

Physician Assisted Suicide: A Psychiatric Perspective

Committee on Therapeutic Care  
Of the  
Group for the Advancement of Psychiatry

Alan M. Gruenberg, M.D., Chairperson

Thomas E. Curtis, M.D.

Donald C. Fidler, M.D.

Donald W. Hammersley, M.D.

William B. Hunter, M.D.

Milton Kramer, M.D.

John Lipkin, M.D.

Robert E. Switzer, M.D.

We acknowledge the contributions of our fellows, Andrew Rosensweig, M.D. and  
Bridgete Robertson, M.D. and our consultant, Jennifer Trahan, Esq.

“To cure sometimes, to relieve often, to comfort always.”

French Folk Saying, 15<sup>th</sup> Century

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## Chapter 1. An Introduction

One of the major moral dilemmas that confronts a physician in working with the dying patient is how to respond to the request a patient makes to be assisted in ending one's life. The legal right to refuse or to terminate treatment has been well established. The right has been supported in a decision of the U.S. Supreme Court <sup>(1)</sup>. The development of living wills and durable medical powers of attorney are implementing strategies that bolster the patient's right to control the nature and extent of medical treatment in the future. <sup>(2)</sup>.

The right to have medical assistance in ending one's life in the terminal phase of a life threatening illness, has become the focus of vigorous debate in our country <sup>(3)</sup>. Dr. Jack Kevorkian has focused public attention on the plight of suffering terminal patients who desperately want relief from their suffering <sup>(4)</sup>.

In a more subdued and genteel manner, Dr. Timothy Quill has been an effective medical spokesman in calling attention to the desperate need of suffering terminal patients who request to have the help of their physician in providing a death with dignity. The patient wants the physician to provide the tools (medication) to end his suffering and to end his life. Dr. Quill has provided an example of physician-assisted suicide from his own practice, faced possible prosecution, and developed guidelines that might be used in implementing physician-assisted suicide <sup>(5)</sup>. His guidelines would protect the patient, the physician, and the patient's family.

The Dutch have provided us with a legally sub rosa but nationwide application of physician-assisted suicide <sup>(6)</sup>. It has sparked vigorous debate both in Holland and in the United States <sup>(7)</sup>. The recognition that life termination in the Netherlands has gone beyond responding to the requests of presumably rational, suffering terminally ill patients, has been a cause for alarm <sup>(8)</sup>. The Royal Dutch Medical Society has called for a review of the program and for some degree of containment <sup>(9)</sup>.

The state of Oregon in 1994 passed a law legalizing physician-assisted suicide and set up guidelines for its application which were quite similar to those Dr. Quill had suggested <sup>(10)</sup>. The law is currently being

implemented. There were 15 reported deaths in Oregon during 1998 of patients who were assisted by their physician in dying.

The Group for the Advancement of Psychiatry has had a long-standing interest in the psychological aspects of the final stage of life. At a symposium entitled Death and Dying: Attitudes of Patient and Doctor in 1963, members of the Committee on Aging focused on experience, attitudes, and responses to the process of dying<sup>(11)</sup>. The Committee on Aging addressed the more particular issue of life termination in a symposium entitled The Right to Die: Decision and Decision-Makers in 1971<sup>(12)</sup>. Both symposia set out clearly the background for the current debate on euthanasia and in particular, physician-assisted suicide.

In the 1963 symposium, members generally took the position that the psychologically mature person would come to accept, with some degree of tranquility, the inevitability of one's demise (death)<sup>(11)</sup>. The counsel that Dylan Thomas offered his father was not to go gently into the good night<sup>(13)</sup>. This counsel was rejected in favor of the philosophical view of Lao Tze that "Who dies, and in dying does not protest his death, he has known a true old age". This sanguine position was somewhat qualified by the observation that a balance between acceptance and rejection was the more usual mature response, a response described as a "qualified immunity".

In the 1963 symposium the denial of death was linked to our need as individuals to control our fate<sup>(11)</sup>. The belief that we can control our fate is fed by the significant contribution to "premature" death of factors over which we have some control: accidents, suicides and homicides. The recognition that not all factors causing death are inevitable implies for the individual that one may be able to control longevity or to prolong the inevitable. The issue of control was discussed but was not a central topic.

In the 1963 symposium, participants advocated telling the patient, who really already knows, that he or she has a fatal disease. This allows talking about the illness so that the threat of being alone, the core threat in dying, is diminished. To maintain life, in the final phase of living, aloneness must be undercut, hope must be sustained, and meaning must be explored.

In the 1971 symposium The Right to Die: Decision and Decision-Makers the focus was on the autonomy right of the suffering patient in the final phase of life <sup>(12)</sup>. It was directed, not to acceptance, but rather towards control. There was strong support for the right of the suffering patient to decide when and how he would die. There were acceptable reasons for wanting to die. There was a clear recognition that for the human animal, the quality of life was a key determinant of life. The patient should have the right to refuse or to stop unwanted treatment. In the same vein, the standard for the withdrawal of life support should be the permanent loss of consciousness, not the cessation of organ function. The right of the individual to control the circumstances surrounding the end of his life was supported.

In the 1971 symposium there were caveats raised in the exploration of the patient's right to die <sup>(12)</sup>. A concern was expressed about possible subtle social pressures that might encourage the suffering terminal patient to hasten his death. Premature termination of life could be used as a hostile, destructive gesture toward the living, rather than coming to terms with death. One voice, Maurice Linden, spoke for engaging the hopeless patient in a process that restored hope and meaning to life and effectively countered the wish to die.

The philosopher and sage Abraham Kaplan summarized the remarks of the 1971 participants in a highly sympathetic and evocative manner <sup>(12)</sup>. He saw as an elementary right, possessed by all men, the right to die and to decide when to die. He concurred in the view of the hypocrisy of a state that says it can send its citizens to die in war, terminate their lives for crimes they have committed, but withholds the right of the suffering terminally ill to end their lives. Professor Kaplan acknowledged that for physicians, death is the enemy, and that physicians are dedicated to saving lives. He reminded us of the injunction from Deuteronomy in which God says, "Behold, I have this day set before you the way of life and the way of death. Now, therefore, choose life!" However, human life has a significant qualitative dimension. He agreed that death could be a relief from the burdens of life. The doctor must not abandon the patient to loneliness and depersonalization. The doctor's own fear of death must not lead to the over response of

futile treatment or the under response of withdrawal and neglect. Professor Kaplan concluded that, "If the person's life has been fulfilled, then death can be a closure in which dignity may remain".

The symposium audience raised a number of issues that should have been addressed by the speakers. Such issues included the recognition that death is a social matter and that death affects the bereaved survivors. The meaning of death and the rituals that surround it vary significantly from culture to culture. It was the failure to address euthanasia and particularly the physician's role in euthanasia that was thought by the audience to be missing in the symposium.

It is the request, if not the demand by the patient that one has the right to have physician assistance in dying and to die with dignity. This is the unfinished business from the 1971 symposium on the Right to Die<sup>(12)</sup>. It is this issue that focuses attention by the Committee on Therapeutic Care of the Group for the Advancement of Psychiatry. What is stance of the physician and particularly the psychiatric physician in respect to euthanasia and to physician-assisted suicide? Physician-assisted suicide is the major moral dilemma for American physicians. Hopefully, in this examination we will serve to illuminate the problems inherent in physician-assisted suicide.

## References

1. Cruzan vs Director, Missouri Department. of Health, 497 U.S. 261 (1990).
2. Omnibus Budget Reconciliation Act of 1990, Pub L No 101-508. 4206, 2751.
3. Humber, J.M., Almeder R.F. and Kasting G.A. (Eds). Physician Assisted Death. Totowa, New Jersey: Human Press, 1994.
4. Kevorkian, J. Prescription Medicide. Buffalo, N.Y.: Prometheus Books, 1991.
5. Quill, T.E.: Death and Dignity: Making Choices and Taking Charge. New York: W.W. Norton & Co., 1993.
6. Van deer Amass, P.J. van Deled, J.T.M., Pignenborg L. and Looman, C.W.N. Euthanasia and other Medical Decisions Concerning the End of Life. *Lancet* 338:669-74, 1991.
7. Rigter H. Euthanasia in the Netherlands: Distinguishing Fact from Fiction. *Hasting Center Report Supplement* 19:31-32, 1989.
8. Gomez, C.F. Regulating Death: Euthanasia and the Case of the Netherlands. New York: Free Press, 1991.
9. Dutch Group Favors Distancing Doctors from Euthanasia. *American Medical News*. September 11, 1995.
10. Oregon Death with Dignity Act. Ballot Measure 16, November 8, 1994, General Election.
11. Group for the Advancement of Psychiatry. *Death and Dying: Attitudes of Patient and Doctor*. GAP Symposium #11, October 1965.
12. Group for the Advancement of Psychiatry. *The Right to Die*. GAP Symposium #12, November 1973.
13. Thomas, Dylan. Quote From "Do Not Go Gentle into That Good Night".

## Chapter 2. Definitions

What do physician-assisted suicide and what is excluded mean? The work of Koenig<sup>(1)</sup> and Lundberg<sup>(2)</sup> provide some distinctions that are potentially useful. Koenig<sup>(1)</sup> describes passive euthanasia “as involving the removal of tubes, respirators or any other type of artificial support that may prolong life”. Physician-assisted suicide “occurs when a physician intentionally and willfully takes actions that help a suicide to end his or her life.” “This may involve providing information on ways of committing suicide, supplying a prescription for a lethal dose of medication, providing a syringe filled with a lethal dose of medication, inserting an intravenous line so that the patient can inject the drug, or providing a suicide device that the patient can operate”. “Active euthanasia involves a physician willfully and intentionally performing an action that directly and immediately results in the patient’s death. Here, the physician is the actor, but acts at the patient’s request.” “Some but not all see differences between passive forms of assisted suicide (providing a lethal dose of medication or apparatus to inject it) and active euthanasia (physician injecting a lethal drug), pointing to different degrees of physician influence or control over the process leading to death”.

Lundberg<sup>(2)</sup> defines euthanasia as “an easy death or means of inducing one, or the act or practice of painlessly putting to death a person suffering from incurable conditions or diseases.” He believes there are six identifiable major types of euthanasia. He offers examples of each:

1. Passive. A physician may choose not to treat acute bronchopneumonia or sepsis in a person with Alzheimer’s disease or may not resuscitate a patient with carcinomatosis who has experienced a cardiac arrest.
  2. Semipassive. A physician may withhold medical treatment, such as nutrition or fluids, from a person who is in coma from postnecrotic cirrhosis and hepatoma with cerebral metastasis.
  3. Semiactive. A physician may disconnect the ventilator from a patient who is in a stable vegetative state from massive cerebral infarction and has no hope of regaining consciousness.
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4. Accidental (“double-effect”). A physician may administer a narcotic to relieve bone pain in a patient with terminal metastatic breast cancer, and the narcotic may incidentally depress respiration sufficiently to cause death directly or facilitate the development of a fatal bronchopneumonia.
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5. Suicidal. A person with metastatic lung cancer may intentionally overdose on alcohol and barbiturates causing his or her own death; a physician may have provided the drugs.
  6. Active. A physician may administer a large, surely fatal overdose of morphine or potassium to a patient with the acquired immune deficiency syndrome who has widespread Kaposi’s sarcoma, pneumocystis carinii pneumonia, and the dementia of cerebral toxoplasmosis .

The first four euthanasia categories Dr. Lundberg views as legal. The fifth is often practiced. The sixth is illegal and feared by physicians as uncontrollable and contrary to our cultural beliefs. Dr. Lundberg believes physicians must confront the problem of physician-assisted suicide. We can ignore the public demand or develop guidelines to cover the passive-active continuum of “euthanasia”. Working with informed and consenting patients, close family members, appropriate religious advisors, and knowledgeable and consenting physicians, we can deliberate together with full disclosure and documentation, developing a series of rules such as Quill<sup>(3)</sup> has suggested for P-A.S..

Dr. Lundberg writes “pain and human suffering, quality of life, productivity, and financial costs to individuals and society must be weighed together against perceived benefits of preventing death by prolonging dying”. We must as physicians “...honor a tradition that has persevered for thousands of years: the necessity to preserve the best possible life for the longest possible time. When one backs away in any sense from the utter sanctity of maintaining human life, the slope becomes very slippery indeed”.

