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# Legalization of Physician-Assisted Suicide for Increased Patient Autonomy

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Legalization of Physician-Assisted Suicide for Increased Patient Autonomy

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## Legalization of Physician-Assisted Suicide for Increased Patient Autonomy

### **Introduction**

Not long ago, in 2014, I remember a news-breaking story about a woman named Brittany Maynard, a twenty-nine-year-old who was diagnosed with terminal brain cancer. As a California native, she picked up and moved to Oregon with her husband to undergo a process, legal in the state of Oregon, commonly known as physician-assisted suicide (PAS). While many opposed her decision to do so, Maynard became an advocate for the legalization of PAS through her life-ending ordeal. She sparked a conversation that would continue to grow in the following years.

Though she faced much opposition, the legal status of PAS in Oregon allowed Maynard to choose, for herself, the manner in which she wished to leave this world and continue on into the next. What PAS truly is, how it relates to patients, and responses from the public sphere as well as licensed physicians, among other factors, play into the reasoning for why PAS should be nationally legalized in the United States in order to allow patients the opportunity to decide for themselves whether or not to pursue PAS as an end-of-life measure.

### **Defining PAS**

To begin, the true definition of PAS often becomes blurred with another controversial topic in the medical world termed voluntary euthanasia. PAS is defined as “suicide by a patient facilitated by means (such as a drug prescription) or by information (such as an indication of a lethal dosage) provided by a physician aware of the patient’s intent”<sup>1</sup>. Common usages of PAS

occur when laypeople, often patients of serious, terminal illness, discuss end of life options with their medical providers. Though many countries around the world and states within the U.S. have laws against the use of PAS, to make a patient-centered policy we must put aside our feelings about death and our potentially distasteful role in it, and be guided by what people want<sup>2</sup>. In many cases, this will be comfort in familiar surroundings, or preservation of autonomy to the very end, as well as the ability to preempt and avoid lack of dignity<sup>3</sup>. PAS, alternatively, differs from active voluntary euthanasia, for, unlike euthanasia, the final act—the one that brings on death—is performed by the patient, not the doctor<sup>4</sup>. PAS is thus not the same as voluntary euthanasia, and for the purposes of this essay they will remain separate entities. Arguments for legalization of PAS as a means of end-of-life care remain separate from voluntary euthanasia, as well.

### **Hospice Care and Terminally Ill Patients**

For hospice and terminally ill patients, PAS has become a means for many to die with dignity. While the Death with Dignity Act, originally enacted in the state of Oregon in 1997, poses new challenges for hospice's identity and integrity, it permits terminally ill patients to request a physician prescription of lethal drugs to end their life<sup>5</sup>. Those in hospice care have medical conditions in which dying is a realistic possibility. For these patients, death may not be swift or simplistic, but rather painful, drug-out, and with much suffering. The idea of self-deliverance is a popular expression which reflects emerging patient autonomy and self-determination as a primary principle in the ethics of medicine<sup>6</sup>. This has created moral tensions for hospice, as hospice gives patients control over the quality of life they can experience in death. However, this patient control does not currently extend to decisions to terminate one's life by PAS, though it is precisely this sense of control that is presupposed by the principle of autonomy

and by Oregon's legalization of physician-prescribed medications to end one's life<sup>7</sup>. If the stance of a progressive state like Oregon for the legalization of PAS to allow patient autonomy goes in accordance with the ideals of hospice care, then legalization of PAS for terminal patients everywhere only becomes clearer. In reflecting on the prominence of this autonomy in medical ethics, some hospice caregivers contend that patient control—meaningful patient control—should include decisions regarding the timing, circumstances, and method of death<sup>8</sup>. Hospice fails its patients when it does not provide the choice to end one's life through means of PAS<sup>9</sup>. National legalization of PAS, for this fundamental principle of hospice care, is necessary to allow a choice to those in their final stages of life of how they wish to leave.

