

The Ethics of Ending Life: Euthanasia and Assisted Suicide, Part 2

Ethical Questions in Euthanasia and Assisted Suicide

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One positive aspect of a Presidential election year is that there are many opportunities to address misconceptions and false statements that arise during the campaign season. Rick Santorum's recent assertions regarding euthanasia (EU) in the Netherlands¹ provide another welcome chance to address common urban legends regarding physician-assisted suicide (PAS) and EU in the United States and abroad.

Currently, PAS is legal in several European countries (Belgium, the Netherlands and Luxembourg) and in three of the United States (Oregon, Washington and Montana). Assisted suicide (with or without a physician) is legal in Switzerland. EU is legal in Belgium, the Netherlands, and Luxembourg, with the proviso that it be voluntary and requested by a competent patient.

A large majority of the American public favors PAS (70 percent), and a significant majority support EU,² yet the public and physicians have deep and legitimate concerns about the ethics of these activities. Concerns regarding PAS and EU include the following: 1) that patients who seek suicide are incompetent by virtue of being depressed and hopeless; 2) that PAS and EU are unnecessary: better pain management practices will eliminate requests for PAS and EU; 3) that vulnerable populations—i.e., the poor, elderly, isolated, less educated, and those less able or likely to access the health care system—will be more likely to commit suicide; 4) that physicians or others will abuse the legality of PAS or EU to take the lives of persons who would not choose to die; and 5) that participating in PAS or EU will damage the professional ethics of physicians. After a decade in which PAS and/or EU has been legal in several European countries, and up to a decade in the three American states, we now have data to examine these claims.

Are Patients Who Seek PAS or EU Incompetent?

Depression is a significant component of many patients' perspectives at end-of-life, and it does influence their wish to die in 8.5 to 17 percent of cases.^{3,4} But depression and other mental illness per se are not synonymous with incompetence,^{3,5,6} and their role in end-of-life decisions remains unclear.⁷

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Investigations do not consistently show that depression affects patients' end-of-life treatment decisions.⁸ And depression does not appear to be significantly different between patients who request EU and those who do not.⁹ Studies do suggest that the diagnosis of clinical depression may be missed by Oregon physicians assisting suicides, but they do not indicate whether depression affected patient decision-making in a significant way.¹⁰ An unanswered question is: should a decision regarding PAS or EU require a *higher standard* of competence than other end-of-life decisions, and if so, how high should that bar be? Requiring that dying patients not be depressed seems unreasonable, if even achievable, and sets an insurmountable barrier. And what then happens to patients' decisions regarding other care at end-of-life—for example, undergoing terminal chemotherapy, a question requiring the balancing of many complex concepts involving extreme risk, minimal benefit, “futility,” and morbidity?

Is Better Pain Control the Solution for EU and PAS?

Despite a widespread belief that untreated pain is the most worrisome problem for patients at end-of-life, repeated studies show that this is not so.⁶ In fact, satisfactory end-of-life pain control is achieved in all but a small minority of patients.¹¹⁻¹³ One study even suggests that oncology patients who are experiencing pain are actually *less* likely to find PAS or EU acceptable.¹² The most prominent concerns for patients at end-of-life are loss of autonomy and loss of dignity.⁷ PAS and EU are generally rated highly desirable by patient groups because they do answer such fears. Statistics from Oregon and Washington, where PAS has been practiced since 2001 and 2010 respectively, show that many patients who ask for PAS and receive lethal prescriptions never use them.^{12,14,15} Families have indicated that patients who have the means of a humane death at their disposal gave comfort and confidence to their relatives, thereby enabling them to want to—and actually—live longer. Jerome Sobel and Ludvig Minelli, who direct the Swiss suicide organizations EXIT and DIGNITAS, respectively, both claim that they are in the “*suicide prevention business*,” because their many experiences parallel those findings.¹⁶

Are Vulnerable Populations at Risk?

Review of data from Oregon and Washington do not support a contention that vulnerable populations are selectively victimized by legalized PAS, nor that PAS is becoming epidemic. PAS accounted for approximately 22 deaths per 10,000 total deaths in Oregon in 2011.¹⁵ Most patients were white (95.6 percent), well educated (>70 percent with college education), and insured (96.7 percent). The majority (96.7 percent) were enrolled in hospice care. Only 1.4 percent were referred for psychiatric evaluations. Furthermore, Washington and Oregon residents are likely to be well educated with regard to their end-of-life options.¹⁷

Will Physicians Be Encouraged to Kill Patients Against Their Will?

