Special Article

Legalizing Physician-Assisted Suicide: Some Thoughts and Concerns

Harold G. Koenig, MD, MHSc
Durham, North Carolina

Surveys show that most Americans favor the decriminalization of physician-assisted suicide in certain circumstances. Several states are now considering legislation to bring this about and make the United States the first place in the civilized world where physician aid in dying is sanctioned. In the Netherlands, where physician-assisted suicide is practiced but officially remains illegal, 85% of assisted suicides occur in the elderly, and most involve the help of general practitioners. In the United States, family physicians provide health care to many older adults with chronic or terminal illness whose numbers will increase as the elderly population expands. The legalization of physician-assisted suicide would affect the way American physicians practice medicine in unpredictable ways, yet physicians are participating relatively little in deliberations concerning this issue. The problem of suffering in persons with chronic and terminal illness cannot be ignored. Compassionate, effective, and ethical solutions must be found. As a former family physician and now geriatric psychiatrist, I review the pros and cons of physician-assisted suicide (emphasizing arguments against legalization) and encourage family physicians to debate this matter.

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Most physicians have had patients with advanced cancer, end-stage heart failure, severe chronic obstructive pulmonary disease, or other disabling and painful diseases. Many of these persons experience great physical and emotional suffering during the final few weeks or months of their lives. In such circumstances, it is our professional, ethical, and moral duty to do everything possible to relieve such apparently meaningless suffering. Should physicians be allowed to honor requests by terminally or chronically ill patients to assist them in ending their lives? This subject has special relevance for older adults, who are most likely to be affected by terminal or chronic diseases, and for family physicians who care for them. In the Netherlands, more than 85% of euthanasia cases occur in medically ill persons aged 50 years or over, and most are performed by general practitioners.[1]

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From the Departments of Medicine and Psychiatry, Duke University Medical Center, Durham, North Carolina. Requests for reprints should be addressed to Harold G. Koenig, MD, MHSc, Box 3400, Duke University Medical Center, Durham, NC 27710.

Clarification of Terms

To discuss this topic intelligently, one must carefully define one's terms, or risk ambiguity and confusion. First, withdrawal of life support, or *passive euthanasia*, involves the removal of tubes, respirators, or any other type of artificial support that may prolong life. The excess use of medical technology to extend apparently meaningless life and prolong suffering, especially in cases of terminal or near-terminal illness, is one of the factors that have stirred a public outcry for physician assistance in dying. *Physician-assisted suicide* occurs when a physician intentionally and willfully takes actions that help a suicidal patient 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 (such as the "suicide machine" invented by Jack Kevorkian, MD). *Active euthanasia* involves a physician willfully and intentionally performing

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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.

Watts and Howell[2] argue that there are clear philosophical distinctions between passive forms of assisted suicide (providing information), more aggressive assisted suicide (providing a lethal dose of medication or apparatus to inject it), and active euthanasia (physician injecting a lethal drug), pointing to the differing degrees of physician influence or control over the process leading to death. Others, however, contend that legalizing any form of physician-assisted suicide may open a door that is not easily closed. They refer to the strategy taken by advocates of euthanasia in the Netherlands, who gradually won widespread acceptance of active euthanasia by first endorsing more palatable, less offensive categories.[3] Making distinctions between forms of assistance, while easy in theory, is difficult in practice. If one can justify providing support and advice, a lethal dose of medication, or a suicide device to a patient who is both intent on and capable of killing himself or herself, it becomes difficult to ignore the desperate pleas of another severely ill patient who needs assistance to die but cannot complete the act because of problems with swallowing, physical frailness, or a lack of emotional fortitude.

If one can justify that it is ethical and safe for a physician to assist the suicidal patient, then it is difficult to argue against more active interventions in more complex, and perhaps more appropriate, circumstances. Physicians in the Netherlands acknowledged this obvious conclusion almost a decade ago, when the Royal Dutch Medical Association (KNMG) recommended that the distinction between euthanasia and assisted suicide be abolished on grounds that the intent in both cases is to bring about the patient's death.[3] For these reasons, the arguments proposed in this article will apply to all forms of assistance in dying, including active euthanasia.