### **PAS for Chronic Mental Illness**

While proponents of PAS may easily agree that it be legalized for hospice and terminally ill patients, the subject of PAS for mentally ill patients is a sector of PAS that may not be as widely agreed upon. However, it is up to the discretion of the patient of whether or not they wish to pursue PAS as an end-of-life measure. According to the Swiss high court, “a distinction should be made between temporarily impaired individuals who wish to die as ‘an expression of treatable psychological disturbances’ and those individuals with severe, long-term mental illness who have made ‘rational; and ‘well-considered’ decisions to end their lives to avoid further suffering”<sup>10</sup>. But how does one make such a distinction between the two? Jacob Appel argues that there is obviously a difference between a terminally ill cancer patient and an acutely depressed teenager who transiently desires to end his life after a romantic setback. He continues, saying it seems logical to prevent patients from committing suicide until they have considered all options over an extended time period to ensure they are not acting in haste. For those still unsure, psychological evaluations are an option to determine that patients are in good understanding of

decisions they may choose to make regarding PAS, even if diagnosed with severe and chronic mental illness, like depression. However, the “difference between a patient who desires suicide after enduring the long-term agonies of rheumatoid arthritis or trigeminal neuralgia and the patient who wants to end his life after years of debilitating anxiety or intermittent psychotic episodes is not so clear”<sup>11</sup>. Who are we, as either laypeople or physicians, to be making the call as to which patients may undergo suicide and which should be restrained from the same action? Who are we to decide who’s pain or suffering is worse, and is therefore justified in pursuing PAS? While some may argue that for terminally ill patients, death will be the end result and therefore justifies PAS, it seems reasonable to afford mentally ill patients the same choices if the window of opportunity for discovering effective treatment may be longer in cases of chronic mental illness. If the same offer is that effective treatment may eventually be found but the patients will have to continue suffering for decades before it happens, then it might still be rational to prefer suicide as the alternative<sup>12</sup> and thus should be afforded the same opportunity as terminally ill or hospice patients to decide for themselves whether or not to pursue PAS as a means to end their life on their own terms. Opponents of PAS may argue that the decision-making competence of these chronically mentally ill patients therefore disqualifies them from any opportunity to pursue PAS. Nevertheless, one can be both deeply depressed, for example, and capable of making rational decisions<sup>13</sup>. If the values of PAS advocates are maximization of autonomy and minimization of suffering, then it follows that the chronically depressed, as well as patients of other chronic mental illnesses, who are competent individuals would be ideal candidates for the PAS procedure<sup>14</sup>. Appel further reasons that, “at the very least, a patient with a history of mental illness who is currently experiencing a temporary remission of symptoms will certainly be competent enough to make such a choice before the return of the disease”<sup>15</sup> which

would provide them the same opportunities as those in hospice and the terminally ill in terms of PAS, should it be nationally legalized in the United States.

### **Popular Culture and Physician Responses to PAS**

The different viewpoints surrounding PAS typically derive from the experience one has surrounding the act itself. Laypeople, physicians, and patients alike have responded to PAS, whether for, against, or by taking a stance somewhere in between. Generally speaking, there are five positions taken among popular culture responses. First, there are those who can say beyond a shadow of a doubt and with total conviction that they know what is right (for themselves and others) and why it is right<sup>16</sup>. These responses may either be supporting or opposing PAS, but with strong personal reasoning to back them up. Second, most respondents acknowledge that PAS is a complex social question with murky moral margins, proclaiming that concerned people can reach opposing positions the same way others can reach supporting positions, through the same sources of evidence, principles, and rhetorical strategies<sup>17</sup>. These respondents typically fall into a middle ground of sorts, acknowledging both sides. Third, for another group of respondents, the meandering moral issue has been replaced by a straightforward, technical one. In this replacement, doubt, remorse, and regret attendant on an existential decision are beside the point<sup>18</sup>. Fourth, a reaction of an entirely different sort characterizes the handling of this “American question” in the foreign press<sup>19</sup>. Observers see it in a cultural guise, as “another indication that American culture is unable to assimilate the complexities and darker, more morally ambiguous aspects of human experience”<sup>20</sup>. This view would likely assume that America as a country and within its culture cannot make the difficult decisions regarding life and death. Finally, fifth, for some, the issue is a stalking horse for much broader moral critique of the way we live and die in the world today<sup>21</sup>. These popular culture responses display the complexity