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The euthanasia continuum, which Dr. Lundberg describes, is essentially a passive-active one. He raises a number of points in regard to suffering, the quality of life, and financial costs, all of which need clarification and definition. Who will define suffering, the quality of life, or the value of a human life?

It may be worthwhile to quote that part of the Hippocratic oath related to our present exploration, “...I will

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Give no deadly drug to any, though it be asked of me, nor will I counsel such". The active and some of the passive forms of euthanasia are proscribed. The active form of euthanasia is also clearly forbidden by the AMA Ethical Code<sup>(4)</sup>.

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It is crucial to recognize as Cassell<sup>(5)</sup> has pointed out that "bodies don't suffer, people do". This directs our attention towards the person who is suffering, not just on the illness in his or her body. Those who request P-A.S. are requesting relief from their suffering; they no longer want to endure the pain, harm, injury, or loss that define their suffering. Physical pain is not the major reason for requesting life termination. When asked in a survey<sup>(6)</sup> why they might request P-A.S, Americans place not being a burden on their families first (47%) and to avoid pain second (20%). Patients in Holland<sup>(7)</sup> who have requested P-A.S. gave loss of dignity (57%) as their main reason with avoidance of pain second (46%). The so-called nobility of suffering is more often experienced as some sort of unfair unpunishment or penalty, one the sufferer feels is unjust and from which he seeks relief.

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When life has become senseless as a result of suffering, some patients want help in dying. The loss of life's significance is inevitably the consequence of how the patient assesses the quality of life. A life without meaning is a life not worth living is the formula that can be applied in the patient's request for P-A.S. The suffering that the patient experiences leads to the request for P-A.S. Pain relief without restoration of meaningfulness to life, may serve as an inadequate correction.

We have not addressed the complexities of determining terminal illness that underlies the patient's suffering. Given the difficulties in predicting death, how long before death is a patient terminal? If a patient is suffering, must he or she be terminal? Dr. Kevorkian has assisted patients who are not terminal, and the Dutch have extended their assistance to patients who are not terminal.

## References

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- 1) Koenig, H.G. Legalizing Physician-Assisted Suicide. Some Thoughts and Concerns. *J Family Practice* 37:171-179, 1993.
  - 2) Lundberg, G.D. 'It's Over, Debbie' and the Euthanasia Debate. *JAMA* 259:2142-2143, 1988.
  - 3) Quill, T.E. Death and Dignity: Making Choices and Taking Charge. New York: W.W. Norton and Co.,1993.
  - 4) Council on Ethical and Judicial Affairs. Code of Medical Ethics: Current Opinions with Annotations. Chicago: American Medical Association, 1994.
  - 5) Cassell, E.J. The Nature of Suffering and the Goals of Medicine. New York: Oxford University Press, 1991.
  - 6) Blendon, R.J., Szalay, U.S. and Knox, R.A. Should Physicians Aid Their Patients in Dying? The Public Perspective. *JAMA* 267:2658-2662, 1992.
  - 7) Van der Maas, P.J., van Delden, J.J.M., Pijnenborg, L., and Looman, C.U. Euthanasia and other Medical Decisions Concerning the End of Life. *Lancet* 338:669-674, 1991.

### Chapter 3. Legal Issues

Medicine in the United States, as a regulated profession, has a long history of involvement with the legal system. The privilege to practice medicine is delineated on a state by state basis by the legislature of each state and controlled through a regulatory medical board. Both state and federal authorities regulate a physician's prescribing of medication. Physicians are open to civil and criminal prosecution for breaches in professional conduct. Physicians contribute to decision-making in administrative, civil, and criminal legal procedures in their roles as medical examiner or expert witness.

One area of the law in which psychiatry is more specifically involved with the legal system than other branches of medicine involves establishing the mental competence or incompetence of a person (or patient). Psychiatrists have been central in assisting courts in making these decisions. If patients are judged to be incompetent, then patients can be held in a health facility against their will. If incompetent, patients can be treated over their objections in some circumstances. As a result of a competency hearing, the last will and testament of a deceased person can be set aside.

If physician-assisted suicide (P-A.S.) is legalized in the United States, then psychiatrists may be asked, as part of the legal regulatory process, to certify that the patient is not mentally ill and mentally competent to request assistance in dying. If all patients seeking P-A.S. had to be screened for competence, psychiatrists would object<sup>(1)</sup>.

Psychiatry, therefore, may engage the political process as advocates for or against P-A.S. Psychiatrist may welcome an understanding of the legal principles that bear on the questions surrounding "the right to die".

The freedom to act, free of legal encumbrances, is a right that has been guarded as precious by the United States Constitution and by the United States Supreme Court in its constitutional interpretations. The Bill of Rights, in the 9<sup>th</sup> Amendment to the Constitution, after enumerating a number of specific rights in the preceding amendments, makes clear that the list is not inclusive, and that there are rights which remain with

the individual. The 9<sup>th</sup> Amendment provides that "...the enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people." In his dissent in *Olmsted vs. the United States* (1928)<sup>(2)</sup>, Brandeis concluded that the makers of the Constitution "...conferred (to the individual) as against the government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men". This was cited by Justice Goldberg in *Griswold vs. Connecticut* (1965),<sup>(3)</sup> which first recognized marital privacy rights. Justice Douglas in *Roe vs. Wade* (1973)<sup>(4)</sup> pointed out that one area of privacy under the liberty right in the 14<sup>th</sup> Amendment was "...freedom from bodily restraint or compulsion, freedom to walk, stroll, or loaf." Justice Harlan opined, "liberty guaranteed in the Due Process Clause of the 14<sup>th</sup> amendment "...is not a series of isolated points...and...includes a freedom from all arbitrary impositions and purposeless restraints...and which also recognizes...that certain interests require particularly careful scrutiny if state needs are asserted to justify their abridgement." (*Poe vs. Ullman*, (1961)<sup>(5)</sup>).

One has the freedom to act, to have freedom, and to do what one wants. What about the right to decide when to die? The state has an obligation to restrain certain activities because it has an obligation to protect the life of its citizens<sup>(6)</sup>. From a legal point of view, suicide is an act, which the state will go to great lengths to prevent. The state has a general interest in preserving the life of its citizens and a more specific interest in preventing suicide. The state has an interest in avoiding the involvement of third parties and precluding the use of arbitrary, unfair or undue influence, particularly among the elderly, the infirmed, and the poor and minorities, to assent to their own death. The state wants to protect innocent people such as individuals with depression, children, individuals who are handicapped, and those individuals who are an economic burden to society from life termination. The state has an interest in protecting family members and loved ones. The state has an interest in protecting the integrity of the medical profession. The state has an interest in avoiding the adverse consequences that might ensue from permitting physician-assisted suicide as has been reported to have occurred in the Netherlands<sup>(6)</sup>.

Is the right to decide when to die a fundamental right? It is not mentioned in the Constitution or its amendments. Other rights have been found that are not stated directly in the Constitution. Will the right to decide when to die become one of those rights?

What is the basis for finding a right, which has no textual support in the language of the Constitution?

This finding rests on the view that fundamental liberties are so-called because they are “implicit in our concept of ordered liberty” and that “neither liberty nor justice would exist if they were sacrificed.” (*Palko vs Conn*, 1937)<sup>(7)</sup>. Fundamental liberties are considered to be those that are “deeply rooted in the Nation’s history and tradition” (*Moore vs City of East Cleveland*, 1977)<sup>(8)</sup>. The fundamental rights that have been recognized are those contained in the Bill of Rights. The freedom of association, equal participation in the political process, the right to interstate travel, and the right to basic fairness in criminal procedures are maintained. Procedural safeguards against governmental deprivation of life or liberty and the right to privacy are also recognized. The right to privacy is family oriented and involves personal decisions in regard to marriage<sup>(9)</sup>, procreation<sup>(10)</sup>, family relationships<sup>(11)</sup>, child rearing, education<sup>(12)(13)</sup>, contraception<sup>(14)</sup>, and abortion<sup>(4)</sup>.

Is the right to decide when to die another privacy right? If there were a right to decide when to die, as there is a right to terminate an unwanted pregnancy, then the involvement of physicians is required. Since a physician may terminate a pregnancy, physicians may be asked by right to die supporters to assist in life termination. A patient’s relationship to a physician during treatment for a terminal illness bears on the problem.

There has been a long history in English Common Law and codified by state legislatures that a competent person has the right to refuse medical treatment. The modern history of these cases starts with *Karen Quinlan* in New Jersey (1976)<sup>(15)</sup>, *Saikewicz* in Massachusetts (1977)<sup>(16)</sup>, *Bouvia* in California (1986)<sup>(17)</sup> and ends with the United States Supreme Court’s decision in the case of *Nancy Cruzan* (1989)<sup>(18)</sup>.

In order to treat a patient, one needs the permission of the patient. To treat a mentally competent adult against his or her will is considered illegal. In order to treat a patient against one's will, an incompetency judgment must be accomplished. In assessing the patient decision to refuse treatment, the consequences of no treatment is not an issue.

The United States Supreme Court has observed that "...no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of the law"<sup>(18)</sup>. As a result, one requires the informed consent of the patient to engage in a medical treatment. Justice Cardozo aptly described this doctrine: "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages"<sup>(19)</sup>.

Ms. Karen Quinlan was in a vegetative coma on life support and her parents petitioned for removal of the life supports. The hospital where she was hospitalized and her physicians opposed this decision. The State Supreme Court of New Jersey<sup>(15)</sup> found that Ms. Quinlan's parents, as her guardians, had the right to stop such treatment and have her taken off her respirator. They held that Ms. Quinlan had a privacy right to terminate treatment grounded in the Federal Constitution.

After Quinlan, most courts have subsequently based a right to refuse treatment either solely on the common law right to informed consent or on both the common law right and a constitutional privacy right<sup>(18)</sup>.

The guardian of a severely retarded 67 year- old leukemia patient who was resident in a state institution refused medical treatment for his charge. The Supreme Court of the State of Massachusetts<sup>(16)</sup> upheld the guardian's right as "a person has a strong claim in being free from non-consensual invasion of body integrity (1977)." However, the Court went further and said, "... of even broader import...is the constitutional right to privacy".

Ms. Bovia, a 28 year-old competent, quadriplegic patient in California requested that the feeding tube, which had been placed against her, be withdrawn. The California Appeals Court (1986) <sup>(17)</sup> upheld her right to refuse treatment and ordered the tube withdrawn. The Court explicitly stated that her motivation and the consequence of her decision could play no role in altering her right to refuse treatment. The Court saw the decision to terminate one's life as the ultimate exercise of one's right to privacy. This is a striking contrast to Callahan's view<sup>(20)</sup> following John Stewart Mill, that a free man does not have the freedom to embrace an activity such as slavery, which would destroy his freedom. The decision to destroy life cannot be seen as consonant with one's right to control one's life.

The United States Supreme Court has held that privacy does not protect all personal decisions. One's choice of living companions can be restricted by ordinance,<sup>(21)</sup> and there is no constitutional right to homosexual sodomy between consenting adults <sup>(22)</sup>.

The implications of legal arguments supporting the right to assistance in dying are quite different if the line of argument supporting a decision is based on a right to refuse medical treatment or on the basis of a right to privacy. The former implies a passive position protecting bodily integrity, while the latter implies the right to an activity in which positive action can be taken.<sup>(23)</sup> If P-A.S. is seen as a privacy right, the state would be prohibited from interfering, and physicians could be permitted to assist in life termination.

The United States Supreme Court's only "right to die" decision prior to its June 26, 1997 decisions<sup>(6)(24)</sup> occurred in *Cruzan vs. the Director, Missouri Dept. of Health*<sup>(18)</sup>. The parents of Nancy Cruzan, who was in an irreversible vegetative coma, petitioned that her nutrition and hydration be withdrawn. The Court acknowledged that the United States Constitution grants a competent person a constitutionally protected right to refuse-life saving hydration and nutrition. However, the State could demand that prior evidence of the incompetent patient's wishes be provided by clear and convincing evidence before the life support could be withdrawn.