Proponents of Assisted Suicide

Between one half and two thirds of Americans today favor the legalization of physician-assisted suicide in certain circumstances.[4,5] The public's attitude toward assisted suicide has changed during the past 15 years. In 1975, a Gallup poll showed that 41% of respondents believed that persons in great pain without hope of improvement had a moral right to commit suicide; in 1990, the figure had increased to 66%.[6] Similarly, a survey by the Harvard School of Public Health reported that 61% of all Americans would vote for an initiative legalizing physician-assisted suicide; 52% said they would consider some option to end their life if they had an incurable illness and were in a great deal of pain.[5]

Leading and organizing the effort to legalize physician-assisted suicide is the Hemlock Society, founded in Los Angeles in 1980 and now numbering over 40,000 members. Englishman Derek Humphry, its principal founder, was the organization's leader and spokesman until 1992 when, following adverse publicity surrounding the suicide of his second wife,[7] he stepped down as executive director. Humphry's most recent book, *Final Exit*,[8] marketed as a "how to do it" manual for those wishing to commit suicide, sold over 500,000 copies within 6 months of publication.

The Hemlock Society has led initiatives to legalize assisted suicide in Washington and California that were only narrowly defeated (both by a 54% to 46% margin). The issue, however, remains very much alive, and similar measures are expected to qualify for the 1994 ballot in California, Oregon, and Washington.[9] In a speech to the 1992 annual meeting of the Academy of Psychosomatic Medicine, Humphry emphasized that he hoped that future legislation would be as carefully considered and well reasoned as the California initiative. A number of California psychiatrists, on the other hand, argued that Initiative 161 was "a potential disaster" because of a lack of safeguards to prevent persons with treatable mental illnesses, eg, depression, from committing suicide.

Proponents' View

Almost two decades ago, philosopher James Rachels[10] argued that there was no ethical distinction between passive and active euthanasia. If one can justify not treating or withdrawing treatment from hopelessly ill patients to quicken death and reduce suffering, then providing them with more active assistance in ending their lives should pose no moral or ethical dilemma. In a more recent article, Weir[11] argues that assisted suicide is morally justifiable. Rather than harm the patient, physician-assisted suicide benefits him or her by relieving intolerable and useless suffering, some of which may not be amenable to even the most expert palliation. Assisted suicide enhances patient autonomy and reduces fear by giving the person control over the dying process. The argument for physician-assisted suicide has also been presented in several recent articles by Timothy Quill and Christine Cassel in *The New England Journal of Medicine*.[12–14] Death with dignity and control is seen as better than an agonizing, prolonged, and unpredictable death. Furthermore, the right to die is guaranteed in the first and fourth amendments to the Constitution, and therefore the right to end one's life is seen as being as impor-

tant as the right to life.[15] Finally, assisted suicide can benefit society by reducing the use of scarce medical resources on hopeless cases. The latter argument is seldom stressed, since proponents believe that if assisted suicide became available, it would be chosen by relatively few persons, and thus have little impact on resource conservation or on discouraging efforts by society to care for the needs of persons with debilitating illnesses.[2] Dr Quill has recently published a book entitled *Death with Dignity*,[16] which poses a very serious challenge to all physicians who would oppose physician-assisted suicide across the board.

