Moral and Practical Challenges of Physician-Assisted Suicide

Karl Lorenz, MD, MSHS, Veteran Affairs Greater Los Angeles Healthcare System, Los Angeles, Calif, Geffen School of Medicine at UCLA, and Joanne Lynn, MD, MA, MS, The Washington Home Center for Palliative Care Studies, Washington, DC

Statutory proposals for physician-assisted suicide (PAS) have often included provisions for a waiting period and a consultation for mental disability. This is important because sick and dying people are often responding to pain or psychological anguish, or searching for meaning and control.1 Subtle impairments of cognition and attention can compromise the decision-making ability of even seemingly competent persons.2 These factors can distort patients’ perceptions of their own interests and affect the decisions they make. Many such requests turn out to be transient and ameliorated by symptom improvement or psychological adjustment with time.1

Research has demonstrated that almost all patients can be made physically comfortable with methods that are readily at hand.3,4 The few who cannot be awake and reasonably comfortable can have ongoing sedation through to death, as authorized by existing law.5,6 Thus, policymakers might reasonably question relying on the decisions of very sick people who may misperceive the symptoms they will have to bear or whose suffering could be ameliorated by better access to effective palliative care.

Another problem is that many patients with progressive, eventually fatal illness find that they cannot count on reliable care with only reasonable burdens on loved ones. Persons might well prefer suicide to overwhelming pain, de-meaning nursing home conditions, or family bankruptcy. Patients weigh the impact of their survival and death on their loved ones,7 and financial and emotional pressures can shape decision making.8 In our society there are pervasive disparities in health care access and utilization,9 with those who are physically frail, poor, socially isolated, uninsured, illiterate, or non–English speaking are likely to need a helpful care system and simultaneously least likely to be able to find help. For example, minorities, people with Medicaid, or those living in lower income areas are less likely to use hospice services.10,11 Serious illness has become the most common cause of personal bankruptcy, with studies showing that nearly half of US bankruptcy filings result from the financial burden of severe illness or injury.12

Descriptions of the practice of PAS and euthanasia where these practices are legal do not provide definitive information on the implications of legalizing PAS for disadvantaged persons. On the one hand, in 1998, nearly one third of Oregon residents who made requests for lethal medication under Oregon’s law authorizing PAS gave the reasons of fear of “being a burden,” financial pressures, and the lack of social support.13 However, patients requesting PAS in Oregon have been similar to the general population in being 97% white and 98% insured for hospice,14 and Oregonians who received lethal prescriptions were relatively affluent and insured.15 In 1 study in the Netherlands, where PAS is also legal, education and income did not correlate with the utilization of PAS.16 Most states, however, are characterized by much greater social inequalities and cultural diversity. Both the Netherlands and Oregon have authorized PAS for only a few years, and the practice remains under close scrutiny. Certainly, many persons in the United States cannot count on living out the end of life with comfort, companionship, and financial resources.3,17

Finally, empowering physicians to assist in suicide might seriously undermine patients’ trust in the medical profession. Physicians play an inescapable role in presenting and shaping health care decisions. Patients and families find it essential to rely on physicians when fear, lack of information, unfamiliarity, and other factors limit their independence and authority. By empowering physicians to help the patient to take his or her own life, legalizing PAS threatens to make patients and families suspicious at a time when they would like to rely on a trusting relationship with their physician.

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REFERENCES