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VIEWPOINT

Physician-Assisted Dying A Turning Point?

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In 2014, Brittany Maynard, who was dying of brain cancer, took a deliberative decision supported by her family to move from California to Oregon to utilize the Oregon Death with Dignity Act. Highly visible, deeply personal decisions by Maynard and others have influenced social and political discourse around physician-assisted dying (PAD). Although PAD broadly encompasses physician-assisted suicide (PAS) (medicines prescribed specifically for the purpose of being taken by patients to end their lives) and euthanasia (lethal medicines administered by physicians at the patient's request), states currently only authorize the former.

Constitutionality and States' Rights

As long ago as 1997, the Supreme Court invited state experimentation regarding a "profound debate about the morality, legality, and practicality" of PAD.¹ Although the Supreme Court found no constitutional "right to die" it granted states wide scope to legislate. The Court ruled that the federal government could not prohibit physicians from prescribing controlled drugs to assist patient deaths if authorized under state law.² This ruling led to numerous states enacting law governing end-of-life care (Table).

At the time the Supreme Court issued its decisions on PAD, Oregon was the only state to authorize the practice; all the rest criminalized PAD. Recently, however, California became the fourth state to enact legislation allowing PAD; Montana allows PAD through a court decision. Bills are pending in nearly half the states in the 2015 legislative session. The debate over PAD appears to be at a turning point, with public opinion polls across 15 countries in North America and Europe finding strong support.³

Evidence Evaluating the Practice of PAD

Because PAD has been lawful in some countries since the 1940s and in the United States since 1997, there is a body of social and scientific research. Research has focused on whether the practice has been misused and whether gaps exist in legislative safeguards. There are multiple concerns with physicians assisting patients to die: incompatibility with the physician's role as a healer, devaluation of human life, coercion of vulnerable individuals (eg, the poor and disabled), and the risk that PAD will be used beyond a narrow group of terminally ill individuals.

Incompatibility With Medical Practice

Whether PAD is incompatible with the physician's oath to "do no harm" is hotly contested. The evidence suggests, however, that physicians who work closely with terminally ill patients are more likely to support PAD than their peers⁴; in jurisdictions where PAD is not available,

physicians report using alternative methods to assist their patients in hastening death.⁵ Furthermore, all states that have legalized PAD provide opt-outs to accommodate physicians who have a conscientious objection to PAD or simply do not wish to participate; these statutes protect physicians against civil or criminal liability for refusing to participate.

Devaluing Human Life

As the abortion and capital punishment debates demonstrate, there is no consensus as to whether taking a life can ever be morally justified. Yet, demographic data from the Oregon Death with Dignity Act annual report shows that patient motivation for seeking PAD is primarily focused on dying with dignity, retaining self-respect, and retaining a connection to the patient's community in their final days.⁶ Statutes in non-US jurisdictions often capture patients' subjective experiences through criteria such as "intolerable suffering." These laws appear to shift the debate from a social and political decision to a personal choice.

Opening the Floodgate

To narrow the group of patients eligible for PAD, all state statutes limit the practice to terminally ill adults. Although a diagnosis of terminal illness is complex and uncertain, current legislation requires agreement by 2 independent physicians that the individual has a condition that will likely result in death within 6 months. Research also suggests that PAD laws do not significantly increase rates of patients who request assistance in dying, even after PAD is legally available over long periods of time.^{6,7} Many patients who request physician help in dying, moreover, do not use the prescribed medications immediately, or ever.

Since the Death with Dignity Act was enacted in 1997, only 65% of the 1327 patients who have received a lethal prescription have died from ingesting that prescription medicine.⁶ All state statutes empower patients to change their minds at any time. These laws have narrow definitions of consent and capacity, and specifically authorize patients to retract their consent.

Disproportionate Access for the Poor

Most patients who request PAD are well educated, insured, and in hospice care, rather than being poor and in public hospitals.⁶ It is unknown whether the Affordable Care Act might increase patient preferences for hospice and other palliative care services over PAD. Universal health coverage that includes high-quality end-of-life care would be the most effective way of ensuring that the poor and vulnerable are not drawn to PAD for financial reasons.

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Table. State Laws Authorizing Physician-Assisted Dying

| | State, Year of Legislation | | | | |
|-----------------|--|--|--|--|--|
| | Oregon, 1997 | Washington, 2009 | Montana, 2009 ^a | Vermont, 2009 | California, 2016 |
| Patient request | 2 Oral and 1 written request | 2 Oral and 1 written request | Court found that the consent of a terminally ill, competent adult to lethal medication protects physicians from liability for homicide; bill has been put forward in the current legislative session to impose rules | 2 Oral and 1 written request | 2 Oral and 1 written request |
| Waiting period | 15 d between patient's second oral request and prescription; 48 h between written request and prescription | 15 d between patient's second oral request and prescription; 48 h between written request and prescription | | 15 d between patient's oral requests; 48 h must pass between patient's final oral request and written request | 15 d between oral requests (statute doesn't specify a timeline for the written request) |
| Witnesses | 2 Witnesses required; 1 witness must not be a relative, beneficiary, employee of patient's health care facility, or attending physician | 2 Witnesses required; 1 witness cannot be a relative, beneficiary, attending physician, or employee at patient's health care facility | | 2 Individuals at least 18 y old and not "interested persons" | 2 Individuals, 1 must not be relative, beneficiary, attending physician, or employee at patient's health care facility |
| Capacity | If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment | If either physician suspects psychiatric/psychological disorder or depression, patient must be referred for counseling; no prescription provided without confirmation that the patient does not have impaired judgment | | If either physician has doubt whether the patient's judgment is impaired, patient must be evaluated by a psychiatrist, psychologist, or clinical social worker; no prescription may be given until capacity is established | If the attending physician suspects a mental disorder, patient is referred to a mental health specialist; no prescription provided until the specialist clears the patient of impaired judgment due to mental disorder |
| Diagnosis | 2 Physicians agree death likely within 6 mo | 2 Physicians agree death likely within 6 mo | | 2 Physicians agree death within 6 mo | 2 Physicians agree death within 6 mo |
| Opt-out | Physicians may refuse to participate | Physicians may refuse to participate | | Physicians may refuse to participate | Physicians may refuse to participate |

^a By court decision.

Abuse of PAD

All existing laws require safeguards against abuse. In addition to the requirement of 2 physicians certifying that death is imminent, state laws require a mandatory assessment by mental health professionals if either physician suspects the patient may lack full mental capacity, which includes depression. Following capacity assessments, all states require a waiting period, after which patients must restate their request orally and in writing. Two individuals must witness patient requests in all states, with at least 1 witness having no personal interest (a relative, beneficiary, or attending physician).

To increase safeguards, states could consider introducing multidisciplinary panels to support patients through the entire process, including verifying consent and capacity, ensuring appropriate psychosocial counseling, and discussing all palliative and end-of-life options.

Turning Point in Social and Ethical Thought

For the first time, a 2015 poll found that more than half of physicians surveyed favored medical assistance in dying. Although the American Medical Association opposes PAD, the California Medical Association shifted its position to "neutral" following the passage this year of the End of Life Option Act.

Just before Maynard took the final step in her life's journey, she wrote, "Goodbye to all my dear friends and family that I love. Today is the day I have chosen to pass away with dignity in the face of my terminal illness, this terrible brain cancer that has taken so much from me ... but would have taken so much more."⁸ Her final words reflect that PAD is a deeply personal choice. The question is whether more states will authorize the practice and, if so, what safeguards will be put in place to ensure the practice is not misused and remains consistent with prevailing social and ethical thought.

ARTICLE INFORMATION

Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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