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# The Ethical and Economic Concerns of Physician Assisted Suicide

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# **The Ethical and Economic Concerns of Physician Assisted Suicide**

## **Introduction:**

The issue of physician assisted suicide (PAS) has been becoming increasingly relevant in the past decade as more countries and states have been adopting laws allowing its practice. PAS is defined as by the Canadian Medical Association as “knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs” (Canadian Medical Association 2007). PAS is often sought out from patients who are suffering from terminal illnesses with no prospects of survival. Many people who support PAS do so because it may limit the suffering of individuals who are terminally ill and allow these individuals to die in the way they prefer with dignity. Others support this practice because of its ability to save resources and time on individuals who will end up dying regardless of further treatment. However, many also object to the practice of PAS due to ethical concerns raised about whether or not the intentional taking of one’s life should be allowed or even legalized. Some major concerns towards PAS include the possibility it impacting “vulnerable” groups of people disproportionately and its potential for abuse of safeguards/control measures set in place if enacted (Pereira 2011). Others argue that PAS may not be as cost effective as many expect and point out that it may be difficult to determine whether or not a patient has no possibility of survival. As a result, public support of PAS in the U.S. has plateaued since the 1990’s in the range of 47%-69% (Emanuel et al. 2016).

Many countries have adopted legislation making PAS legal including the Netherlands, Belgium, Luxembourg, Colombia, Canada, and Switzerland (Emanuel et al. 2016). Five states in the U.S. (Oregon, Washington, Montana, Vermont, and California) currently allow PAS as well.

Of notable importance is Oregon's "Death With Dignity Act" (DWDA) which was enacted in 1997 and has provided insight into the statistics of PAS and how effective it is (Oregon Health Authority 2016). Data gathered from the jurisdictions where PAS is legal around the world has also given insight into the realities of PAS and those who participate in its practice. In what follows, I will present economic and ethical arguments towards PAS and explain why I believe PAS should be permitted.

### **Economic Advantages:**

The first thing that may come to mind when thinking about the economic advantages of PAS is the potential to save both resources and time on patients who are terminally ill. Usually when a patient is terminally ill, the expenses for medical care can rise quickly due to aggressive treatments, costly medications, and long durations of hospital visits. Not only do the expenses pile up for the patients and their insurance companies, but the expenses can pile up for the patients families as well. In the United States, family members provide substantial care to dying patients which adds to the costs of care at the end of life (Emanuel et al. 1998). Data obtained from the Netherlands has been useful in attempting to extrapolate the costs of PAS and the amount of money and resources it may save. In the Netherlands, about 80% of all PAS deaths involved patients with cancer (Emanuel et al. 1998). Extrapolating this data to the United States indicates that approximately 62,000 Americans would elect to participate in PAS if it were legalized federally (Emanuel et al. 1998). This represents about 2.7% of the 2.3 million people that die each year (Emanuel et al. 1998). Further analysis of the Dutch statistics indicates that the average length of life reduced in patients choosing PAS was around 3.3 weeks (Emanuel et al. 1998). An average reduction in life of 3.3 weeks means that the resources and effort used by the

doctors and healthcare professionals during this normal time period could be saved or allocated elsewhere to patients with legitimate chances of survival.

While this may seem promising, determining the amount of money potentially saved may make the advantages clearer. The best possible source of end of life care and costs in the United States comes from Medicare data. According to data in 1998, 33% of the medical costs in a person's last year of life are spent in the last month of life (Emanuel et al. 1998). This percentage indicates how severely costs can rise as an individual approaches the end of his/her life. Specifically for families of dying patients, the savings over this period of time could be substantial if PAS were chosen. Medicare data indicates that uninsured families could save nearly \$15,800 (2016 dollars) in end of life costs if a patient were to choose PAS (Emanuel 1998). The savings could be even larger if uninsured non-hospice patients were to choose PAS six months before their natural deaths (the earliest point allowed under proposals such as DWDA). If 2.7% of patients that die each year would reduce nearly 4 weeks of their lives by choosing PAS, that would equate to a savings of \$990 million (2016 dollars) on healthcare spending each year.

The final economic consideration for support of PAS is the potential savings in social security benefits for the government. Since the elderly constitute a majority of terminally ill patients who are likely to consider PAS, these are the individuals who are also receiving social security benefits each month. In the year 2015, nearly 43 million retired Americans received monthly social security benefits (Fact Sheet: Social Security 2016). The average monthly benefit for retired workers in 2015 was \$1,342 (Fact Sheet: Social Security 2016). This means that if the average patient who chooses PAS shortens their life by nearly 4 weeks, the government is saving an average of \$1,342 per patient who chooses PAS. Since nearly every patient who elects to

pursue PAS would be elderly/retired, the federal government would save money on the monthly benefits for each of the 62,000 people projected to pursue PAS annually. This equates to a savings of \$83.2 million dollars each year for the federal government. These projected savings could be allocated elsewhere for federal government spending or possibly contribute to lessening the federal deficit.