of PAS in the modern world. Physicians in a 2007 Vermont survey additionally show a mixed bag of opinions surrounding PAS. 16% of those surveyed believed PAS should be illegal, and 26% believed it should not be legislated<sup>22</sup>. However, physicians who did not care for patients through the end of their lives were more likely to say that PAS should in fact be legalized (48%)<sup>23</sup>. Generally, toward the practice of PAS, if it were to be legalized 37.7% of physicians surveyed said they would not participate in PAS, while 50.1% indicated they would<sup>24</sup>. Often times there is no right or wrong, no black or white, but rather in-betweens and shades of grey that make up the feelings surrounding ethical issues like PAS in the medical field. This indicates further strength for the support of national legalization of PAS for patient autonomy at the end of their lives. Brittany Maynard, a right-to-die advocate, underwent PAS in 2014 after being diagnosed with a terminal brain tumor at 29 years old. For Maynard, having a choice about how she would die gave her the peace of mind she needed to enjoy the limited time she had left<sup>25</sup>. Without the option of PAS through Oregon's Death with Dignity Act, Maynard, with a young and relatively healthy body, would likely have hung on for a long time, even with the cancer eating away at her mind. However, she believed she would have suffered in hospice care for an extended period of time, which she decided she did not want to experience<sup>26</sup>. Maynard believed that "the freedom is the choice"<sup>27</sup> and "if the option of [Death with Dignity] is unappealing to anyone for any reason, they can simply choose not to avail themselves to it. Those very real protections are already in place"<sup>28</sup>. This personal testimony from Maynard is still applicable today. Those who qualify for PAS in locations where it is currently legalized have the option to utilize it, but do not have to if they do not desire to do so; they are given a choice. This same choice must be extended to all persons who meet the necessary qualifications of such laws, like Oregon's Death with Dignity Act (DWDA). To do this, PAS must therefore be legalized at the

national level to allow an equal playing field on the matter. It matters not what laypeople or physicians feel toward PAS, but rather the feelings of the patients involved in the process themselves.

### **Religion: What Role Does it Play, if Any?**

In terms of opposition to PAS, the greatest opponent of legalization has been the Catholic Church. This fierce opposition began when Andrew Denton and others initiated their first attempt to legalize PAS in the state of Oregon. Their strategy in response to the Catholic Church's resistance was to "treat the Church with respect, accept their moral objections, and not attack them head on"<sup>29</sup>. Instead, Denton and his colleagues used the trusted voices of nurses to aid them in their cause. One nurse in particular, Patti Rosen, delivered a line in an advertisement which essentially hushed the opposition almost altogether; "When did we decide to let one church make the choice for all of us?"<sup>30</sup>. The people of Oregon responded by voting in favor of Denton's bill, making PAS legal in the state. Immediately after passing, the Right to Life movement found a judge and filed an injunction to stop the bill, which led to three years of the legislation being held up in court until being re-voted on by people who passed the bill yet again and legalized PAS in Oregon<sup>31</sup>. However, the stance of the Catholic Church on PAS does not encompass all denominations, nor each affiliated member. In truth, Protestant groups often tend to emphasize an individual's right to control end-of-life care<sup>32</sup>. These people are advocates for autonomy and argue that God has granted humanity personal choice, which extends to matters of life and death<sup>33</sup>. Absolute Dominion of God also plays a role in some religious views on PAS. In this view, God holds exclusive authority over the transition of one's life to their death<sup>34</sup>. Yet another survey of religious groups in the United Kingdom found that most religious followers actually support PAS. Of those surveyed, 64% claimed to follow a religion, and also believe that

there should be a change in the law to allow PAS for those who are terminally ill<sup>35</sup>. This belief, supported by 82% of those surveyed, stems from the belief that individuals have a right to choose when and how they die<sup>36</sup>. Opponents of PAS may suggest that opposing views to PAS, like those of the Catholic Church, should be respected by being upheld by being extended upon other religious groups as well as persons who are not religiously affiliated. Nevertheless, one church and its belief system does not have the ability to dictate matters into law; hence the separation of church and state by the United States government. The stance of any religious group on PAS does not matter for purposes of legalization. As seen in this evidence of religion and views on PAS, what matters is the individual and their right to choose. If nationally legalized, anyone who does not wish to partake in PAS, whether religiously affiliated or not, has the option not to while those who wish to undergo PAS may decide for themselves what the best course of action may be and whether that course of action is in fact PAS as an end-of-life measure.

### **Public Policy and Legalization**

Those who oppose legalization of PAS are often ill-informed on the current legalization status of PAS in a variety of U.S. states and countries around the world. Oregon has championed PAS through their DWDA which began in 1997. According to Oregon's DWDA, those who choose to undergo PAS do so primarily for reasons of losing autonomy and being less able to engage in activities which make life enjoyable<sup>37</sup>. Some might argue that the quality of palliative care, or "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"<sup>38</sup> has decreased since the passing of the DWDA