Santorum asserted that 10 percent of all Dutch elderly are killed by their doctors, half of them against their will, and that the elderly wear bracelets begging doctors not to euthanize them.¹ If this were true, then we would indeed all have reason for alarm. But Santorum's assertions actually bear little resemblance to reality. In the Netherlands, both PAS and EU are legal but require competent, voluntary and repeated requests by the patient. PAS and EU account for 1.8 percent of all deaths in the Netherlands annually, or fewer than 2,000 deaths in 2007.¹⁸ Of those, only nine did not follow the strict legal procedures, and all nine were shown to be documentation errors, not errors in ascertaining competence, questions of voluntariness, or other substantive issues that might have affected outcomes.¹⁹ Far from being terrorized, the elderly population of the Netherlands strongly favors the option of euthanasia (70 percent in 2008).²⁰

Surveys show that EU is actually practiced by a surprising number of physicians globally, without the regulation of law. Thirty-six percent of Australian surgeons report giving drugs to hasten death,²¹ 3.7 percent of U.S. oncologists admit to performing EU, and 10.8 percent to assisting suicide prior to its legalization.¹² Up to 38 percent of German physicians admit to performing EU at some time,²² and in the U.K., 7.4 percent of surveyed physicians reported giving drugs with the intention of hastening death.²³ In *none* of these countries is EU legal. In the Netherlands, prior to legalization, EU had been practiced and poorly regulated. A 2005 study reported that before legalization, 0.4 percent of EU cases in the Netherlands involved ending a life without explicit request, a rate that was *cut in half* by legalization and regulation.¹⁹ If anything, studies suggest that legalization provides regulation, oversight and investigation that is otherwise absent, and that episodes of EU and PAS may even decline with legalization.

Is It Ethical for Physicians to Participate in EU or PAS?

Tough questions arise when we look at the issue of physician professionalism and PAS and EU. There is no doubt that the traditional view of physicians has held that our primary goal is to preserve life, regardless of the consequences. The ancient oaths are unequivocal in vowing not to use the privileged position that we as physicians have for the purpose of killing. It is, or at least was, an impenetrable rule necessary to patient trust.²⁴

But modern physicians have already breached "the trust" as it probably would have been understood in ancient times. Abortion was specifically prohibited by the Hippocratic oath, but is now considered by many an acceptable and ethical practice bound by the privacy of the doctor-patient relationship.²⁵

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Withdrawing life-supportive interventions would almost certainly have been seen as a form of killing and not allowed (had our physician forefathers been able to foresee such technology). It seems impossible to reconcile a profession that now embraces facilitating death under certain circumstances with the ancient oaths. Nonetheless, the concept that facilitating death is permissible within the purview of ethical medical care is gaining traction, both in European cultures and with the American public. Increasingly, the role of the physician is seen as one that is intimately involved in issues related to patient dignity and ending suffering, not just preserving life.

The professionalism argument forces us to ask whether our professional mandate is truly unalterable over time. A stance that physicians can only practice in the context of ancient beliefs regarding right and wrong would seem to posit medicine as an ideology and not a profession. The “social contract” physicians have with society implies that there are two sides to the contract: the profession and society. The benefits physicians have demanded of society have changed over the centuries: does society have a right to alter their expectations of physicians as well?

A very real concern is the possibility that participating in activities that facilitate death as directly as PAS and EU do will be morally corrupting to physicians. There is some strong evidence that this might be so. In 2005, Osofsky and colleagues²⁶ examined the effects of participating in legal executions on several tiers of participants: chaplains and spiritual supporters, prison guards, and death chamber participants. Their findings were both relevant and disturbing.

For most people, participating in killing is a powerful emotional and moral event. In order to manage internal conflicts, participants in executions at all levels of involvement employ various degrees of “moral disengagement.” Moral disengagement is the creation of beliefs that allow individuals to rationalize that they are not morally responsible for activities in which they nevertheless play a critical role. In the case of executions, such arguments include distancing themselves from the decision to kill (i.e., the judge and jury condemned the prisoner, not I); dehumanizing the prisoner (he or she is an animal, a monster, different from us, and therefore not subject to moral rules and protections); and rationalizing that execution isn’t terrible (because it is “humane”). The authors found that, no matter how “engaged” morally a participant initially may have been, participation in killings uniformly converted them to moral “disengagers.”

Dehumanization of subjects and denial of moral responsibility are not qualities that would generally be considered desirable in a caring physician. Yet nothing is known at this time about what, if any, moral and psychological defenses

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physicians utilize while engaging in the facilitation of death under other circumstances, and how it may affect, for better or worse, the qualities we feel are essential for a physician's professional life.

Not So Final Thoughts

Here is what we know: our patients are worried about how we will care for them at end-of-life, and while most generally have confidence that their medical needs, including pain control, can be managed, they are doubtful that their spiritual and social needs (e.g., autonomy, dignity) will be adequately addressed. PAS and EU are options that a large majority of the public feels very strongly have a rightful place in their end-of-life care, and they want their physicians to help them with support, information, and even participation. In areas where PAS and EU are practiced legally, there is little evidence at this time to support concerns that the socially vulnerable are being systematically exploited. But physicians must still address the following fundamental questions: 1) does their social contract to relieve suffering extend so far as to include facilitating death at a patient's request, and if so, 2) whether by doing so, the profession as a whole—or the individuals who participate—will suffer significant moral harms of sufficient gravity as to warrant continued professional sanctions against participation in PAS and EU.

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MARK TWAIN'S WIT AND WISDOM

When in doubt, tell the truth.

Wit, by itself, is of little account. It becomes of moment only when grounded on wisdom.

Any mummerly will cure, if the patient's faith is strong on it.*

**Useless or silly show or ceremony.*