In a concurring decision, Justice Scalia held in the Cruzan Case, that there is no constitutional right to suicide or any form of elective death. Suicide can be accomplished by passive means such as refusing to take medication or refusing to continue dialysis that would lead to death or by active means such as engaging in activities that are intended to cause death. He argued the intent is the same and the distinction questionable.

The significance of this holding is that the liberty interest in Cruzan is related to the right to refuse treatment and not a privacy right. This distinguishes the decision from that in Roe vs. Wade<sup>(3)</sup> and particularly from Casey vs. Planned Parenthood<sup>(23)</sup>, a reaffirmation and elaboration of Roe vs Wade. If the Cruzan decision were seen as analogous to other privacy protections, then the right to die would be a foregone conclusion. This would not preclude the right of the states to limit the right to physician-assisted suicide with rules and regulations, as they did the right to abortion.

The U.S. Supreme Court on June 26, 1997 rendered its opinion that the prohibition on assisting suicide does not violate either the Equal Protection Clause<sup>(24)</sup> or the Due Process Clause<sup>(6)</sup> of the 14<sup>th</sup> amendment. The court recognized that "...Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits the debate to continue..." and "...allow(s) reasonable legislative consideration"<sup>(6)</sup>.

If physicians address meaningfully physician-assisted suicide in the public arena, then it is essential to understand the Court's reasoning in finding no constitutional right to physician-assisted suicide.

Misunderstandings between physicians and the legal community are often due to a lack of knowledge of each other's views. Clarification of the finding of no constitutional right to assisted suicide by the Supreme Court either under the Equal Protection Clause<sup>(24)</sup> or the Due Process Clause<sup>(6)</sup> may be required.

A challenge has been brought by physicians and patients in New York State<sup>(24)</sup> stating that the mentally competent, terminally ill, were differentially treated based on whether they were on life support systems or not. Those on life support could have their wish to die honored by requesting of their physicians that their

life support systems be withdrawn. Those terminally ill, mentally competent not on life support, could not get their wish honored by their physician's prescribing medication that would end their lives. The physicians asserted that it would be consistent with the standards of their medical practice to prescribe lethal medication for mentally competent, terminally ill patients who are suffering great pain. Patients request their doctors' help in taking their lives, but they are deterred from doing so by New York State's assisted suicide ban. The U.S. Second Circuit Court of Appeals (New York) agreed with the petitioners and saw no difference between withdrawing life support or taking medicine to die when the intent and outcome were the same. The U.S. Supreme Court did not agree and saw the patient petitioners as differently situated. To let nature take its course such as withdrawing life support, is different than affirmatively intervening such as taking pills to facilitate death. The Equal Protection Clause was not violated. The Court saw mentally competent terminally ill individuals on life support as differently situated than those who were not on life support.

The physicians and claimants from the State of Washington<sup>(6)</sup> asserted that there is a liberty interest based upon the Due Process Clause of the 14<sup>th</sup> Amendment, which extends to mentally competent, terminally ill adults, the right to commit suicide with a physician's assistance. The claim relies on the Court's decisions in two cases: Nancy Cruzan<sup>(18)</sup> and Casey<sup>(23)</sup>. The former gave control over one's body, an autonomy issue, to the individual to decide not whether to live or die, but how to die, i.e. by withdrawing life support. In Casey, the right to define the meaning of one's life and the right to make intimate decisions was described as an autonomy issue and was seen as fundamental to liberty. The right to choose when to die was argued by the Washington State claimants as similar to the right of a woman to have an abortion.

The U.S. Supreme Court applied its two-part substantive due-process analysis<sup>(6)</sup>. First, the Court did not find that the right asserted for physician assisted-suicide is rooted in the nation's history and tradition. Second, a careful, specific description of the liberty interest in question was not provided. The liberty interest was variously described as 1) a right to determine the time of one's death, 2) the right to die, 3) a liberty to choose how to die, 4) a right to control one's final days, 5) the right to choose a humane, dignified death, and 6) the liberty to shape death. The Court felt that the specific question at issue was

whether the liberty protected by the Due Process Clause includes a right to commit suicide, which would include a right to assistance in doing it. Casey<sup>(23)</sup> recognized that many of the rights protected by the Due Process Clause are grounded in personal autonomy, but the Court noted that not all important, intimate, and personal decisions have due process protection.

The State of Washington's assisted suicide ban must be related to a legitimate government interest. The State claimed these interests included: 1) prohibiting intentional killing and preserving human life, 2) preventing suicide, especially among the young, the elderly, and those suffering from untreated pain, depression, or other mental illnesses; 3) protecting the medical profession's integrity and ethics and maintaining the physician's role as the patient's healer, 4) protecting the poor, the elderly, disabled persons, the terminally ill and persons in other vulnerable groups from indifference, prejudice, and psychological and financial pressure to end their lives, and 5) avoiding the slide to voluntary or involuntary euthanasia as the experience in the Netherlands suggests might happen. The Court found these arguments persuasive in supporting the State's interest in prohibiting physician-assisted suicide.

Physicians in the New York State<sup>(24)</sup> case expressly stated that prescribing medication to allow a patient to end one's life would be consistent with their medical practice, and they would do it if it were legal. This is the view of a significant minority of American physicians, but at odds with the code of ethics of the American Medical Association<sup>(25)</sup>.

The history of the legal attitude toward suicide and assisting someone in a suicide has taken two different directions in Anglo-American legal tradition<sup>(26)</sup>. The ban against suicide as a crime leading to forfeiture of real and personal property has evolved to decriminalization. The forfeiture is now recognized as punishing the survivors. Suicide was recognized as non-felonious. Assisting someone to commit suicide continues to be seen as the same as assisting in murder. It was and is a crime. It is not legal to murder someone even if they request it. To find assisting in suicide acceptable would be to reverse 700 years of history and legal tradition.

The Due Process Clause goes beyond guaranteeing a fair process and protecting against physical constraints. It gives heightened protection against government interference with certain fundamental rights and liberty interests, such as the right to marry<sup>(9)</sup>, to have children<sup>(10)</sup>, to direct their education<sup>(11)</sup> and upbringing<sup>(12)</sup>, to marital privacy<sup>(3)</sup>, to the use of contraception<sup>(3)</sup>, to bodily integrity<sup>(19)</sup>, to abortion<sup>(4)</sup> and to refuse life saving medical treatment<sup>(18)</sup>.

In the June 1997 U.S. Supreme Court judgment,<sup>(6)(24)</sup> Justice O'Connor asserted that the constitutional question about physician-assisted suicide does not have to be addressed. Patients in both New York and Washington have access to medication to relieve suffering. The state's interest lies in protecting the vulnerable and those not facing imminent death. She supported a legislative process that strikes a balance between the alleviating the suffering of competent, terminally ill and the state's interests.

Justice Stevens concurred in the majority opinion and agreed that it was important that the debate continue<sup>(6)</sup>. The debate should also include the limits the Constitution places on the state's powers. By deciding that capital punishment is constitutional, we have accepted that a lesser value can be placed on some lives. The Court accepted capital punishment by defining a narrow category for capital punishment. He does not accept unlimited autonomy. The loss of one of us is a loss for all of us. He opined that every application of the prohibition on physician-assisted suicide may not be valid as is also true in capital cases. We have already accepted hastening death in accepting capital punishment. We have moved beyond the protection of every life.

Justice Stevens identified the issues as not whether to live or die, but how to die. As we deal with the competent, terminally ill, the threshold in regard to living has already been passed. He saw Cruzan<sup>(17)</sup> as allowing the individual to make judgments about the quality of life. The individual can, he asserts, choose the final chapter in his life. The state's interest in preventing abuse does not apply to an individual who is not the victim of abuse. Justice Stevens asserts that all suffering cannot be alleviated. If one is adequately informed of all alternatives, a rational choice for suicide might be made. The state's interest in preventing error and abuse would be minimal. The integrity of the medical profession might be better served by not

withholding treatment, but by easing suffering and making death tolerable. Doctors are already engaged in withholding life support and giving terminal sedation. Justice Stevens asserted that the so-called unqualified interest in the preservation of human life is not sufficient to outweigh the interest in liberty. Stevens provided the basis for a constitutional right to physician-assisted suicide. A very careful definition in a given case or a law is required which, like capital punishment, is narrowly tailored.

In the June 1997 judgment, Justice Souder reviewed the Washington State case<sup>(6)</sup> and articulated that the respondents (petitioners and doctors) acknowledged the historical basis for the prohibition on suicide and assisting suicide. The respondents noted that the Court has rejected historical precedence in the past. The claimants suggested that criminal penalties on suicide are now limited only to assisting. Yet, in *Cruzan*,<sup>(18)</sup> the doctor can stop treatment and treat residual anxiety. The right to an abortion reversed history and allowed doctor participation. Decisions about life that are part of the control over one's body are an autonomy decision. We already permit a doctor to withdraw life support on request and to perform an abortion on request. Is there not a right to assistance, with limitation, to suicide?

The State argued that its interest is to protect life generally, discourage suicide, and to protect the terminally ill from involuntary suicide and voluntary and involuntary euthanasia. Justice Souder wants to protect the irresponsible, to protect against the mistake of inadequate medication, to protect against mistaken diagnosis and prognosis, and to support the need to guard against voluntary and involuntary euthanasia. Justice Souder clearly fears the slippery slope.

Vigilance by physicians is not enough. Doctors will do what patients want. There are economic pressures on doctors and patients. The contrary views of the Dutch experience raise questions for Justice Souder. Justice Souder wants to allow legislators to experiment with solutions to the problems of the terminally ill. Legal activity regarding physician-assisted suicide will now revert back to the states. The law is in place in Oregon to permit implementation of physician-assisted suicide under a set of rules.

What is the effect if the action is up to the states? There will be considerable pressure on legislatures to pass laws, similar to Oregon's, to permit physician-assisted suicide. There will also be considerable pressure to maintain the status quo, as 44 states currently have laws against physician-assisted suicide. The role of psychiatry is to highlight concerns about the impact physician-assisted suicide will have on doctor-patient relationships. These concerns will be discussed in other sections of this report.

## References

- 1) Sullivan, M.D., Ganzini, L. and Youngner, S.J., Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide? *Hastings Center Report* 28:24-31, 1998.
- 2) *Olmstead v. United States*, 277 U.S. 438 (1928)
- 3) *Griswold v. Connecticut*, 381 U.S. 479 (1965)
- 4) *Roe v. Wade*, 410 U.S. 113 (1973)
- 5) *Poe v. Ullman*, 367 U.S. 497 (1961)
- 6) *Washington v. Glucksberg*, 1997 U.S. Lexis 4039; U.S.L.W. 4669
- 7) *Palko v. Connecticut*, 302, U.S. 319 (1937)
- 8) *Moore v. City of East Cleveland*, 431 U.S. 494 (1977)
- 9) *Loving v. Virginia*, 388 U.S. 1 (1967)
- 10) *Skinner v. Oklahoma*, 316 U.S. 535 (1942)
- 11) *Prince v. Massachusetts*, 321 U.S. 158 (1944)
- 12) *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)
- 13) *Meyer v. Nebraska*, 262 U.S. 390 (1923)
- 14) *Eisenstadt v. Baird*, 405 U.S. 438 (1972)
- 15) *Quinlan* 70 N. 110, 355 A2d 647 (N.J.) (1976)
- 16) *Superintendent of Belchertown State School v. Saikewicz*, 373 Massachusetts 728 (1977)
- 17) *Bouvia v. Superior Court (Glenchur)* 179 Cal. APP 3d 1127, 225 Cal. Rptr. 297 (CT.APP.1986), Rev Den. (CAL-June 5, 1986).
- 18) *Cruzan v. Director, Missouri Department of Health*, 497, U.S. 261 (1990)
- 19) *Schloendorff v. Society of New York Hospital* 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914) Cited in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).
- 20) Callahan, D. What Kind of Life: The Limits of Medical Progress. New York: Simon & Schuster, 1990.
- 21) *Village of Belle Terre v. Boraas*, 416 U.S. 1 (1974)
- 22) *Bowers v. Hardwick*, 478 U.S. 186 (1986)
- 23) *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)

- 24) *New York v. Quill*, 1997 U.S. Lexis 4038; U.S.L.W. 4695
- 25) American Medical Association: Code of Ethics, Current Opinions and Annotations. 1994 Edition.
- 26) Marzen, T.J., O'Dowd, M.K., Crone, D., and Balch, T.J. Suicide: A Constitutional Right? *Duquense Law Review*. 24:1:148, 1985.

