprofessional* – Destroys trust , sanctions physician killing
- *Unnecessary* – Suicide is legal

For over 2400 years
the medical profession
has withstood the allure
of promoting death.



Position Statement on Medical Euthanasia

“The American Psychiatric Association, in concert with the American Medical Association’s position on Medical Euthanasia, holds that a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death.”

APA, December 2016



“I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.”

Oath of Hippocrates
5th Century B.C.



Consider Two Myths

- If forbidden, assisted suicide does not occur
- If permitted assisted suicide can be controlled

For the good of our patients, profession and society,
it is the second myth that we must reject.



AXIOMS

Medical treatments may be withdrawn or withheld
if the burden of treatment exceeds the benefit.

Adverse consequences of medical actions (or withdrawals) can be justified by the principle of double effect.



Double Effect

- I. Act** – Morally good or neutral
- II. Intention** – Only the good effect desired; bad effect foreseeable
- III. Means** – The bad effect is not the means to the good effect
- IV. Proportionality** – Good effect outweighs the bad effect



Suppositions

- All intentional killing is morally wrong (except defense of self or others)
- Some “allowing to die” is morally permissible
- Some “allowing to die” is morally wrong



Can Intention be Judged or Determined?

Questions to suggest intent:

- Do I feel I have failed the patient if they continue to survive?
- Do I make new plans that will more certainly lead to the patient's death?
- Does my action leave no room for any outcome except death?



Historical Perspective

I. Ancient Greece and Rome (500 B.C.)

A. Tolerant of infanticide and active euthanasia

II. Hippocrates, the Father of Medicine (460–370 B.C.)

A. Hippocratic Corpus (collection of medical works)

“The physician must be able to tell the antecedents, know the present, and foretell the future, must mediate these things, and have two special objects in view with regard to disease, namely, to do good or to do no harm.”*

**Of the Epidemics*, Book I, Section II, Part V:



Hippocratic Oath

“I will follow that system of regimen,
which, according to my ability,
I consider for the benefit of my patients
and abstain from what is deleterious
and mischievous.

I will give no deadly medicine to anyone if
asked, nor suggest such counsel.”



Good Discussions Follow Good Definitions

Definitions:

Euthanasia, Active:

The “intentional life-terminating action,” by someone other than the person concerned.

Voluntary:

At the request of the person concerned.

Non-Voluntary:

Without a request or consent being possible.

Involuntary:

Despite a patient’s wishes to the contrary, or no consent sought.

Assisted Suicide:

Providing a lethal dose of medication or making other means available, for someone to end their own life, without direct participation of the provider.



History of Assisted Suicide

- I. 1960: Euthanasia viewed as “choice”
- II. 1980: Derek Humphrey forms “Hemlock Society”
- III. 1990:
 - A. Derek Humphrey’s best-selling book *Final Exit* stimulates a national “Right to Die” movement
 - B. Jack Kevorkian assists Oregonian Janet Adkins
 - C. “Compassion in Dying” is founded and submits several assisted-suicide ballots in Washington and California
- IV. 1994: the Oregon “Death with Dignity” Act passes



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- Court Decisions support patient's right to accept/refuse LSMT (Quinlan 1975, Cruzan 1990) but find no constitutional guarantee for PAS (1997) (Vacco v. Quill)
- Legislation has decriminalized suicide/attempted suicide but all states outlaw euthanasia; 3 states – OR, WA, VT – permit physician assisted suicide, Courts in 1 state has vacated laws (MT) ,California?
- Referenda/State Legislatures have rejected PAS in at least 24 other states
- American Medical Association, American Nursing Association: REJECT PAS/Euthanasia



Oregon's "Death with Dignity" Act

After patient request for a deadly prescription:

- Second opinion required (can be done over phone)
- 2-week waiting period prior to filling
- Doctor writes prescription, usually barbiturates



Oregon's "Death with Dignity" Act

- No peer-review
- Doctor protected from civil lawsuit
- Reporting is voluntary

The law provides for doctor-ordered, doctor-prescribed, and doctor-directed suicide



Effect on Patients:

- PAS requests not motivated by pain
*(Control, fear of being burdensome,
depression)*
- 1% of Oregon patients get a psychiatric evaluation, but researchers found 25% were depressed