in Oregon. Conversely, this is not the case. Palliative care has been better since the PAS law passed as patients are empowered and know they can bring up the question of PAS with their doctors, and the doctors know that their patients can bring this up<sup>39</sup>. Because the doctors do not want their patients to ask about PAS, they are working harder to do a better job with patients at end-of-life stages so the patient does not have to raise the issue of PAS with their physician<sup>40</sup>. In terms of palliative care, PAS and the DWDA in Oregon allow people to make the decision to end their lives when they have a terminal condition without being at the mercy of the medical profession<sup>41</sup>. This idea of autonomy surrounding death and dying affords patients a choice at the end of their lives, but only if the status of PAS is legal in the state in which they hold residency. Washington state's DWDA went into effect in 2009<sup>42</sup>. This DWDA was modelled after that of Oregon and allows terminally ill adults, who are Washington residents with less than six months to live and seeking to end their life, to request lethal doses of medication from medical and osteopathic physicians<sup>43</sup>. Many of the same safeguarding provisions are afforded to Washington's DWDA as that of Oregon; mainly that the patient must be declared mentally competent to make the request, two doctors must certify that the patient has six months to live or less, the patient's request must be put into writing and witnessed by two people and must also make two oral requests 15 days apart before being able to receive the lethal medication<sup>44</sup>. These safeguards protect both patients and physicians from arguments of a "slippery slope" towards involuntary euthanasia. Across the Atlantic Ocean in Switzerland, PAS has been legal since 1918<sup>45</sup>. Alternatively, Switzerland does not require residency to undergo PAS and does not require that a physician be involved in the process<sup>46</sup>. Write-in respondents on the issue of PAS have claimed there is no evidence that patients are pressured by family or relatives to partake in PAS in Switzerland<sup>47</sup>. One respondent even states, "I am in good health but have already

discussed with my doctor here in Geneva the circumstances under which she would help me to take my own life to shorten such suffering. Her positive response has made me feel relieved and more confident about growing old”<sup>48</sup>. This individual’s stance on PAS is not unlike others, similar to those in the United States, who claim they wish to leave the world in a way of their choosing and on their own terms. This is clearly not only a European stance on the issue, but an American sentiment as well. The Netherlands and Belgium, alternatively, have a looser position on PAS and its legalization. In the Netherlands PAS is allowed in nonterminal cases of “lasting and unbearable” suffering, and Belgium offers PAS for nonterminal patients who claim constant suffering which “cannot be alleviated”<sup>49</sup>. This very progressive stance on PAS borders on euthanasia, both voluntary and involuntary, which in truth has been practiced in these countries<sup>50</sup>. If legalized in the United States, the law surrounding PAS would best be modelled after that of Oregon’s DWDA, which would protect and safeguard patients who seek PAS from scenarios bordering euthanasia which sometimes occur in the Netherlands and Belgium. With these safeguards in place, patients who wish to partake in PAS would be afforded the personal choice surrounding the stance they take on the matter and whether they choose to use it at the end of their lives.

### **Potential Economic Benefits to Legalization**

Economically speaking, national legalization of PAS in the United States would save both money and resources for terminally ill patients. According to Medicare data, roughly \$30,000 is spent on a beneficiary who dies of cancer after receiving conventional care in the last year of life<sup>51</sup>. An estimated 33% of that, about \$10,000, is spent in the last month of life, and 48%, roughly \$15,000, is spent in the last two months<sup>52</sup>. PAS as an end-of-life measure would likely reduce these numbers, as some terminally ill patients may opt for PAS rather than

traditional end-of-life care. Assuming that (1) 2.7% of patients who die each year (roughly 62,000 Americans) would choose PAS, (2) these patients would forgo an average of about four weeks of life, and (3) the medical costs in the last month of life for each patient who dies are roughly \$10,000, it is estimated that legalizing PAS would save approximately \$627 million<sup>53</sup>. When viewing numbers like these, it proves difficult to argue against legalization of PAS on the basis of economics and healthcare spending. Furthermore, when extrapolating from the Medicare data, one can calculate that the typical uninsured patient may save his or her family \$10,000 in healthcare costs by dying one month earlier by means of PAS, having spent as much as \$20,000 in that year already<sup>54</sup>. For those unable to accommodate the ever-rising cost of healthcare, legalization of PAS may be the most financially feasible option for these patients at this point in their illness. Legalizing PAS in the U.S. would save money and resources of the government and citizens alike. PAS should thus be legalized in order to allow the option to leave the world on one's own terms with a choice which by the nature of the decision itself would save resources for the U.S.