#### Chapter 4. A Philosophical Basis for Opposing Physician-Assisted Suicide

What position can a physician, and by extension the society, take toward physician-assisted suicide? An examination of the fundamental assumptions that underpin medical care is in order. Such an exploration is often considered too theoretical to be helpful in practical situations. Without such an examination, decisions are made and behaviors are undertaken because of current trends in the society. The implications of the act are not described and euphemistic phrases such as a “good death” are presented in a misleading manner.

Pellegrino reports that the solutions that we seek come from a conceptual framework.<sup>(1)</sup> If we are not to leave our responses to intuitive, visceral or unarticulated value judgments, our views about our professional role in life and death must be undertaken. Dr. Pellegrino depicts a need to re-examine medical ethics because of the changes in our society’s view of moral issues. He argues that medicine must focus on medical ethics in a serious philosophical inquiry.

For the religious person, God gives the individual, and God will decide when and under what circumstance life will end. If one does not base one’s decision on religious tradition, where does one start? The appropriate starting place is to address the condition that man finds himself in a godless world, constrained by Darwinian rules. If evolution is blind, man finds himself in a hopeless dilemma.<sup>(2)</sup> Should I ask for specialized help in ending my life? These questions are irrelevant, if we view human life from an evolutionary perspective of several million years. What difference would it make in a world without meaning? What does it matter if one member of a species dies or for that matter if an entire species disappears?

The existential dilemma posed by an evolutionary perspective is intolerable for us all. The human imperative is to infuse meaning into life and to give life a value. Efforts to derive the meaning of life from our biology have been most unconvincing<sup>(3)</sup>.

The effort to solve the existential crisis may surface at two points in the developmental process. In adolescence, as the adolescent addresses the physiological and psychological changes which to a greater or lesser extent characterize the stormy period in which identity begins to take shape<sup>(4)</sup>. The struggle in adolescence can give rise to an existential depression.

In the second half of life, it may occur after one has established oneself as a working person and as a biologically procreative person who has nurtured the next generation. When all these have been attempted and mastered, what then? The question what does it all mean is asked most poignantly by those who have mastered successfully the first half of life. “A new meaning may be sought, often a transcendental one”<sup>(5)(6)</sup>. In this brief review, all people must confront conceptual basis for our moral reasoning. It requires accompanying awareness that provides us with a clue as to our direction<sup>(7)</sup>.

Given that we give life meaning, the necessary fundamental basis for our later reasoning is lost, if life is lost. The behaviors that have been identified as self-preservation or the life instinct reflect the centrality of life.

The solution to the existential horror is to infuse life with meaning. We must “delude” ourselves that our life is deemed important, or perhaps supremely important. We will acknowledge the problem potentially posed by altruism<sup>(8)</sup>, where we give our life for another. Altruism underscores how precious we value our own lives; to give it up for another is the supreme sacrifice.

In the limited time of our Republic, the centrality of life has been honored in two statements. In the Declaration of Independence, the inalienable rights of all men are seen as life, liberty and the pursuit of happiness. In the 14<sup>th</sup> amendment to the Constitution, the same formula is approximated when it says “...nor shall the state deprive any person of life, liberty or property without due process of law”. Life, liberty, and autonomy has become the basis for human rights. Autonomy underpins the right of women to have control over the content of their bodies<sup>(9)</sup>. This autonomy right is the basis for arguing that one has

the right to take one's life<sup>(10)</sup>. It is this autonomy right that some physicians want to use as a rationale to permit their assisting patients to die.

The pursuit of happiness reflects a comment on the quality of life. Life and liberty are intrinsic, but happiness, one has the right to pursue and perhaps obtain, but it is not guaranteed.

In a meaningless world, we have arbitrarily chosen life and its protection as our primary concern. We do not see this as derived from our biology. We see it as the consequence of our thinking. We must make sense out of our trivial and pointless lives in order to make our lives tolerable.

If life is the essential postulate, then autonomy and quality of life issues becomes secondary. A basis for moral decision making becomes possible. The implication for physician-assisted suicide as well as active and passive euthanasia still needs to be explored.

If life and its preservation are the most important, although arbitrary, human values, how does this view impact on those situations in which society has traditionally sanctioned the taking of human life, such as war, self-defense, capital punishment, and abortion? It seems that each of these situations is an exception, each being more or less compelling.

In the case of war, the national interest is threatened. Those in authority, with the consent of the governed, enter a war in which the enemy and our own people, both wanting to preserve life, are killed. The contradiction to the primacy of preserving life is clear. The threat from the former Soviet Union was to our autonomy and to our liberty. Pacifist solutions are viable if the opponent (enemy) is rule-governed, or if constraints on life quality and liberty, but not on life itself, are involved. To die for life, so someone else can live, is acceptable.

War is an argument provided for killing in self-defense. An exception is made to our fundamental goal.

The preservation and maintenance of life is invoked, but only when it is one life or the other. Restraint in

the act of self-defense is a legitimate expectation. Only enough force to prevent your losing your life is generally acceptable.

What is the attitude about capital punishment? The State has the right to terminate a life. The necessity for such activity is generally argued to deter subsequent killing. The exception here is that the criminal has gone too far. An individual who has taken a life will have his life taken, not to balance the scales but to teach others not to do this. Whether the deterrence works, the logic of the argument and its morality is in question. If nurturing and maintaining a life is our overriding goal, capital punishment is a strange way to sustain this goal.

The most recent challenge to the primacy of life is the establishment of a woman's right to abortion. Termination of a pregnancy on request (demand) is the woman's choice. If one sees the fetus in the first trimester as a life, then the society has allowed one person, the mother, to have the right to terminate the life of another, the fetus. In this view, the state has sanctioned murder. Abortion is not a threat to our national interest or to the life of the attacked, as in self-defense. It is not done to teach a moral lesson, as in the case of capital punishment. The argument in this circumstance challenges the order of life, liberty and the pursuit of happiness because it places liberty before life. If the fetus is not seen as a life, then the argument is moot. Calling the fetus pre-viable makes the fetus non-living, and abortion is not killing.

What are the implications for a society of placing the autonomy standard as the principle virtue? It is the autonomy standard that is the principal challenge to the life standard in the question of physician-assisted suicide. The quality of life issues are a challenge in problematic situations, such as euthanasia and eugenics.

In war, self-defense, capital punishment, and abortion, there is a challenge to life as the primary virtue. There are justifications for each exception. The most serious challenge to life as the prime value is the autonomy argument inherent in the right to choose abortion.

The role of the physician is, as has been argued elsewhere<sup>(11)</sup>, derived from the collective of the society. The role of physician is not an intrinsic right of the practitioner. It is a right delegated from the society to the physician. Chases<sup>(12)</sup> has argued that there are rules, developed by the profession, which govern the actions of physicians. Rules have been enunciated to enhance and to support a physician's functioning. The goals of the physician, set by society, precede the rules.

What is the primary goal of the physician? It is to nurture and to sustain life<sup>(13)</sup>. If life is not the prime goal, the physician's role is absurd. The physician's job is to foster life and to abstain from those activities, which can curtail life. Real life experiences must guide the physician and facilitate decision-making in complex and painful human situations. The physician's role is to promote life.

Should the physician respond to the patient who requests his expert help in terminating his life, in committing suicide? To be consistent with his societal mandate, the professional must refuse the request. This need not and should not lead to abandonment of the patient. On the contrary, a physician is commanded to nurture life and to utilize the ameliorative techniques of comfort care as part of one's role<sup>(14)</sup>. To cure on occasion, to comfort when possible, and to do no harm is the creed of the physician.

But what are the other roles a physician fulfills in providing service to patients? In abortion on request, the physician has already accepted that a fetus is not a life, or that the liberty and autonomy rights of the mother are a legitimate exception to a commitment to life. The patient says that the right to commit suicide is equal to the right to have an abortion. The patient expects assistance in the exercise of liberty and autonomy to terminate life.

Callahan<sup>(15)</sup> has argued that a freedom, which destroys freedom, makes a mockery of freedom, as it terminates the ability to exercise freedom. If life and its preservation are the prime virtue for physicians, then its destruction, as the physician would in physician-assisted suicide, is prohibited. How free is a choice, if suffering is so great that dying is the only choice?

Autonomy places life in a secondary position. As a rationale for P-A.S, autonomy would require another exception. The conflict in our society is between autonomy and life,<sup>(1)</sup> with quality of life,<sup>(16)</sup> not far behind. The exercise of autonomy contradicts our fundamental goal, which is preservation of life. This is not the same as our recommending a course of action to a patient, and the patient not accepting the treatment recommendation.

Conflict between the life supporting role and the patient's autonomy rights has been resolved in favor of autonomy in the development of living wills and durable medical powers of attorney. Patients now define the extent of treatment, which is acceptable<sup>(17)</sup>. This is an extension of the patient's autonomy right to refuse treatment<sup>(18)</sup>.

As Gaylin, Kass, Pellegrino and Siegrist have stated,<sup>(19)</sup> "Physicians must not kill". They must not kill because it is such a contradiction to their fundamental societal roles, the nurturing and sustaining of life. Pellegrino writes, "...the moral basis for medical practice must proscribe euthanasia because it contravenes the primary healing purposes of medical activity."<sup>(1)</sup>

We have not explored other reasons why physicians should not kill. These are ably and convincingly presented by Pellegrino<sup>(1)</sup>. He posits that killing by physicians distorts the healing relationship by destroying trust and anticipates the grave social consequence, the slippery slope, that results from such behavior.

The fundamental human condition is being alive. It is being alive that allows us to give life its meaning. The goal of medicine is to support and nurture life.

## References

- 1) Pellegrino, E.D. Doctors Must Not Kill. *J Clin Ethics* 3:95-102, 1992.
- 2) Dawkins, R. The Selfish Gene. New York: Oxford University Press, 1976.
- 3) Monod, J. Chance and Necessity. New York: A.A. Knopf, 1971.
- 4) Erikson, E. Childhood and Society. New York: W. W. Norton, 1964.
- 5) Segaller, S. and Berger, M. The Wisdom of the Dream: The World of C.G. Jung. Boston: Shambala Publications, 1989.
- 6) Kubler-Ross, E. On Death and Dying. New York: MacMillan Co., 1969.
- 7) Johnson, M. Moral Imaginations: Implications of Cognitive Science for Ethics. Chicago: University of Chicago Press, 1993.
- 8) Trivers, R. The Evolution of Reciprocal Altruism. *Q Review of Biol* 46:35-36, 1971.
- 9) Roe v. Wade, 410 U.S. 113, 211 (1973)
- 10) Compassion in Dying et al. v. State of Washington C-94-119R. 1994 U.S. Dist. Lexis 5831.
- 11) Kramer, M. and Roth, T. Responsibility and Accountability: A Look From Within. *World J. Psychosynthesis*. 10:29-33, 1978.
- 12) Kass, L.R. Toward a More Natural Science. New York: The Free Press, 1985.
- 13) Cassell, E. The Nature of Suffering and the Goals of Medicine. New York: Oxford University Press, 1991.
- 14) Emanuel, L.L. Facing Requests for Physician Assisted Suicide: Toward a Practical and Principled Clinical Skill Set. *JAMA* 280: 643-647, 1998.
- 15) Callahan, D. What Kind of Life! The Limits of Medical Progress. New York: Simon and Schuster. 1990.
- 16) Blendon, R.J. Szalay, U.S. and Knox, R.A. Should Physicians Aid Their Patients in Dying? The Public Perspective. *JAMA* 274: 2658-2662, 1995.
- 17) Omnibus Budget Reconciliation Act of 1990, Pub. No. 101-508, 4206, 4751,
- 18) Bouvia v. Superior Court (Glenchur), 179 Cal. App. 3d1127, 225 CAL. RPTR, 297 (CT.APP.1986) rev. den. (Cal. June 5, 1986).