Proponents believe that guidelines can be developed that would protect the safety of patients and prevent physicians, patients, and society from abusing this privilege.[12] Such guidelines, according to Quill et al,[14] include the following: (1) the patient must have a condition that is incurable (not necessarily terminal) and associated with severe suffering without hope of relief; (2) all reasonable comfort-oriented measures must have been considered or tried; (3) the patient must express a clear and repeated request to die that is not financially or emotionally coerced; (4) the physician must ensure that the patient's judgment is not distorted; (5) physician-assisted suicide must be carried out only in the context of a meaningful physician-patient relationship; (6) consultation must be obtained from another physician to ensure that the patient's request is voluntary and rational; and (7) there must be clear documentation that the previous six steps have been taken and a system of "reporting, reviewing, and studying such deaths" must be established.[14(p 1382)] A number of these guidelines are already in place in the Netherlands, where proponents believe the system works quite well.[17] As a final safeguard in the United States, ethics committees could be established to remove the responsibility for such decisions from any one physician. The practical aspects of exactly how monitoring would take place to ensure that guidelines were being followed, however, have yet to be worked out to everyone's satisfaction.

Opponents of Assisted Suicide

Those who oppose physician-assisted suicide include many influential and respected groups in America, among which are several professional organizations. The American Medical Association,[18,19] the American Geriatrics Society,[20] and the American Bar Association[21] have all spoken out against the practice and legalization of physician-assisted suicide. A recent article in the *American Journal of Psychiatry* by Herbert Hendrin (director, American Suicide Foundation) and Gerald Klerman (former director of the federal Alcohol, Drug Abuse, and Mental Health Administration) voices considerable concern within the psychiatric community about physician-assisted suicide.[22] I focus here on four major groups that tend to oppose physician-assisted suicide: physicians, bioethicists, the elderly, and religious organizations.

Physicians

Information on physicians' attitudes toward assisted suicide was sparse until recently. Evidence for opposition comes from the state of Washington, where the state medical society in 1990 voted 114 to 22 against Initiative 119, which would have legalized physician-assisted suicide. Similarly, the majority of the members of the California state medical society voted to oppose Initiative 161, which also failed to gain the majority vote from the public in the November 1992 election. A survey of Florida internists in 1991 found that 87% would not administer a lethal dose of a drug under any circumstances.[23] Opposition, however, is not uniform. A survey by the American Board of Family Practice found that 90% of 300 internists, family physicians, and psychiatrists agreed that terminally ill patients had a right *to choose to die*; however, this opinion primarily reflected support of withdrawal of life-sustaining therapy (passive euthanasia) rather than assisted suicide.[23] However, evidence of increasing support within the medical community for physician-assisted suicide comes from a recent decision by Michigan physicians to reverse their stand against the practice, preferring that it not be considered a felony.

Perhaps the best data are available from a study conducted by Watts and colleagues,[24] who surveyed 727 internist geriatricians on their attitudes toward assisting suicide among dementia patients. Fourteen percent of physicians said Dr Kevorkian's assistance of Janet Adkins' suicide in 1990 was morally justifiable; 26% favored easing restrictions on assisted suicide for competent, nondepressed dementia patients; and 21% would themselves consider assisting in the suicides of such patients. Again, these findings suggest that only a minority of physicians support physician-assisted suicide. Finally, a recent survey of hospice physicians, nurses, and volunteers found overwhelming opposition to assisted suicide.[25] Hospice physician David Cundiff provides an articulate and well-reasoned case against physician-assisted suicide in his book entitled *Euthanasia Is Not the Answer*.[26]

Medical Ethicists

A number of medical ethicists oppose the legalization of physician-assisted suicide in the United States.[27–33] Lead-

ing this group is Daniel Callahan, director of the Hastings Center of Bioethics.[34] In his book *Setting Limits*,[35] Callahan warns against the legalization of physician-assisted suicide, arguing that such an action may send unintended messages to older persons in our society. Callahan fears that elders will come to feel that "old age can have no meaning and significance if accompanied by decline, pain and despair." He is also concerned that younger persons will come to believe "that pain is not to be endured, that community cannot be found for the old, and that a life that is not marked by good health, by hope and vitality, is not a life worth living."[35(pp 193–197)] In a December 1990 international meeting of euthanasia experts at the Institute of Bioethics (Maastricht, the Netherlands), Callahan's strong opposition to physician-assisted suicide became explicit.