### **Economic Disadvantages:**

However, there are many limitations to these assumptions along with other points to consider. Since the calculations provided for savings are based on Dutch data, it is difficult to determine whether or not they can be accurately extrapolated to the United States. For example, surveys of American physicians have shown that a majority of them would refuse to provide suicide assistance even if it were legal (Emanuel et al. 1998). Therefore, fewer patients would be likely to receive PAS and that means less money would be saved overall. The assumptions also made about most patients dying of cancer means that some calculations could be overestimated. Patients with other terminal diseases such as multiple sclerosis have lower medical costs in comparison to patients with cancer meaning that less money would be saved by choosing PAS (Brown et al. 2002). In addition, while the savings of money and time may seem enticing, the savings of \$990 million each year only represents less than 0.07% of healthcare spending in the United States (Emanuel et al. 1998). This amount of savings is nearly negligible in the grand scheme of healthcare spending. Another factor to consider is the cost comparison of hospice care during the last two months of life to conventional care in the same time period. Medical expenses for patients in hospice care are substantially lower than patients receiving conventional care for similar illnesses (Emanuel et al. 1998). This means the projected savings of patients choosing PAS would be much smaller for patients under hospice care.

Not only will legalizing PAS not save as much money as many would have assumed, but the costs of legalizing its practice also must be considered. For example, Oregon's Death With Dignity Act contains requirements for physician consultations and referrals for patients considering PAS (Oregon Health Authority 2016). Patients who are eligible to request PAS must have confirmed diagnoses from a prescribing physician and a consulting physician (Oregon Health Authority 2016). In the case that either physician believes the patient's judgement may be impaired by a psychiatric or psychological disorder, the patient must be referred for psychological evaluation to confirm that the patient has sound judgement (Oregon Health Authority 2016). Referral of patients choosing PAS to other doctors and services would add to medical costs. Measure 16 of the DWDA also mandates that the state assembles statistics on the use of PSA meaning time and resources are being spent in order to gather this data (Oregon Health Authority 2016). In addition to these costs, legalizing PSA will undoubtedly lead to investigations and prosecutions of physicians who are suspected of violating safeguards. All of this would lead to increased medical and legal costs associated with PSA and reduce from the projected net savings.

An important question to consider when looking at the economic aspects of PAS is whether or not it is always certain that a patient will die from their illness. For example, consider a patient that has advanced stage cancer but is in so much pain and suffering from chemotherapy that he/she elects to pursue PAS. There could be a possibility that the doctor the patient is consulting is not completely correct in his/her diagnosis or prognosis. If a mistake is made in either the diagnosis or prognosis, then the patient may end his/her life when there was still a possibility of conquering the illness. If the patient were to recover from the cancer and go on to live a somewhat normal life, he/she would be able to be productive in society in numerous ways.

The patient could continue to be a consumer in the economy as well as an employee contributing services to a sector. Ending a patient's life early when the prospect of death from their illness was not always certain would eliminate the possibility of all of these economic benefits. In order for PAS to become a viable practice, there *must* be certainty that the patient's prognosis is accurate in order to avoid these costs.

### **Arguments Against PAS:**

Perhaps some of the biggest factors in assessing whether or not PAS should be legalized are the ethical considerations. Many arguments on both sides of PAS use ethical reasons to support their views. Therefore, I will begin by presenting the arguments against legalizing PAS and then present the arguments in favor of legalizing PAS in order to provide evidence to refute claims made by those opposing PAS legalization.

One of the biggest arguments against the legalization of PAS is the "slippery slope" that legalization may cause. The "slippery slope" argument asserts that one exception to a law or rule is followed by more exceptions until a point is reached that would have been initially unacceptable (Pereira 2011). Those who view PAS in the context of the "slippery slope" argue that PAS would be regulated with safeguards, but over time those safeguards could be followed less closely. As a result, instead of being a last resort, PAS could become an option that is sought out more quickly or even become a first choice for some people (Pereira 2011). This "slippery slope" has led many to worry about the potential for abuse of the safeguards set in place if PAS were to be legalized. For example, in the Netherlands more than 560 people (0.4% of all deaths) were given lethal substances without having given explicit consent (van der Heide 2007). The potential for abuse of safeguards is very worrisome due to the possibility of PAS becoming something comparable to euthanasia. Conflicts of interest with physicians are supposed to be

controlled under the Oregon DWDA but there are instances of disregard for that provision. For example, a physician member of a pro-PAS lobby group provided the consultations for 58 out of 61 consecutive cases of patients receiving PAS in Oregon (Pereira 2011). Other worrisome data indicates that no patients in 2007 who participated in PAS were evaluated by psychologists or psychiatrists (Pereira 2011). This is strange considering the prevalence of depressive syndromes among terminally ill cancer patients is around 59% (Chochinov et al. 1995).