- 19) Gaylin, W., Kass, L., Pellegrino, E.D. and Siegrist, M. Doctors Must Not Kill. JAMA 259:2139-2140, 1988.

.Chapter 5. Psychiatrists' Attitudes towards Physician-Assisted Suicide: A Survey\*

A patient's right to control the time and process of death has become an increasingly pressing issue in medical practice in the United States. A patient's right to refuse life prolonging or life saving treatment has been firmly established by judicial decision and by statute<sup>(1-3)</sup>.

In a brief review of ethical issues,<sup>(4)</sup> Dr. Edmund Pellegrino argues that physician-assisted suicide is one of the two major issues, (the other is embryo research) that "promises to dominate public discourse in medical ethics in the immediate future." He urges that "individual physicians, the profession and the public acquaint themselves with the arguments and their implications for the kind of society we are, and want to become, and the role that medicine should play in our treatment of human life."

There has been a remarkable change in the attitude of the general public toward a patient's right to request assistance in dying<sup>(5)</sup>. In 1947, thirty-seven percent of the public favored making such a request legal; by 1991, seventy percent of the adult population of the United States favored such a law. Age, religion, and race influence one's view of the withdrawal of life support and euthanasia<sup>(6)</sup>. More younger people (18-34) are in favor of legalizing euthanasia and physician-assisted suicide (70%) than are older people (54%), Catholics (72%) more than Protestants (59%), and whites (71%) more than blacks (49%).

The survey data on physician attitudes and practices in regard to physician-assisted suicide and euthanasia is not as clear.<sup>(7-12)</sup> Physicians in Wisconsin are not supportive<sup>(7)</sup>, while those from Michigan<sup>(8)</sup>, Oregon<sup>(9)</sup> and the state of Washington<sup>(10)</sup> are marginally so. Critical care physicians are actively making such life terminating decisions<sup>(11)</sup>, while Hospice physicians oppose such practices<sup>(12)</sup>.

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Overall, the climate for legalizing physician-assisted suicide is positive as reflected in the passing of Proposition 16 in Oregon<sup>(13)</sup> and the extension of euthanasia practices in the Netherlands<sup>(14)</sup>. The moral

barrier to physician-assisted suicide would appear to have been breached in the United States with the passage of the Oregon Death with Dignity Act in 1994<sup>(13)(15)</sup>.

The 9th Circuit Federal Court of Appeals<sup>(16)</sup> has found that the provision of the Washington State law banning assisted suicide violates the due process clause of the 14<sup>th</sup> Amendment of the Constitution. The 2<sup>nd</sup> Circuit Federal Courts of Appeals<sup>(17)</sup> has found that the New York statutes criminalizing assisted suicide violate the equal protection clause of the 14<sup>th</sup> Amendment. They prohibit a physician from prescribing medications to be self-administered by a mentally competent terminally ill person in the final stages of his terminal illness. Therefore, they are not rationally related to any legitimate state interest. The legal status quo appears to be changing in regard to physician-assisted suicide in the United States, although it remains illegal in almost all jurisdictions. The United State Supreme Court has ruled that there is no constitutional right to physician-assisted suicide.

Psychiatrists are uniquely confronted with the problem of life termination from many of their patients that they be allowed to die or they be assisted in dying. Death from suicide occurs in 10% to 15% of patients with major depressive disorder<sup>(18)</sup>. Psychiatrists have generally viewed these requests and patient behaviors as expressions of the patient's illness<sup>(19)</sup>. They have taken steps to protect the patients from themselves and to institute treatment of the illness associated with the suicidal thoughts or behaviors.

Nonpsychiatric physicians tend to view their patients as competent and their requests as rational<sup>(19)</sup>. When a profoundly ill patient with a poor prognosis requests to be allowed to die (treatment withdrawal), the possibility of a rational or reasonable request is raised in the non-psychiatric physician's mind, whether the physician is Jack Kevorkian<sup>(20)</sup> or Timothy Quill<sup>(21)</sup>.

The debate within psychiatry about the right, not to die, but to claim physician-assistance in dying has created considerable tension. The opposing views are reflected in the writings of Herbert Hendin<sup>(22)(23)</sup> on the one hand and Sullivan and Youngner<sup>(19)</sup> on the other. Hendin has been a vocal critic of those who espouse assisting patients in dying<sup>(22)</sup>. Sullivan and Youngner<sup>(19)</sup>, working as liaison psychiatrists, have

suggested that in the profoundly physically ill, requests for assistance in dying may be rational and assistance might be appropriate. They point out that the usual criteria for the diagnosis of depression in the terminally physically ill may not be valid.

Very little has been published about the attitudes of psychiatrists toward physician-assisted suicide or euthanasia. Nothing is known about the prevalence of such practices among psychiatrists. In a 1990 telephone survey by the American Board of Family Practice of 100 internists, 100 family practitioners and 100 psychiatrists, 91% of psychiatrists indicated that they believe that “terminally ill patients have the right to choose to die” and 77% of psychiatrists were of the opinion “that patients have the right to choose to die if they have an illness that permanently impairs their quality of life” <sup>(24)</sup>.

In a carefully done mail survey of 1,355 Washington State physicians on physician attitudes toward life termination, 250 psychiatrists were included, along with family practitioners, general internists, general surgeons, hematologists and oncologists, and other specialists. The response rate was 67%. Overall, 48% of these respondents felt euthanasia was never ethically justified. Fifty four percent said there were some situations in which it should be legalized, and 33% of the respondents said there were some situations in which they would be willing to perform euthanasia. In regard to physician-assisted suicide, 39% of the respondents said it was never ethically justified, 53% felt it should be legalized in some situations, and 42% of the respondents felt that there were some situations in which they would participate. Among the physician groups, psychiatrists were the most supportive of euthanasia and physician-assisted suicide, while hematologists and oncologists were the least supportive.

If psychiatry and psychiatrists are to address the issues involved in physician-assisted suicide and euthanasia, an exploration is necessary of the attitudes and practices psychiatrists have in regard to assisting patients to die. It has been shown that such attitudes vary among members of various medical specialties <sup>(7-12)(24)</sup>.

## METHODS

In preparation for a monograph on the issues involved in physician-assisted suicide and euthanasia from a psychiatric perspective, the Therapeutic Care Committee of the Group for the Advancement of Psychiatry (GAP) surveyed the membership of GAP, not about their practices in regard to physician-assisted suicide or euthanasia, but rather their attitudes about assisting patients in dying.

The format used to explore the membership's attitudes was to present a brief vignette about a patient and ask: 1) would you directly assist this patient to die? 2) would you refer this patient to someone else to assist him or her to die? 3) would it be acceptable for other physicians to assist similar patients to die? and 4) would it be acceptable for non-physicians to help similar patients to die? Each question could be answered absolutely not, probably not, uncertain, possibly yes and absolutely yes.

The survey was approved by the Board of Directors of GAP and was mailed to the 375 members in September of 1994. A second mailing to those who had not responded to the first mailing was done in April 1995. The present report is the response to both mailings.

The survey presented the membership with four case vignettes. The first was a severely incapacitated 30-year old man with rapidly progressing amyotrophic lateral sclerosis who wants to die. The second was a 50-year old woman with severe intractable pelvic pain, associated depressive disorder, and a somatoform pain disorder. She had eight years of unsuccessful psychotherapy, had refused antidepressants and electroconvulsive therapy, and wanted to die. The woman then had antidepressant therapy and electroconvulsive therapy, which both failed and the patient still wants to die. The surveyed psychiatrists were queried about her before and after her biological treatment. The third case was a 37-year-old rapist-murderer who had four years of psychotherapy and medroxyprogesterone treatment while in prison to decrease his sexual desire. He was released from prison, then raped and killed again. He is serving a life sentence, but wants to die by lethal injection. The last vignette was a 27-year old woman with AIDS who is on a respirator with pneumonia, a morphine drip and in an irreversible vegetative coma. Her family wants her to die. The psychiatrists were asked, would you turn off the respirator? This was done and she lingered three weeks. They were then asked, would you hasten her death by increasing her morphine drip?

Three additional questions were asked to assess what may have influenced the respondents' decisions. The respondents were asked about the influence of their religious beliefs, medical training, or personal philosophy on their answers.

Limited demographic data was gathered. This included the age, gender and major area of professional activity of the respondents, i.e. clinician-teacher, administrator, researcher or other.

## RESULTS

There were 227 responses to the 375 questionnaires that were sent to members of GAP, of which 224 were usable. The response rate was 60%.

The mean age of the respondents was 59 years ( $\pm 14$ ). The group was made up of 80% men and 20% women. 75% of the group were clinician-teachers, 15% were administrators, 3% researchers, and 7% other.

Results are summarized in Table 1. The respondents would not assist the patient with amyotrophic lateral sclerosis (ALS) to die (58% versus 33%); nor the depressed woman with pelvic pain (97% versus 0%), even after biological treatment failed (88% versus 6%); nor the prisoner rapist-murderer (81% versus 16%). They would turn off the respirator for the woman in a persistent vegetative state (82% versus 12%) and they would try to hasten her death by increasing the morphine drip (50% versus 42%).

The respondents would refer the ALS patient to someone else to assist him to die (53% versus 38%). However, they would not refer the lady with pelvic pain to be assisted to die (93% versus 1%) even after failed biological treatment (83% versus 9%), nor would they refer the rapist-murderer (72% versus 23%). For the 27-year old woman with AIDS, in a persistent vegetative state, the respondents would allow someone else to turn off the respirator as well (91% versus 6%), and they would allow someone else to hasten her death by increasing her morphine drip (54% versus 31%).

Regarding the more general question of whether it would be acceptable for other physicians to assist similar patients to die, the responses are essentially identical to what respondents said about referring the patients in the vignettes to someone to help them die. For the ALS patient, 59% would find the referral acceptable. For a patient with pelvic pain, 92% would not refer to another physician before biological treatment, and 78% would not refer after such treatment failed. For a rapist-murderer, 68% would not refer. For patients similar to the woman with AIDS in a vegetative coma, 91% would find it acceptable for a physician to turn off the respirator in a similar situation, and 61% would agree to increase the morphine drip.

The respondents agreed that a non-physician should not be involved in helping patients to die. For the ALS patient, 60% opposed non-physician involvement; for the pelvic pain patient 95% were opposed before biological treatment, and 88% were opposed after biological treatment failed. The opposition to a non-physician assisting the patient in the case of the rapist-murderer is 72%. The exception is the terminally ill comatose woman. Sixty-one percent felt it would be acceptable for the family to turn off the respirator, but 68% felt it would not be acceptable for a non-physician to increase the morphine drip.

Twenty eight percent of the respondents were influenced by their religion, while their medical training and personal philosophy influenced the answers for 84% and 98% of the respondents respectively.

There was a statistically significant relationship between the survey respondents' answers and their ages. There was a small, but statistically significant, positive correlation between the respondents' age and willingness 1) to assist the ALS patient to die (.23); 2) to assist the woman with pelvic pain to die after the failure of the biological treatments (.23); 3) to allow other physicians to help similar patients with pelvic pain to die (.22); and 4) to increase the morphine drip to help the patient in a persistent vegetative coma to die (.22). These correlations were significant at the  $p < .001$  level.

In only one situation did the religious beliefs, medical training or philosophy of life responses correlate with the answers to any of the questions about the four cases. Those psychiatrists who felt that their religious beliefs were influential in their decisions were in the case of the patient in an irreversible vegetative coma, less likely to 1) increase the morphine drip (-.31); 2) approve of others increasing the morphine drip (-.30) or 3) approve of other doctors doing similar things with similar patients (-.26). All of these correlations were significant at the  $p < .001$  level.

In an effort to look at the consistency of respondents across the four cases, the answers to each question were correlated with each other. There was a clear pattern of a significant correlation matrix. The overall mean intercorrelation was .31 ( $p < .001$ ).