> To legitimize active euthanasia is to add a new category of killing. It is to add indeed the worst category of killing, namely private, self-determined killing between people, not for the sake of protecting the nation (as in war), not for the sake of justice (as in capital punishment), and not for the sake of saving a life (as in self-defense), but rather to satisfy private wants and desires.[35(p 29)]

The Elderly

Proponents of physician-assisted suicide argue that older persons should be allowed to end their lives if they choose. Humphry has supported the right of elderly couples to commit double suicide to avoid bereavement after one spouse has become terminally ill.[7(pp 96–99)] Although old age may be a criterion for physician-assisted suicide proposed by some advocates, many elders feel quite differently about this. Age has a strong impact on the percentage of Americans who favor physician-assisted suicide. The Harvard survey mentioned earlier found that whereas 79% of 18- to 34-year-olds favored physician-assisted suicide, only 64% of 35- to 49-year-olds and 53% of those over the age of 50 did so.[5] Although information was not given on the views of persons aged 65 years or older, the downward trend among the above three age groups suggests that the percentage of persons in this age group favoring physician-assisted suicide would probably fall below 50%.

Why does age make a difference? First, older persons tend to have more conservative values. Second, older persons may be less fearful of death and thus less desperate to be in complete control of the process. Finally, there may be concern that if physician-assisted suicide were legalized, elders with chronic or terminal illness might be manipulated, either consciously or unconsciously, into viewing themselves as unnecessary burdens and therefore pressured into committing suicide. Elders who have chosen to live rather than die may be made to feel guilty because they are consuming their family's inheritance or placing a burden on their caregivers. Besides guilt, this is likely to arouse feelings of resentment toward those (family members or others) who would put them in a position of having to choose between life and the more "heroic" or "dignified" option of assisted suicide.[28] The current law provides a buffer against pressures that might prompt elders to end their lives for others' sake. Legalizing physician-assisted suicide could subject the 998 out of 1000 terminally or chronically ill older persons who choose life over death to experience unnecessary psychological turmoil over their decisions to live.[36]

Religious Organizations

Although some religious denominations in the United States have spoken out in favor of legalizing physician-assisted suicide (Unitarian Universalist Church), most oppose it. Traditional doctrines in Christianity, Judaism, and Islam oppose the killing of oneself to avoid personal pain or suffering, and no major world religion condones suicide for self-serving purposes.[37] While this article does not explore the religious arguments for or against the legalization of physician-assisted suicide, a strong religious faith can make even the most intolerable suffering tolerable for some persons.[38] It does so by providing a framework in which suffering can have meaning and purpose.[39]

The Opponents' View

Opponents argue that although there may be cases where physician-assisted suicide could be considered an ethical alternative, it is one thing to justify an act, but quite a different thing to justify a general practice.[36] Undoubtedly, there are circumstances in which even the most stringent opponents would agree that assisted suicide is the best and possibly only ethical solution, particularly in cases where optimal medical care and pain relief are unavailable. Nevertheless, the risks of legalizing physician-assisted suicide on a more general basis are seen as far outweighing the benefits that it might provide to a few, especially given that sensible and safer alternatives exist.[32,36,40–42]

Concerns About Assisted Suicide

I will present here five reasons for displaying caution in legalizing physician-assisted suicide. The focus is primarily on medical and psychiatric considerations; social fac-

tors will be touched on only briefly. These concerns, which are hardly exhaustive, include the following: (1) ambiguous indications, (2) physician biases, (3) the "slippery slope," (4) failure to follow guidelines, and (5) the existence of sensible alternatives.

Ambiguous Indications

Most agree that three conditions must exist for physician-assisted suicide to be justifiable: (1) intolerable suffering and intractable pain, (2) terminal illness, and (3) a request by a rational patient. None of these conditions are easily verified.