The possible abuse of safeguards leads to another important consideration when legalizing PAS: the threat PAS could impose on “vulnerable” groups in society. Specifically, those considered most “vulnerable” include those who are elderly, disabled, female, uninsured, of low educational status, poor, chronically ill, affected with psychiatric illnesses, or of racial/ethnic minority (Battin et al. 2007). These groups of people have the potential to be disproportionately impacted when the options for PSA are presented. For example, those who are uninsured and diagnosed with a terminal disease could be persuaded by a physician or hospital to consider PSA because their interest could be to save money rather than spending resources on someone that will die anyway. The possibilities are limitless for abuse but there appears to be little evidence supporting the assumption that these groups are affected disproportionately.

In addition to the possibilities for impacts on vulnerable groups, the possibility for social pressure on those who are terminally ill to choose PAS is another major concern. It is very likely that a patient who knows that he/she is terminally ill will feel as somewhat of a burden on those around him/her. Studies have shown that in Oregon and Washington in 2010, nearly 25% of patients who died from ingestion of lethal drugs did so, at least in part, because they no longer wanted to be a “burden” on their family members (Oregon’s Death With Dignity Act 2010). This evidence is worrisome since it may indicate that many patients are choosing PAS because they

may feel forced or feel pressure from their own families to pursue it. For example, the Oregon Death With Dignity Act requires two people to be present during the request for PAS (Oregon Health Authority 2016). However, one of those people can be a family member which raises the question of whether or not that family member could have coerced the patient into electing to pursue the option of PAS (Harned 2012). If PAS is to be legalized, safeguards pertaining to the possibilities of coercion/pressure from families and people around the patients must be put into place to protect patients.

Another concern for the legalization for PAS is the possibility for people becoming deterred from palliative care once PAS is included as an option. Usually when a patient is nearing the end of their life, they are sent to hospice where nurses and physicians practice “palliative care”. Palliative care is defined by the World Health Organization as “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.” (Herx 2015). The goal of palliative care is to make patients as comfortable as possible when nearing the end of their lives. Unfortunately, many patients and families are reluctant to pursue palliative care due to the mistaken belief that death is imminent and they are giving up hope (Herx 2015). Many argue that the addition of PAS to palliative care would deter patients from pursuing this option and they would end up suffering more as they lack the resources to die comfortably in hospice (Hudson 2015). Dr. Leonie Herx even goes as far to say that “Physician-assisted suicide and euthanasia go against the very core of the palliative care approach and have no place within palliative care.” (Herx 2015).

One of the core values of medicine is the principle of non-maleficence. This is the notion that a physician should “do no harm” towards a patient (Pantilat 2008). This means that physicians should refrain from providing ineffective treatments or acting with malice towards patients (Pantilat 2008). This principle by definition goes directly against the practice of PAS. However, this principle can become subjective and difficult to interpret in certain scenarios such as providing treatments that also have serious risks. The important ethical issue that comes into play with this principle is whether the benefits outweigh the burdens. In the case of PAS, a physician must decide whether the benefit of saving a person from suffering will outweigh the harm of shortening that person’s life by an act that intentionally kills the patient. Many opponents against legalization of PAS cite non-maleficence as a core value of why PAS should not be legalized.

#### **Arguments in favor of PAS:**

A major reason for increasing support of legalization of PAS comes from the hope to limit the suffering of patients who suffer from terminal diseases. Supporters of PAS place a high value on personal autonomy which is commonly lost in the late stages of a terminal disease. The loss of autonomy can be diminishing for a patient and add to the physical and emotional suffering already ongoing from their terminal disease. The role of a physician is not only to preserve one’s life, but to also help improve their patients’ health and alleviate their suffering. If a patient’s life cannot be preserved indefinitely, then the best a physician can hope for is to alleviate their suffering and let a patient make his/her own decisions. Between March of 2009 and December of 2011 in Oregon, 255 patients chose to participate in the Death With Dignity program (Death With Dignity Act Annual Reports 2016). Out of those patients, 97% cited a loss of autonomy as their reason for participation while 75% of participants also listed loss of dignity

as their reason (Death With Dignity Act Annual Reports 2016). These numbers indicate that a majority of the people who are choosing PAS are doing so because of their own dignity and loss of independence. To these patients, taking action to end their own life is better than passively waiting for death to occur.