## DISCUSSION

Most psychiatrists, who are members of GAP, say that they are not willing to assist in an active manner in the termination of a patient's life. They would not terminate the life of the patient with ALS (58%) or the patient with pelvic pain (97% -88%). This reluctance is in contrast to 91% of psychiatrists in one study<sup>(24)</sup> who agreed that terminally ill patients have the right to choose to die; and, the 77% of psychiatrists who believe that patients have the right to choose to die if they have an illness that permanently impairs their quality of life. It is also different from psychiatrists in the Washington State study<sup>(10)</sup> who are more favorably disposed toward euthanasia and physician-assisted suicide than other physicians, particularly hematologists and oncologists.

The majority of psychiatric respondents do not apparently see themselves as agents of a rapist-murderer, who requests life termination as an alternative to life imprisonment (81%). This is in keeping with the medical ethical prohibition on a physician participating actively in an execution<sup>(25)</sup>. It raises a question about the position taken by those advocates of physician-assisted suicide or euthanasia, who base their support on the existence of a significant alteration in the patient's quality of life<sup>(10)(24)</sup>. Clearly, life imprisonment poses a serious impairment in the quality of the prisoner's life, yet life-termination is not supported.

In the situation of a persistent vegetative state, psychiatrists are willing to participate in the termination of life by turning off the respirator (82%). The number falls to 50% when they are asked to directly hasten death by turning up the morphine drip. Letting nature take its course is acceptable; while actively ending a life, if a persistent vegetative state is life, is marginally acceptable. Letting nature take its course is considered ethical by The American Medical Association<sup>(26)</sup> and universally practiced by critical care physicians<sup>(11)</sup>. The U.S. Supreme Court supported such action in the Cruzan decision<sup>(2)</sup> but Justice Scalia, who sees no difference between active and passive suicide, questioned this view.

The attitudes of psychiatrists shift when they are asked if they would refer the patient to someone else who will respond to the patient's wishes to have their life ended. The majority support terminating the life of the ALS patient (53%), and the life of the patient in irreversible coma (91%). They are opposed to referring the patient in pelvic pain (93%/83%) or the rapist-murderer (72%) for life termination.

The attitude of the respondents towards life termination depends on whether the patient may be seen as terminally ill or not. In the terminally ill situation, psychiatrists are willing to have someone else do it and will refer the patient if they cannot do it. They would not refer in the case of a patient who requests help in dying but is not terminally ill such as the pelvic pain patient and the rapist-murderer. This distinction is maintained by physicians in surveys directed at attitudes and practice in regard to physician-assisted suicide and euthanasia<sup>(7-12)</sup>. Among those who support life termination, the number goes up when asked if it is acceptable for other physicians to do it.

The data cannot separate whether psychiatrists who oppose the patient with pelvic pain being helped to die is because she is not terminally ill or if she is a type of patient with whom they are familiar. Termination for "one of theirs" is not to be countenanced. The same might be said for the unwillingness to refer the rapist-murderer who had psychotherapy and hormone treatment to alter behavior.

Psychiatrists, like other physicians<sup>(7)</sup>, are unwilling to substitute a non-physician in the role of providing assistance in dying in the four case vignettes. The only exception is their willingness to let the family turn off the respirator, a strange act of compassion.

In some studies the age<sup>(14)</sup>, gender<sup>(10)</sup>, and professional activity<sup>(10)</sup> of the physician covary with attitudes toward life termination. The age of the current respondents covaries, very modestly, ( $r=.22$ ,  $p<.001$ ) with their responses to the case vignettes. The older the psychiatrist, the more willing he or she would be to assist three of the four patients (ALS, pelvic pain, vegetative state) in dying. In keeping with the Dutch study<sup>(14)</sup>, we found a relationship between age and willingness to perform euthanasia or physician-assisted suicide. However, the greater permissiveness with age by physicians toward life termination is in striking contrast to the finding in the general population. The older person is less supportive of physician-assisted suicide or euthanasia<sup>(6)</sup>.

The respondents felt that religion made the least important contribution to their decisions, and that medical training and personal philosophy were major determinants. However, in treating the patient in a persistent vegetative state, those who felt religion influenced their responses were less likely to increase the morphine drip ( $-.31$ ), allow someone else to do it ( $-.30$ ), or allow physicians in similar cases to do it ( $-.26$ ) (all  $p<.001$ ). Other studies of non-psychiatric physicians have found that religion plays an inconsistent role in determining physician attitudes such that it may co-vary with greater or lesser permissiveness<sup>(7)(12)(14)</sup>.

The attitudes of the respondents is internally consistent (mean  $r=.31$ ). The statistically significant correlation ( $p<.001$ ) supports the position that the respondents shared a consistent point of view as they moved from case vignette to case vignette. The only exception is in turning off the respirator in the case of the patient in a persistent vegetative coma.

Survey data on physician attitudes and practices in regard to life termination<sup>(7)(10)(12)</sup>, including this one, all suffer from serious methodological problems. These problems include small sample size, low response rate, limited generalizability, ambiguous terminology, insufficiently detailed questions, and respondent

bias. Surveys need to focus more clearly on physician-assisted suicide and euthanasia, to explore beliefs underlying physician attitudes, and to explore what specific restrictions and safeguards might be acceptable to physicians<sup>(10)</sup>. In a case based study<sup>(7)</sup>, variables such as the underlying disease, the patient's mental capacity, the patient's age and the degree of family support, the physicians' specialty, and physicians' religious affiliation need to be examined when exploring the attitudes toward life termination. It is crucial to remember, as Pellegrino has warned<sup>(27)</sup>, that ethics by plebiscite is not a basis for moral judgment.

**Table I. Psychiatrists' Responses to Questions About Case Vignettes (N=224)**  
(In Percent)

| Patient*                                   | A.L.S. | Pelvic Pain | Pelvic Pain After Biol. Treat. | Rapist-Murderer | AIDS: Stop Respirator | AIDS Increase Morphine Drip |
|--|--------|-------------|--------------------------------|-----------------|-----------------------|-----------------------------|
| <b>Would you directly assist to die?</b>   |        |             |                                |                 |                       |                             |
| 1. Absolutely Not                          | 33%    | 84%         | 62%                            | 67 %            | 04%                   | 19%                         |
| 2. Probably Not                            | 25     | 13          | 26                             | 14              | 08                    | 23                          |
| 3. Uncertain                               | 11     | 02          | 06                             | 04              | 06                    | 08                          |
| 4. Possibly Yes                            | 29     | 00          | 06                             | 11              | 44                    | 36                          |
| 5. Absolutely Yes                          | 04     | 00          | 00                             | 05              | 38                    | 14                          |
| <b>Refer for help in dying?</b>            |        |             |                                |                 |                       |                             |
| 1. Absolutely Not                          | 16%    | 75%         | 50%                            | 56%             | 03%                   | 13%                         |
| 2. Probably Not                            | 22     | 18          | 33                             | 16              | 03                    | 18                          |
| 3. Uncertain                               | 09     | 05          | 08                             | 05              | 03                    | 14                          |
| 4. Possibly Yes                            | 42     | 01          | 08                             | 15              | 42                    | 37                          |
| 5. Absolutely Yes                          | 11     | 00          | 01                             | 08              | 49                    | 17                          |
| <b>Similar case helped to die</b>          |        |             |                                |                 |                       |                             |
| 1. Absolutely Not                          | 14%    | 72%         | 49%                            | 51%             | 04%                   | 12%                         |
| 2. Probably Not                            | 16     | 20          | 29                             | 17              | 02                    | 13                          |
| 3. Uncertain                               | 11     | 05          | 11                             | 07              | 03                    | 13                          |
| 4. Possibly Yes                            | 41     | 02          | 09                             | 16              | 37                    | 39                          |
| 5. Absolutely Yes                          | 18     | 00          | 02                             | 10              | 54                    | 24                          |
| <b>Non-physician helps patient to die?</b> |        |             |                                |                 |                       |                             |
| 1. Absolutely Not                          | 37%    | 83%         | 71%                            | 62%             | 15%                   | 42%                         |
| 2. Probably Not                            | 23     | 12          | 17                             | 10              | 18                    | 26                          |
| 3. Uncertain                               | 13     | 04          | 08                             | 09              | 07                    | 09                          |
| 4. Possibly Yes                            | 23     | 01          | 03                             | 12              | 29                    | 16                          |
| 5. Absolutely Yes                          | 3      | 00          | 01                             | 07              | 32                    | 07                          |

\*See text for description of case

## References

- 1) Quinlan, 70 N, II0, 355 A2d 647 (1976)
- 2) Cruzan v. Director, Missouri Department of Health, 110 S. Ct. 2841 (1990)
- 3) Omnibus Budget Reconciliation Act of 1990, P.L. 101-508:4206, 2751
- 4) Pellegrino E.D. Ethics. JAMA 1995; 273:1674-1676
- 5) Miller, F.G. and Fletcher, J.C. Physician-assisted suicide and active euthanasia, in Physician-Assisted Death. Edited by Humber J.M., Almeder R.F., Kasting, G.A. Totowa, N.J., Humana Press, 1994.
- 6) Blendon, R.J., Szalay U.S. and Knox, R.A.: Should Physicians Aid Their Patients in Dying? The Public Perspective. JAMA 1992; 267:2658-2662
- 7) Shapiro R.S., Derse A.R., Gottlieb M., Schiedermayer D. and Olson M: Willingness to Perform Euthanasia: A Survey of Physician Attitudes. Arch Intern Med 1994; 154:575-584
- 8) Bachman, J.G., Alcer, K.H., Doukas, D.J., Lichtenstein, R.L., Corning, M.A., and Brody, H: Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. N Engl J Med 1996; 334:303-309.
- 9) Lee, M.A., Nelson H.D., Tiden, V.P. Ganzini, L., Schmidt, T.A. and Tolle, S.W.: Legalizing assisted suicide-view of physicians in Oregon. N. Engl J Med 1996; 334:310-315.
- 10) Cohen J.S., Fihn S.D., Boyko E.J., Jonsen A.R. and Wood R.W.: Attitudes toward Assisted Suicide and Euthanasia among Physicians in Washington State. NEJM 1994; 331:89-94.
- 11) Asch D.A., Hansen-Flaschen J., and Lancken P.N.: Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes. Am J Respir Crit Care Med 1995; 155:288-292.
- 12) Meier, D.A. Doctors' Attitudes and Experiences with Physician-Assisted Death: A Review of the Literature. In: Humber, J.M., Almeder R.F., and Kasting, G.A. [Eds.] Physician-Assisted Death. Towata, N.J.: Human Press, 1994.
- 13) Oregon Death with Dignity Act. Ballot measure 16. November 8, 1994, General Election.
- 14) van der Maas, P.J., Pijnenborg, L, van Delden, J.J.M.: Changes in Dutch Opinions on Active Euthanasia. 1966 through 1991. JAMA 1995; 273:1411-1414.

- 15) Alpers, A. and Lo, B. Physician-Assisted Suicide in Oregon: A Bold Experiment. JAMA 1995; 274:483-487.
- 16) 1996 U.S. App. Lexis 3944 (9<sup>th</sup> Cir. March 6, 1996)
- 17) 1996 U.S. App. Lexis 6215 (2<sup>nd</sup> Cir. April 2, 1996)
- 18) Coryell W.R. Noyes, R. and Clancy, J: Excess Mortality in Panic Disorder: A Comparison With Primary Unipolar Depression. Arch Gen Psychiatry 1982; 5:311-7.
- 19) Sullivan, M.D. and Youngner, S.J. Depression, Competence and the Right to Refuse Life Saving Medical Treatment. Am J Psychiatry 1994; 151:971-978.
- 20) Kevorkian J: Prescription Medicide. Buffalo, N.Y., Prometheus Books, 1991
- 21) Quill TE: Death and Dignity: Making Choices and Taking Charge. New York, W.W. Norton & Co., 1993
- 22) Hendin, H. and Klerman, G. Physician-Assisted Suicide: The Dangers of Legalization. Am J Psychiatry 1993; 150:143-145.
- 23) Hendin, H. Selling Death and Dignity. Hastings Center Report 25:19-23, 1995
- 24) Charnow, J.A. Most Internists Support Patients' 'Right to Die', Surveys Find. American College of Physicians (ACP) Observer, June 8, 1991, Pg. 8
- 25) AMA Code of Medical Ethics. 1994 2.06 Capital Punishment
- 26) AMA Code of Medical Ethics. 1994 2.20 Withholding or Withdrawing Life-Sustaining Medical Treatment
- 27) Pellegrino, E.D.: Doctors Must Not Kill. J Clin Ethics 1992; 3:95-102.