Intolerable suffering and intractable pain. We all suffer to some extent over losses, failures, unmet expectations. There comes a point, however, when the severity of suffering crosses a threshold from tolerable to intolerable. That threshold varies widely from individual to individual for a given level of physiological pain. There is reason to believe that this "toleration threshold" can be affected without changing the level of physiological pain, since the psychological aspects of suffering often far outweigh the physical aspects. Suffering includes emotions such as fear, hopelessness, discouragement, fatigue, anger, and feelings of entrapment. Even if the level of pain remains unchanged, suffering can still be lessened, at least to the point that it is tolerable, by addressing emotional elements through psychological or psychosocial interventions.

Next, one must establish the intractability of pain or other physical discomforts such as nausea or breathlessness. According to Saunders,[43] approximately 10% to 15% of terminal cancer patients die with pain that cannot be entirely eliminated. Many of these patients, however, *choose* to tolerate pain to maintain mental alertness to take care of "unfinished business" in their final days. "Intractable pain" is actually a misnomer, since pain can always be reduced or even eliminated, if by no other means than by continuous anesthesia. Under such circumstances (when food and fluids are not forced), death quickly follows.

It is hard to say exactly how much suffering might be *made* tolerable, given adequate pain relief, support, and nurturance from others, and maximization of autonomy by providing personal control over health care decisions. Unspoken personal and interpersonal issues are commonly involved in a request for assisted suicide: fear of loneliness or abandonment, fear of dependency on others, frustration over a dismal situation, and anger toward family members or health care providers over unmet expectations. It may also represent a cry for someone to demonstrate that this patient's life is important, valuable to others, and worth the struggle to continue living. If the physician agrees to assist in the suicidal plan, the patient may interpret this as a confirmation of his or her worst fears: that life is indeed without purpose, meaning, or value, and *cannot become otherwise* during the patient's time remaining.[36,44]

Terminal illness. The accuracy of diagnosis for many diseases is imprecise. Even when the diagnosis is correct, predictions about the timing of death are quite unreliable. This is true for Alzheimer's disease, cancer, and many other disorders. After a complete medical evaluation, including extensive bloodwork and brain scans, physicians correctly diagnose Alzheimer's disease only about 75% to 80% of the time.[45] Cognitive impairment may be reversible with the treatment of various medical or psychiatric conditions, or at least may not progress if appropriate medical measures are taken (control blood pressure, stop excess alcohol use, replace thyroid medication, remove toxic drugs). Thus, it is hard to say when an illness is terminal and prospects for reversal or stabilization are no longer present.

Unimpaired reasoning. This condition requires that a person is rational, has no significant impairments in judgment, and can freely choose between alternatives. Psychiatrists report that at least 95% of suicide victims have a preexisting mental illness.[46,47] In a study of terminally ill patients, Brown and colleagues[48] found that it was not "normal" for even severely ill patients to either desire death or wish to end their lives. Other studies indicate that a high proportion of elders with chronic or terminal illness experience depression, with rates as high as 40% to 45%.[49,50] When emotional pain reaches a certain level, consciousness becomes constricted to the point where choices other than suicide cannot be appreciated by the patient. In such cases, treatment that lessens the emotional pain will broaden consciousness so that alternatives may be considered. Rather than infringe upon autonomy, the prevention of suicide and treatment of underlying emotional illness act to preserve and restore autonomy. Requests for assistance in committing suicide, then, often mean more than a simple expression of autonomy or individual choice. Although cases probably do exist, "rational" suicidal thinking in the setting of chronic and disabling medical illness is not common.[51]

On the other hand, one study by Lee and Ganzini[52] examined attitudes toward life-sustaining therapy in 50 depressed and 50 nondepressed elderly veterans hospitalized with medical illness. They found that depressed subjects desired fewer interventions (nasogastric tubes, kidney dialysis, ventilator support, etc) than control subjects in hypothetical scenarios with a good prognosis and in their *current* state of health; however, there were no differences between groups in poor prognosis scenarios. Based on the latter finding, one might conclude that depression does not have a major effect on the decision

making of chronically or terminally ill patients. Note, however, that failure to document attitudinal differences between depressed and nondepressed patients occurred only for *hypothetical* poor-prognosis scenarios, not real-life situations. Furthermore, attitudes toward acceptance or rejection of painful or cumbersome life-sustaining procedures may be quite different from attitudes toward suicide.