Patients & PAS:

Increased *Sense of Vulnerability*

- Physically Disabled
- Elderly
- Mentally disabled
- Depressed/Suicidal



Telling the truth about PAS in Oregon Five Oregonians to Remember

- I. The vulnerable are at risk
 - A. Patients with dementia: **Kate Cheney**
 - B. Patients with Depression: **Michael Freeland**
- II. Changing roles of doctors and nurses
 - A. Doctors give lethal injection: **Clarietta Day**
 - B. Nurses now getting involved: **Wendy Melcher**
- III. It doesn't always work
 - A. Waking up after 5 days: **David Pruitt**



Physicians & PAS

- Fundamental challenge to the trust relationship between doctors and patient
- Confusion and conflict of interest in offering as goals of care: cure, palliation, or death
- Assisting suicide less challenging medically than EOL care
- Doctors instructed not to list “suicide” as cause of death
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“Death with Dignity” Act

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doctor-prescribed, and doctor-directed
suicide*



Society and PAS

- Oregon DHS: “No authority to investigate” deaths - and law does not require it.
- Reports of individual coercion (Kate Cheney)
- And, state coercion (Barbara Wagner)
- “Boundaries” do not hold
 - Euthanasia* (Dr. Rasmussen, Corvallis)
 - Non-Terminal* (Patrick Matheny – ALS)
- Death is cost-effective



Physician Assisted Suicide

- Distorts compassion, truncates a good death
- Places vulnerable patients at risk as “burdens”
- Causes damage to doctor-patient relationship and the profession
- Creates uncontrollable effects on public



PAS -- Uncontrollable

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- Defines causing death as a model good, a patient benefit
- Creates “safeguards or boundaries” that are logically inconsistent.



Expansion of Indications

Chronic Disease or Suffering

- Anorexia Nervosa
- Autism
- Chronic Fatigue Syndrome
- Blindness (impending)
- Gender Dysphoria (post-op)
- Aging
- Loss of Attractiveness
- Loneliness



Autonomy-Based Justification and Restrictions are Internally Inconsistent

- Based on autonomy to allow and promote suicide, which results in the ultimate *loss of autonomy*
- Not based on free choice, but a *discriminatory judgment* that some categories of patients (terminally ill, suffering unbearably) are “better off dead”

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- *Arbitrarily* restricts the “death benefit”
 - a) 6 months (why not 12 months, or years?)
 - b) Terminally ill (why not chronically suffering?)
 - c) Suicide not always physically possible.
Why not euthanasia?
 - d) Why not “benefit” comatose, dementia, psychiatric and pediatric patients?



Society and PAS: *Other Suicides*

- Suicide kills more than traffic accidents
- Suicide is 3rd most frequent cause of adolescent death
- Phenomenon of “suicide contagion”
- How do we promote PAS yet reduce suicides?
- Oregon: 40% increase in overall suicide rate (PAS)



PAS: Ethical Implications- Transparency?

Need to conceal:

- Euphemisms: PAS→PAD→DWD
- No “suicide” on death certificate
- No witness required at death

Only 22 of 272 PAS deaths had physician present

C&C directly involved with 75%



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For the good of our patients, profession and society, it is the second myth that we must reject.



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Dutch Doctors Approve Organ Donation Euthanasia, <http://www.mercatornet.com/careful/view/15244>



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Oregon Death with Dignity Act 2014

<http://public.health.oregon.gov>

The History of Physician-Assisted Suicide
and the True Oregon Experience

www.PCCEF.org



“For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world, the doctor and the sorcerer tended to be the same person. He with the power to kill had the power to cure, he who had the power to cure would necessarily also be able to kill. ... [With Hippocrates] the distinction was made clear. One profession, the followers of [Hippocrates], were to be dedicated completely to life under all circumstances, regardless of rank, age or intellect—the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child...”

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(Continuation of quote)

“[T]his is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer—to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. ... [I]t is the duty of society to protect the physician from such requests.”

Anthropologist Margaret Mead, Quoted by Maurice Levine in Psychiatry and Ethics, pp.324-325, 1972