## Chapter 6. The Psychiatrist's Role in Physician Assisted Suicide

The psychiatrist, as a physician, is bound by duty and by law, to have as his primary goals the preservation of life and the relief of suffering. The ethical constraints (precepts) in the Oath of Hippocrates unequivocally opposes responding to a patient's request for assistance in dying or from counseling suicide as a solution to a patient's problem<sup>(1)</sup>. This is a position that is specifically enunciated in the ethical code of the American Medical Association<sup>(2)</sup>.

Dr. Edmund Pellegrino, a recognized leader in medical ethics in the United States, has taught what has been called the Georgetown Mantra<sup>(3)</sup>, namely: beneficence, non-maleficence, autonomy and justice<sup>(4)</sup>. He opposes physician-assisted suicide, because the moral arguments favoring it are morally inadequate, because it distorts the healing relationship, and because the social consequences are morally prohibitive<sup>(5)</sup>. We believe as psychiatrists that we have something to contribute, which can illuminate all three areas.

Autonomy is the major challenge to the traditional "do no harm", guidelines in medicine. Is autonomy really possible in a state of intense suffering? The request for euthanasia is an act of profound desperation. The psychiatrist can contribute by separating autonomy, determined behavior, reasoned action, and emotionally determined behavior. Learning this distinction is a developmental task that must be achieved in adolescence and re-learned from time to time later in life<sup>(6)</sup>.

Compassion is the major argument in favor of physician-assisted suicide<sup>(5)</sup>. Psychiatrists recognize the danger of equating compassion with responding to a patient's request. To understand is not necessarily to agree. Dr. Timothy Quill, the most articulate medical advocate of physician-assisted suicide, decided to help his patient Dianne die by giving her the pills she requested, based on the rational (or rationalization) that he understood<sup>(7)</sup>. Dr. Quill overlooks is the danger of overidentification with the patient<sup>(8)</sup>. The realities of transference and counter-transference can alter, or distort our responses to patients. Rationalizations to justify acquiescence to the patient's wish is the ultimate boundary violation<sup>(9)</sup>.

Physician-assisted suicide distorts the healing relationship<sup>(5)</sup>. The healing relationship is based on trust. Patients trust that a physician will act in their best interest. Patients, particularly the vulnerable, the aged, and the chronically ill, have become afraid to enter Dutch hospitals for fear of being euthanized<sup>(10)</sup>. Psychiatrists are aware that the fear of a doctor can be a great block to seeking help. To expose one's self to another and to put one's self in the hands of another, is exquisitely central to psychiatric treatment. Without trust, treatment is impaired.

Dr. Pellegrino states that the social consequences of physician-assisted suicide are unacceptable<sup>(5)</sup>. The slippery slope in euthanasia is real. The Dutch have seen the expansion of euthanasia from adults to children, terminally ill to chronically ill, intolerable suffering to life dissatisfaction, from consent to contrived consent, from voluntary to involuntary<sup>(11-13)</sup>.

In the common law, case law, and legislation, with the exception of Oregon, it is a crime to assist a person (patient) in terminating his or her life<sup>(14)</sup>. Recent efforts to overturn the law by searching for a constitutional right to have help in terminating one's life have met with rejection by the U.S. Supreme Court<sup>(15)(16)</sup>. In our country, P-A.S. is illegal and only being practiced in Oregon.

The dilemma is that a physician can cling to the goal of preserving life in the face of intolerable suffering. In this conflict, the physician must cling to preserving life, while doing the most to relieve suffering. With the help of medication, living wills, family support, and hospice care, the physician must be available to support their patients and keep their trust.

Why must psychiatrists be involved in the debate about physician-assisted suicide? It is because the manifestly suicidal patient has always been the concern of the psychiatrist. Throughout history, it has been held that the suicidal patient must be mentally deranged. A rational person would not contemplate suicide and certainly would not request help in doing it or attempting it.

The advocates of physician-assisted suicide have argued for assistance in life termination in order to avoid the pain, suffering and the decline of a terminal illness as rational<sup>(17)</sup>. They see that death with dignity is a reasonable desirable alternative. They believe that adequate safeguards to prevent exploitation or misuse can be established<sup>(18)</sup>.

There is a difference in approach to the patient if one is a psychiatrist or a non-psychiatric physician<sup>(19)(20)</sup>. The presumption for the psychiatrist is that the patient is mentally ill (irrational), and that the request for suicide assistance is a product of the illness. For the non-psychiatric physician, the presumption is that the patient is rational, and requests and decisions about treatment are to be honored. This provides a very different orientation to patients. The assumption about the irrationality by psychiatrists of patient's requests to die comes largely from the experience that patients who want to die, and who are treated successfully, are often relieved.

The assessment of profound depression in the severely physically ill presents difficulties<sup>(19)</sup>. The presence of vegetative signs: loss of appetite, weight loss, insomnia, diminished libido, diminished energy, and increased irritability, so helpful in the diagnosis of depression, may be a result of a physical illness as opposed to depressive disease. Further research is needed in the area of depression in the physically ill in order to delineate the effect of depression in the very sick.

With regard to physician-assisted suicide, problems emerge when the non-psychiatric physician overidentifies with his patient. To understand the basis for a request does not justify acquiescence with the request. Failure to agree is not necessarily a failure to understand. Psychiatrists do not accept the patient's request for assistance in dying at face value<sup>(8)</sup>. Decisions are alterable as one's emotional state changes.

Suicide remains a public health problem of great concern<sup>(21)</sup>. While death rates are falling in the United States for heart disease and cancer, the suicide rate overall has risen 6%. For males over 15, it has risen some 15% from 1970 to 1985. Rise in death rates for adolescents<sup>(22)</sup> and black males<sup>(21)</sup>, two socially vulnerable groups, have been reported. Elderly males living alone are at highest risk for suicide<sup>(23)</sup>. More

vigorous treatment strategies directed at palliative care and depression must be offered. If a depression is untreated, the possibility of suicide is greatly increased<sup>(24)</sup>. The responsible physician seeks to understand the suicide request of the physically ill patient, but to search for depression as well. Many patients had been seen by their primary care physician shortly before their completed suicide<sup>(25)</sup>.

The current focus in physician-assisted suicide highlights those patients who are hopelessly physically ill. Seventy-percent of patients who complete suicide have one or more active or chronic physical illnesses at the time of death<sup>(23)</sup>. What may be inadequately recognized is that many of these ill individuals are depressed.

Twenty to twenty-five percent of patients with cancer are depressed, not different from the rates in other medical illnesses<sup>(26)</sup>. Suicide in cancer patients, according to Brown, occurs only in patients who are profoundly depressed<sup>(27)</sup>. Physical illness alone does not precipitate completed suicide; the additional factor is depression.

A depressed mood, lasting one to two weeks, is a normal response to being told one has cancer<sup>(28)</sup>. However, 25% of cancer patients suffer a major depressive disorder at some point during their illness<sup>(29)</sup>. The rates of clinical depression are much higher for those with advanced cancer, such that 70% of bedridden cancer patients have a major depressive disorder<sup>(29)</sup>.

Clinical depression is a diagnosable and treatable condition, which occurs commonly in the general population. One in 8 people will experience a clinical depression during their lifetime<sup>(30)</sup>. Clinical depression is a highly treatable condition with a remission rate of 55% to 70%<sup>(31)</sup>.

In disabling diseases, other than cancer, depression and dementia occur with high frequency<sup>(32)</sup>. In Parkinson's disease, 40% suffer dementia and 50% will experience depression during the course of their illness. In Alzheimer's disease, 100% will develop dementia and 30-40% will have a depressive syndrome

during the course of their disease. Thirty five percent to 65% of stroke patients will have a depressive disorder post-stroke<sup>(33)</sup>, similar to the 45% of myocardial infarction patients who will have a depressive disorder after a heart attack<sup>(34)</sup>. Improvement in mental functioning occurs with improvement in the depression.

Studies of suicide, depression, and mental illness in chronically, physically ill patients demonstrate that severely ill patients who request suicide are not likely to be free of mental illness, which may be highly treatable. The assumption that severely physically ill patients are competent may not be warranted.

A system developed to respond to the request for physician-assisted suicide was suggested by T. Quill<sup>(18)</sup>, encompassed in the physician-assisted suicide law in Oregon, and supported by highly informed psychiatric colleagues<sup>(20)</sup>. The assessment of the mental and emotional state of the patient is left to the discretion of the treating physician, who may or may not ask for mental health consultation. The focus is on relief of pain. The mental state of the patient is seen as secondary. In the Dutch experience<sup>(11)</sup> pain was not the most common reason that patients asked the physician to assist them in dying. The Dutch reported that loss of dignity (57%) and feeling worthless (46%) were more common than pain. The fear of being dependent is the major reason for such a request by an American population<sup>(35)</sup>. The quality of life is as important as pain relief in requesting physician-assisted suicide. The mental state of the patient becomes the key element in a physician's assessment of the patient's request for help in dying.

When a depressed patient makes the request for life termination, it should not be taken at face value. Psychiatric experience with the suicidal patient leads to seeing the wish to die as a product of mental illness, as a symptom of a disordered mental state. In psychiatry, if the patient is appropriately treated, the wish for death will disappear. Given the increasing recognition of individual autonomy rights in our society, it is argued that one has a legal and moral right to demand services from their doctor such as physician-assisted suicide.

The decriminalization of suicide, which psychiatrists have vigorously supported, does not imply a right to demand assistance in suicide<sup>(14)</sup>. Psychiatrists and others that have recognized that punishing the completed suicide by confiscating his real and personal possessions impacts their family, not the suicidal individual. Denying burial in hallowed ground to the completed suicide confers rationality on the behavior that church, state, and medicine all have come to recognize not to be the case.

In the protocol offered<sup>(18)</sup> for use in regulating the application of physician-assisted suicide, a terminal illness is either assumed or explicitly described. One of the criteria is that the patient suffers from a terminal illness and has six months or less to live. The physician can be expected reasonably to make a prediction about the probable life expectancy of the patient. The predictive ability of the physician in regard to life expectancy is in question<sup>(36)</sup>. Short-term survival predictions in ICUs are not very accurate and long-term survival is even more poorly predicted<sup>(37)</sup>. Problems exist in predicting survival time in Hospice patients as well<sup>(38)</sup>.

The psychiatrist would have a difficult time participating in physician-assisted suicide because depression and hopelessness accompanies such requests and are often, if not always, treatable. The idea of offering physician-assisted suicide as a legitimate treatment option serves to undermine trust. The patient in Holland<sup>(39)</sup> who has suffered with depression for 10 years, unresponsive to treatment, sees a new psychiatrist once and is given sufficient medication to end her life. This is not a scenario that encourages families and patients to seek psychiatric help. There are enough barriers to seeking medical assistance in general, and psychiatric treatment in particular.

Psychiatrists have observed the mis use of psychiatry by the state as part of the state's social policy. The techniques for the mass destruction in Nazi Germany were developed by psychiatrists in mental hospitals on their mentally retarded and mentally ill patients<sup>(40)</sup>. In Communist countries, mental hospitals were used for the treatment of political dissidents, which was another example state-determined medical activity<sup>(41)</sup>. In our country, 12% to 14% of critical care physicians have terminated a patient's life without consulting

the patient or the patient's surrogate, and 3% have done it even over the objection of the patient's surrogate<sup>(42)</sup>.

Physician-assisted suicide as a legitimate option invites giving in and giving up on the part of the physician. As treatment efforts prove fruitless, or as the patient begins to suffer more, physician-assisted suicide provides an out for both patient and doctor<sup>(5)</sup>. Rather than continue to search for palliative care and to bear the burden of frustration; physician-assisted suicide ends the burden for the patient and the doctor.