During the Durham Veterans Administration Mental Health Survey,[53] we examined the relationship between psychiatric disorder and suicidal thoughts in 444 consecutively admitted younger and older hospitalized medical patients. Among those under age 40 (n = 115), 19% of 57 patients with depression or other psychiatric disorder had at least fleeting suicidal thoughts at the time of evaluation; none of the 58 patients without mental disorder had such thoughts. Among patients aged 70 years or older (n = 329), 14% of 159 patients with depression or other psychiatric disorder had suicidal thoughts, compared with 1% of 170 patients without mental disorder (author, unpublished data, 1991). This suggests that suicidal thoughts almost always occur in the setting of psychiatric disorder.

Ruling out depressive illness and establishing rationality, particularly in the setting of chronic pain, suffering, or terminal illness, is a challenge for even the most expert clinician. Studies have shown that only 9% to 20% of depressed, medically ill older patients are diagnosed with this disorder by their medical physicians.[54,55] Part of the reason is that depression is very difficult to identify in these patients. Many symptoms of physical disease are identical with those of psychological distress. For example, chronic pain is usually accompanied by insomnia, fatigue, decreased concentration, and other psychological and physiological symptoms that are indistinguishable from depression and can impair judgment and reasoning.

Adding to this problem is that depression in the elderly may present *without sadness or dysphoria*. Approximately 50% of all depressed persons seen by physicians come in complaining about physical symptoms, aches and pains, that either have no organic basis or represent an exaggeration of real but minor physical problems.[56] This syndrome has been called "masked" depression.[56,57] Physical symptoms are often more acceptable to elders than emotional ones, which are seen by many as embarrassing and indicative of weak or unstable character. Thus, deciding whether mental illness is present in a suicidal patient with chronic illness often boils down to subtle perceptions, distinctions, and judgments. Such decisions are almost always made subjectively and with some degree of uncertainty, and are therefore easily swayed by the physician's own biases.

Physician Biases

Quill and colleagues[14] see *safety* for the patient in the stipulation that the physician involved ought to have an ongoing and, ideally, long-standing personal relationship with the patient. Indeed, it is precisely that relationship that will aid the physician in identifying intolerable suffering and unimpaired reasoning. Nevertheless, as the physician weighs the various factors noted above, his or her personal attitudes, feelings, and other factors invariably come into play. From a young healthy physician's standpoint, the disabled, chronic or terminally ill elder may appear to lack an acceptable "quality of life." If so, the physician may be more likely to agree that it is "reasonable" and "rational" for that patient to choose to end his or her life, while ignoring symptoms suggesting a reversible depressive illness.

Other factors that may influence a physician's decision include experiences within his or her own family, personal ethical and moral values, anxiety over death, feelings about the patient, and burden of treating that patient. The physician's objectivity may be further compromised by pressure from the patient's family (who are often paying the bills) whose motivations may not reflect the patient's best interests. Leaving the physician as the sole person responsible for deciding the patient's competence and rationality, then, can be problematic.

One solution, noted earlier, is to require that all such decisions either be reviewed by a hospital ethics committee or be reassessed by a second physician. Ethics committees, while preventing a single professional from taking full responsibility for such decisions, do not solve the central problem—that is, establishing with some degree of certainty that the conditions necessary to justify physician-assisted suicide are present. It is also unclear who would be chosen to sit on such committees or how these committees would be monitored and regulated. Many final decisions would ultimately rest on judgments made by the personal physician who knew the patient best. If that physician also had an active role in choosing the consultant who would provide a second opinion, consultation would become a farce.