### **Conservative Approaches Against PAS and Rebuttal of Conservative Approaches**

Opponents of PAS and its legalization have generally conservative approaches to the matter. Harms of legalization of PAS like the "slippery slope" argument, being a burden to family and protecting the vulnerable are often cited as reasons for opposition to legalizing PAS. However, while such claims are necessary to spark an educated conversation on the topic, these claims are without stake and should not be taken into account when considering the legalization of PAS for patient choice at the end of one's life. The "slippery slope" argument "generally asserts that one exception to the law is followed by more exceptions until a point is reached that would initially have been acceptable"<sup>55</sup>. This argument against PAS is generally championed by

those who view PAS as a gateway to voluntary or involuntary euthanasia. While there may be some examples of the “slippery slope” abroad in countries like Belgium or the Netherlands<sup>56</sup>, with a law modelled after that of Oregon’s DWDA, the “slippery slope” would not exist at all, eliminating that argument as a reason for opposition to legalization of PAS in the U.S. In Oregon, the law is written so tightly, applying only to terminally ill people with six months or less to live, that the number of people who use it is less than half of one percent of all people who die in the state; this number is about 100 out of every 35,000 deaths, and is a statistic which has not changed in the last twenty years<sup>57</sup>. Even Daniel Lee, a leading ethicist in the United States and a long-time opponent of assisted dying, sees absolutely no evidence of the “slippery slope” in Oregon<sup>58</sup>. He states that the Oregon law, which limits PAS to medications that can be taken by the patient if he or she wishes, places a firewall that keeps the state from going down the so-called “slippery slope” towards euthanasia<sup>59</sup>. Others argue against legalization of PAS for reasons of patients feeling like a burden to their families, and thus feel coerced into utilizing PAS as an end-of-life measure. Eileen Geller, a spokesperson for True Compassion Advocates, a group that is against PAS argues, ““One person’s autonomy is another person’s coercion”” and adds that the message the patient actually receives once the idea of PAS is raised is that they should do it because they are a burden<sup>60</sup>. This essentially comes down to an idea that there is a perceived duty to die in the minds of the patients to lessen the burden they create on their family members or friends. However, since 2003, as seen in Oregon’s Death with Dignity Act Summaries, burden on family, friends and caregivers has remained fifth on the list of seven possible end-of-life concerns patients of PAS have cited through the years as reasons for pursuing PAS<sup>61</sup>. “Losing autonomy”, “less able to engage in activities making life enjoyable” and “loss of dignity” are cited time and again as reasons patients provide for requesting the lethal

medication, while “burden on family, friends and caregivers” is continually one of the lowest-cited reasons for undergoing PAS<sup>62</sup>. This low number, fifth of seven listed reasons for the last fifteen years, clearly shows that patients are not pursuing PAS because they feel like a burden, but rather because they wish to maintain their autonomy in the dying process. Autonomy, it seems, has become a driving factor in end-of-life decision-making. Yet another argument of PAS opponents is the idea of protecting the vulnerable. Safeguarding populations like the elderly, disabled and mentally ill from potential for coercion, for reasons like care burden or inheritance and euthanasia proves to be especially important. Still, any accusations that the vulnerable are unprotected are unfounded. In Oregon, the DWDA team crafted their proposed legislation building in safeguards to counter physicians’ concerns and their opponents’ objections, like the elderly and disabled being made vulnerable<sup>63</sup>. These safeguards, such as being a competent adult patient and having two physicians who practice in the area of terminal disease reach a prognosis of the patient having six months or less to live, have purposely made clear that patients who choose to undergo PAS are acting voluntarily and willfully with competence<sup>64</sup>. Other protections, such as requests being made orally and in writing, all other treatment options being explained to the patient, and fifteen days after the first request a new, oral, request has to be submitted in order to receive the lethal medication are also part of the Oregon DWDA and protect those populations who are of concern to PAS adversaries<sup>65</sup>. PAS, with the necessary safeguards as modelled within Oregon’s law, should be nationally legalized in the U.S. to allow patients the right to decide whether or not to pursue PAS an end-of-life measure. This self-advocacy and right to autonomy in dying should be afforded to any individual who qualifies under the set prerequisites of the law, and this can only be done if PAS becomes legal in all fifty states. Equality and autonomy in the dying process is of the utmost importance.

## Conclusion

It is plain to see that PAS should truly be legalized nationally in the United States. This legalization of PAS would allow patients the opportunity to make their own decision regarding the practice and whether or not they wish to pursue it as an end-of-life measure. Patient autonomy is an ever increasing sentiment in the medical community, especially for those who are nearing the end of life. Thus, individuals who qualify for PAS under a law surrounding its legalization, modelled after that of Oregon's DWDA, should be afforded a choice. What PAS is, the patients it relates to, public response and physician opinions, among other factors, support the legalization of PAS on a national level. For those like Brittany Maynard, PAS provides relief to know they do not have to die the way it has been described to them, allowing patients to enjoy the time they have left surrounded by those they love and pass in peace.

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