It must be recognized that physician-assisted suicide is socially disruptive<sup>(35)</sup>. It places a demand on the ill and the old to do the right thing, to no longer be a burden on them (children), and to conserve economic resources for heirs. These are not hypothetical scenarios. Depressed and suicidal patients argue that their families would be better off without them. The elderly see themselves as a burden on children. A childless, elderly couple with resources in the millions committed suicide to avoid becoming destitute, gave their sizable estate to the Church, and were encouraged to do so by their minister<sup>(43)</sup>.

If the doctor thinks physician-assisted suicide is appropriate and offers it as an option, will patients be subtly encouraged to pursue such an option? In our current climate of cost effectiveness, sending home underweight newborns is justified by insurance company physicians as fostering necessary maternal-infant bonding. Will physician-assisted suicide be seen as a cost-effective medical procedure, husbanding the limited medical dollars for more productive therapeutic interventions? It is no coincidence that the first law legalizing physician-assisted suicide occurred in the same state, where rationing medical care to the poor has begun.

The psychiatrist's role in physician-assisted suicide is to call vigorous attention to the destructive nature of a medical practice that would include physician-assisted suicide as an option. Psychiatrists must not kill<sup>(44)</sup>.

## References

- 1) Strauss, M.B. [Ed.] *Familiar Medical Quotations*. Boston: Little, Brown and Co., 1968. Pg. 325.
- 2) American Medical Association: *Code of Ethics, Current Opinions and Annotations*. 1994 Edition.
- 3) Glick, S. *Trend in Medical Ethics in a Pluralistic Society: A Jewish Perspective*. 17<sup>th</sup> Annual Rabbi Louis Feinberg Memorial Lecture in Judaic Studies. Judaic Studies Program, University of Cincinnati. April 24, 1994.
- 4) Beauchamp, T.L. and Childress, J.F. *Principles of Biomedical Ethics*, 4<sup>th</sup> Ed. New York: Oxford University Press, 1994.
- 5) Pellegrino, E.D. *Doctors Must Not Kill*. *J. Clinic Ethics* 3:95-102, 1992.
- 6) Erikson, E. *Childhood and Society*. New York: A.A. Knopf, 1971.
- 7) Quill, T.E. *Death and Dignity: A Case of Individualized Decision Making*. *NEJM* 324:691-694, 1991.
- 8) Wesley, P. *Dying Safely*. *Issues in Law and Medicine* 8:467-483, 1993.
- 9) Gabbard, G. and Nadelson C. *Professional Boundaries in the Physician-Patient Relationship*. *JAMA* 273: 1445-1445, 1995.
- 10) Fenigsen, R. *A Case Against Dutch Euthanasia*. *Hastings Center Report*. Supplement 19:522-30, 1989.
- 11) van der Maas, P.J., van Delden, J.J.M., Pijnenborg, L. and Looman, C.W.N. *Euthanasia and other Medical Decisions Concerning the End of Life*. *Lancet* 338:669-674, 1991.
- 12) Gomez, C.F. *Regulating Death: Euthanasia and the Case of the Netherlands*. New York: Free Press, 1991.
- 13) Eads, B., *A License to Kill*. *Reader's Digest*. September, 1997. (Pgs 92-97).
- 14) Marzen, T.J. O'Doud, M.K., Crone, D. and Balch, T.J. *Suicide: A Constitutional Right?* *Duquense Law Review* 24:1-147, 1985.
- 15) *Washington v. Glucksberg*, 1997 U.S. Lexis 4039; USLW 4669.
- 16) *New York v. Quill*, 1997 U.S. Lexis 4038, USLW 4695.
- 17) Kevorkian, J. *Prescription: Medicide, The Goodness of Planned Death*. Buffalo, New York: Prometheus Books, 1991.

- 18) Quill, T.E. Death and Dignity: Making Choices and Taking Charge. New York: W.W. Norton & Co., 1993.
- 19) Sullivan, M.D. and Youngner, S.J. Depression, Competence, and the Right to Refuse-Life-Saving Medical Treatment. *Am J Psychiatry* 151:971-978, 1994.
- 20) Sullivan, M., Ganzini, L. and Youngner, S.J. Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide? *Hastings Center Report* 28:24-31, 1998.
- 21) Group for the Advancement of Psychiatry. *Suicide and Ethnicity in the United States*. Report No. 128. New York: Brunner/Mazel Publishers, 1989.
- 22) Group for the Advancement of Psychiatry. *Adolescent Suicide*. Report No. 140. Washington, D.C.: American Psychiatric Press, 1996.
- 23) Kreitman, N. The Clinical Assessment and Management of the Suicidal Patient. In: Roy, A. [Ed.] Suicide. Baltimore: Williams and Wilkens, 1986.
- 24) Miles, C.P. Conditions Predisposing To Suicide: A Review. *J Nerv Ment Dis* 16:231-246, 1977.
- 25) Robins, E. Murphy, G.E., Wilkinson, R.H. and Kayes, J. Some Clinical Considerations in the Prevention of Suicide Based on a Study of 134 Successful Suicides. *Am J Pub Health* 49:888-898, 1959.
- 26) Plumb, M.M. and Holland, J. Comparative Studies of Psychological Functions in Patients with Advanced Cancer. I. Self Reported Depressive Symptoms. *Psychosom Med* 39:265-276, 1977.
- 27) Brown, J.H., Henteleef, P., Barakati, S. and Rowe, C.J. Is it Normal for Terminally Ill Patients to Desire Death? *Am J Psychiatry* 143:208-211, 1986.
- 28) Massie, M.J. and Holland, J.C. Depression and the Cancer Patient. *J Clin Psychiatry* 51: (Suppl) 12-19, 1990.
- 29) Bukberg, J., Penman, O. and Holland, J.C. Depression in Hospitalized Cancer Patients. *Psychosom Med* 46:199-212, 1984.
- 30) Boyd, J.H. and Weissman, M.M. Epidemiology of Affective Disorders. *Arch Gen Psychiat* 38:1039-1046, 1981.

- 31) Burkem J. and Preskorn, S.H. Short Term Treatment of Mood Disorders with Standard Antidepressants. In. Bloom, F.E. and Kupfer, D.J. [Eds.] Psychopharmacology. New York: Raven Press, 1995.
- 32) Blazer, D.G. Depression in Later Life. St. Louis: Mosby-Yearbook, 1993.
- 33) Eastwood, M.R., Rifat, S.L. Nobbs, H. and Rudeman, J. Mood Disorder following Cerebrovascular Accident. Br J Psychiatry 154: 195-200, 1989.
- 34) Schleifer, S.J., Macari-Hinson, M.M., Coyle, D.A., Slater, W.R., Kahn, M., Gorlin, R. and Zucker H.D. The Nature and Course of Depression Following Myocardial Infarction. Arch Intern Med 149:1785-1879, 1989.
- 35) Blendon, R.J., Szalay, U.S. and Knox, R.A. Should Physicians Aid their Patients in Dying? The Public Perspective. JAMA 267:2658-2662, 1992.
- 36) Charlson, M.E. Studies of Prognosis: Progress and Pitfalls. J Gen Intern Med 2:359-361, 1987.
- 37) Poses, R.M., Bekes, C., Copare, F.J. and Scott, W.E. The Answer to “What are my Changes Doctor?” Depends on Who is Asked: Prognostic Disagreement and Inaccuracy for Critically Ill Patients. Crit Care Med 17:827-833, 1989.
- 38) Schonwetter, R.S., Teasdale, T.A., Storey, P. and Luchi, R.J. Estimation of Survival Time in Terminal Cancer Patients: An Impedance to Hospice Admissions? Hospice Journal 6:65-79, 1990.
- 39) Karel, R. Controversy Over Assisted Suicide Cases Highlights Ethical Issues. A.P.A. Psychiatric News. December 17, 1993, (Pg.-4).
- 40) Caplan, A.L. [Ed.] When Medicine Went Mad: Bioethics and the Holocaust. Totowa, N.J.: Humana Press, 1992.
- 41) Block, S. The Political Misuse of Psychiatry in the Soviet Union. In: Block, S. and Chodoff, P. [Eds.] Psychiatric Ethics. New York: Oxford University Press, 1981.
- 42) Asch, D.A., Hansen-Flashen, J. and Lancken, P.A. Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States. Conflicts Between Physicians ‘Practice and Patients’ Wishes . Am J Respir Crit Care Med 151:288-292, 1995.
- 43) Baenen, L. Suicide Couple Leaves Fortune to Church. Cincinnati Enquirer December 13, 1994.

- 44) Gaylin, W., Kass, L., Pellegrino, E.D. and Siegler, M. Doctors Must not Kill. JAMA 259: 2139;2140, 1988.

## Chapter 7. In Conclusion: A Place to Stand

Supporters of physician-assisted suicide to the dying patient would limit the right to those individuals who have access to good palliative care<sup>(1)</sup>. The Robert Wood Johnson Foundation<sup>(2)</sup> is funding two projects related to the care of the dying patient calling attention to the absence of adequate palliative care for the dying patient. Patients with metastatic lung or colon cancer overestimate their survival probabilities<sup>(3)</sup>. Hospitalized patients 80 years or older<sup>(4)</sup> were unwilling to trade living well for living longer.

The potential role for the psychiatrist in end of life care emerges for those patients who are able to explore their wish to die, an investigation of motives, which may prove clarifying<sup>(5)</sup>. An eight-step guideline to assess a request for physician-assisted suicide is offered by Dr. Linda Emanuel<sup>(6)</sup> of the Institute for Ethics of the AMA. This guideline starts first with an assessment for depression; and, second, with the establishment of the adequacy of a patient's decision-making capacity. Both involve psychiatrists.

The need for psychiatric screening for depression is demanded in view of the difficulty non-psychiatric physician have in diagnosing depression<sup>(7-9)</sup>. The assessment of decision-making capacity remains a psychiatric task, in view of the difficulties non-psychiatric physicians have in diagnosing cognitive impairment<sup>(10)</sup>. Despite the warnings of our colleagues<sup>(11)</sup>, the psychiatric role for assessment in end of life decisions is a necessary one.

The treatment philosophy of the Hospice movement<sup>(12)</sup> best fits with the physician's commitments, if not to cure, then to relieve and to comfort. Psychiatrists must join all physicians to reduce suffering near the end of life.

## References

- 1) Quill, T.E., LO, B. and Brock, D.W. Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide and Voluntary Active Euthanasia. *JAMA* 278:2099-2104, 1997.
- 2) Skolnick, A.A. End-of-Life Care Movement Growing. *JAMA* 278:967-969, 1997.
- 3) Weeks, J.C., Cook, F., O'Day, S.J., et al. Relationship Between Cancer Patients' Predictions of Prognosis and Their Treatment Preferences. *JAMA* 279:1709-1714, 1998.
- 4) Tsevat, J., Dawson, N.V., Wu, A.W., et al. Health Values of Hospitalized Patients 80 Years or Older. *JAMA* 279:371-375, 1998.
- 5) Muskin, P.R. The Request to Die: Role for a Psychodynamic Perspective on Physician-Assisted Suicide. *JAMA* 279:323-329, 1998.
- 6) Emanuel, L.L. Facing Requests for Physician-Assisted Suicide: Toward a Practical and Principled Clinical Skill Set. *JAMA* 280:643-647, 1998.
- 7) Schulberg, H.C., Saul, M., McClland and, M. et al. Assessing Depression in Primary Medical and Psychiatric Practices. *Arch Gen Psychiatry* 42:1164-1170, 1985.
- 8) Eisenberg, L. Treating Depression and Anxiety in Primary Care Settings: Closing the Gap Between Knowledge and Practice. *NEJM* 326:1080-1084, 1992.
- 9) Badger, L.N. deGruy, F.U., Hartman, J., et al. Patient Presentation, Interview Content and the Detection of Depression by Primary Care Physicians. *Psychosom Med* 56:128-135, 1994.
- 10) Titchener, J.L. Surgery as a Human Experience. Oxford: University Press, 1958.
- 11) Sullivan, M., Ganzini, L. and Youngner, S.J. Should Psychiatrists Serve as Gate Keepers for Physician Assisted Suicide? *Hastings Center Report* 28:24-31, 1998.
- 12) Wheeler, W.L. *Hospice Philosophy. An Alternative to Assisted Suicide*. Ohio Northern University Law Review 20:755-760, 1994.