Slippery Slope

The "slippery slope" argument contends that once the legal barrier to physician-assisted suicide is broken, there will be little justification for limiting this practice to the terminally ill. Wennberg[37(p 194)] notes that "once voluntary active euthanasia for the terminally ill is legalized, one can reasonably expect pressure to mount to secure legalized euthanasia for those with illness or physical impairment that is incurable, of a distressing character

but not terminal." This would include the nonterminal accident victim who, unlike terminally ill patients, has to face suffering for the rest of his or her lifetime. The same argument could be used to justify physician-assisted suicide for those suffering from chronic, degenerative diseases like Alzheimer's disease and other disabling conditions associated with old age.

In Holland, where physician-assisted suicide has been tolerated since 1973, 3% to 15% of all deaths occur by this method. Physician assistance with dying has now extended from terminal patients with cancer to chronically ill patients with paraplegia, multiple sclerosis, and "gross physical deterioration at advanced age."[58] According to Dr T. van Berkestijn, secretary general of the KNMG, this Dutch medical organization is now openly preparing guidelines for terminating the lives of incompetent patients: the demented elderly, the mentally handicapped, and defective newborns.[3] The eight cases of assisted suicide by Dr Kevorkian between 1990 and 1992 involving middle-aged or elderly women suffering from chronic but not terminal illnesses demonstrate that such things can happen in America, too.[59]

Social and financial pressures. Powerful social and financial forces exist that could influence the circumstances in which physician-assisted suicide could be carried out in the years ahead if it were legalized. The cost of health care in this country has been spiraling upward, and the pressure to contain costs has been accelerating. With these trends, we can expect an increasing tendency to limit the provision of health care for those who are less productive or seen as profiting least from such expenditures.[35] Physician-assisted suicide, then, would provide an all too expedient solution to the problem of an expanding, chronically ill elderly population.

Substituted judgment. How might a society implement physician-assisted suicide for incompetent patients? "Substituted judgments" made by either the physician or family member might be called on to justify such acts. Substituted judgments would have merit if it could be established that physicians and relatives accurately predict how patients might feel in such circumstances. Unfortunately, evidence for this is lacking.[60] Proponents of physician-assisted suicide argue that assisting the death of incompetent patients or of patients against their will would never happen; the situation in Holland, however, speaks loudly to the contrary. A recent survey of Dutch physicians' participation in patient deaths found that about 3% of all deaths in Holland could be attributable to physician-assisted suicide.[1] Physicians admitted, however, that nearly 28% of such deaths (500 to 1000 per year) were performed "without an explicit and persistent request" by the patient. Given this fact, it is difficult to argue that similar abuses could not occur in the United States.

Generation effect. While the current generation may be reluctant to liberalize conditions necessary to justify physician-assisted suicide, the next generation and the one following that may have other ideas, especially if they have been reared in a society where assisted suicide among the chronic or terminally ill is the norm. Wennberg[37(p 202)] notes that "It is hard to introduce for the first time a practice that conflicts with long-standing moral, social, and legal prohibitions; it is easier the second time."

Failure to Follow Guidelines

If physician-assisted suicide were legalized in America, how likely would it be that physicians would follow (or could follow) established guidelines for this practice? This is not a moot point. Dutch physicians have had many problems in this regard. In Holland, the only safeguard for assisted-suicide is the review of deaths by a coroner (a requirement by law). If physician-assisted suicide accounts for between 2000 and 10,000 deaths per year in that country, then one would expect a similar number of reports to coroners. Dutch coroners, however, say that they receive only about 200 reports of physician-assisted suicide per year.[36] Enforcing laws that standardize physician-assisted suicide has proven difficult in Holland, as it likely would in America. Because of the negative attitudes our society has toward suicide, maintenance of privacy has been a central component of inititatives for physician-assisted suicide in the states of Washington and California. Balancing this need with the need to control the practice and monitor for abuses would be a difficult task.