Evidence has shown that implementation of PAS with safeguards and regulations (such as informed consent policies and comprehensive screening) have not led to widespread abuse (Physician Assisted Suicide 2013). Data from Oregon and Washington has shown that the majority of patients who request PAS are well educated white men who are not a group that is considered to be “vulnerable” (Physician Assisted Suicide 2013). Evidence also indicates that “vulnerable” patients have been receiving PAS at rates equal to those in the general population (Emanuel et al. 2016). Also of notable importance from Oregon and Washington is the fact that only a small fraction of those who inquire about PAS actually elect to participate (Physician Assisted Suicide 2013). This is due to the fact that the option of PAS is a choice that can be abandoned at any point in time in the process under the laws in Oregon and Washington. The provisions in Oregon’s DWDA specify that every patient must be informed of alternative options such as comfort care, hospice care, and pain control (Oregon Health Authority 2016). Research into Oregon’s Death With Dignity Program between 2009 and 2011 has also shown that patients and families were grateful to receive lethal prescriptions (whether or not they were used) (Loggers et al. 2013). This indicates that the patients seeking out this program are doing so because they see PAS as a merciful option compared to prolonged suffering and loss of autonomy. With these provisions set in place, Oregon and Washington have shown that PAS can be carried out in an ordered manner without expansion or abuse of the practice. The concept that

legalization of PAS will lead to a “slippery slope” of further practices has been proven false by the success of the DWDA and Washington legislation.

Furthermore, the argument that legalization of PAS will lead to more people refusing palliative care holds little ground when considering the fact that physicians are professionals who will fully explain the details of palliative care and options for PAS to the patient who is worried. One of the most important provisions of legislation that has been enacted making PSA legal is the requirement of informed consent. Patients are fully informed of their options and it is made very clear that the choice to pursue PAS can be abandoned at any time.

In response to the argument against PAS which cites the principle of non-maleficence, it is important to weigh the benefits of PAS against the obvious harm of ending the patient’s life. A physician is supposed to act in the best interest of the patient and not intentionally harm him/her (Pantilat 2008). However, when the burden of suffering, loss of autonomy, and loss of dignity have reached a certain point for an individual, a physician almost has an obligation to take action and respond to a request from a patient for PAS in order to ease that burden. Some would consider refusing a patient’s request for PAS as going against the principle of non-maleficence. By disregarding a patient’s wishes to end his/her own life, a physician is intentionally prolonging that patient’s suffering which is nearly the same as acting with malice.

**My Viewpoint:**

Taking all of these arguments into consideration, I believe that individuals should be given the right to take control of their own lives and decide when they would like to die on their own terms. Jurisdictions with legal PAS have proven that safeguards can effectively control the use of this practice and that “vulnerable” groups are not disproportionately impacted (Battin et al. 2007). Not only does legalizing PAS help limit the suffering of individuals who are near the end

of their lives, but it also allows time and resources to be saved in the medical field and from the federal government (no matter how small). The number of people who may actually elect to pursue PAS if it were legalized may be a very small percentage of those nearing the end of their lives, but being able to provide comfort and limit the suffering of those few individuals is still extremely important to preserve every individual's right to autonomy. All individuals, no matter how few, deserve to be in control of their own lives. This is a fundamental right that all humans are deserving of. As long as proper safeguards are set in place and physicians follow protocols of informed consent and conflicts of interest, PAS can be carried out in a safe and ethical manner. The current laws in Oregon and Washington have safeguards that attempt to limit the abuse of patients and their rights. However, these safeguards are nowhere near perfect and will need further revision to limit the possibilities of coercion and misdiagnoses of terminal illnesses. Until stricter safeguards are put into place, the current systems in Oregon and Washington will leave some patients vulnerable to coercion and improper treatment. Therefore, the option of PAS for terminally ill patients should be considered a right and stricter safeguards must be put into place in order to ensure that safe and ethical decisions are made in regards to patients who truly wish to pursue PAS on their own. Once this is accomplished, PAS will allow patients to determine how they wish to live the remainder of their lives without being forced to suffer any longer than they want. Taking all of this into consideration, I believe that PAS would be beneficial to the people of the United States and should be legalized at the federal level.

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