Sensible Alternatives

Rather than assist and support patients in ending their lives, physicians may choose to seek the underlying causes for suffering and then aggressively implement measures to correct them. This may include arranging for companionship to alleviate loneliness, mobilizing family members to dispel a sense of abandonment, providing assistive devices to help limit disability, or allowing the patient's participation in medical decision making to maximize autonomy and self-care. More research could be directed into improving medical control of distressing symptoms such as pain, nausea, and breathlessness, and conditions such as constipation, incontinence, and other intolerable physical problems associated with dying. Likewise, comprehensive psychological and spiritual care

could be offered to help lessen emotional discomfort, relieve anxiety or depression, and convey hope. Each of these actions requires more effort, more money, and more time than simply allowing patients to terminate their lives. Nevertheless, these actions preserve the traditional role of the physician as healer, sustainer of life, and afforder of comfort. Furthermore, such efforts prove to our elderly and young people that disabled and chronically and terminally ill persons are valuable to society, that life is worth fighting for, and that tough problems sometimes require tough answers.

Improving care for the dying. With good hospice care, most terminally ill patients can be made comfortable, even if pain cannot be entirely eliminated.[43,61] Adequate analgesia can be maintained with high doses of narcotics that are either self-administered by patient-controlled infusion devices or administered by a continuous intravenous drip monitored by health care providers. The emotional aspects of suffering (feelings of isolation, dysphoria, and anxiety) can be greatly diminished by having a close relationship with another person (family, friend, or hospice staff member), by supportive counseling, or in cases of severe depression, by use of antidepressants, tranquilizers, or sometimes, electroconvulsive therapy.

Allowing to die. Humane care for the dying includes recognizing when provision of comfort must become the primary goal. This is particularly true for terminally ill patients with only a few weeks or months to live who are suffering to the point that life has lost its meaning. This may also be true for certain patients with severe and irreversible dementia, those with irreversible coma, and those who exist in a persistent vegetative state (alive but with only minimal brain activity). Family members and friends should be encouraged to visit and spend time with their loved one. If suspected, depression or anxiety should be vigorously treated in conscious patients.

After arriving at a consensus by patient (when conscious), family, and health care providers (in that order), an agreement can be made to use whatever means necessary to provide comfort and relieve symptoms, even at the risk of hastening death. This plan should be clearly documented in the chart. Advanced directives may guide family and health care providers in making such decisions for unconscious or incompetent patients. At this point, all life support measures, including administration of food and water, may be withdrawn and interventions to prolong life avoided in circumstances where death is imminent and suffering is intolerable, or where consciousness has been obliterated by continuous anesthesia.

While the popular press portrays starvation and dehydration as the epitome of neglect, medical experts are aware that when death approaches, discomfort from hunger or thirst becomes minimal or absent. Starvation in this setting may even cause a release into the bloodstream of natural analgesic substances that act to relieve pain.[62,63] Similarly, limiting fluids will minimize secretions, ease respirations, decrease incontinence, and cause little discomfort to the patient.[64,65] Thus, forcing food or fluids into terminally ill patients who have little desire for these substances is not only counterproductive but cruel.

Instead, all efforts should be directed at simple comfort measures, such as providing good skin and oral care, maintaining a fresh and clean environment, and allowing the patient as much freedom as possible in deciding how and where to spend his or her final days. A narcotic analgesic such as morphine should be used freely and unrestrictedly to relieve pain, nausea, or shortness of breath. In some cases, an excess dose of such medication may inadvertently hasten or cause the patient's death. This risk should be acknowledged and is unavoidable.

Need for Research and Ongoing Debate

Sensible alternatives to physician-assisted suicide do exist and must be pursued. Nevertheless, the case for legalizing physician-assisted suicide is a strong one that cannot be ignored. Further research is needed on attitudes toward physician-assisted suicide held by the elderly and those with chronic or terminal illness, with and without mental illness. In addition, this topic needs continuing debate among those within medicine so that all sides of the question can be carefully considered. If we decide to legalize physician-assisted suicide, then guidelines should be carefully established, with physicians having an active role in the process. Family physicians must enter this debate and voice their support or concerns, since they are the physicians who would assist patients in committing suicide if the practice were legalized.

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