# WHEN DEATH IS SOUGHT

## ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT

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The New York State Task Force on Life and the Law

### The Risks of Legalization

- *Undiagnosed or untreated mental illness.* Many individuals who contemplate suicide – including those who are terminally ill – suffer from treatable mental disorders, most commonly clinical depression. Yet, physicians routinely fail to diagnose and treat these disorders, particularly among patients at the end of life. As such, if assisted suicide is legalized, many requests based on mental illness are likely to be granted, even though they do not reflect a competent, settled decision to die.

- *Improperly managed physical symptoms.* Requests for assisted suicide are also highly correlated with unrelieved pain and other discomfort associated with physical illness. Despite significant advances in palliative care, the pain and discomfort that accompanies many physical illnesses are often grossly undertreated in current clinical practice. If assisted suicide is legalized, physicians are likely to grant requests for assisted suicide from patients in pain before all available options to relieve the patient's pain have thoroughly been explored.

- *Insufficient attention to the suffering and fears of dying patients.* For some individuals with terminal or incurable diseases, suicide may appear to be the only solution to profound existential suffering, feelings of abandonment, or fears about the process of dying. While the provision of psychological, spiritual, and social supports – particularly, comprehensive hospice services – can often address these concerns, many individuals do not receive these interventions. If physician-assisted suicide is legalized, many individuals are likely to seek the option because their suffering and fears have not adequately been addressed.

- *Vulnerability of socially marginalized groups.* No matter how carefully any guidelines for physician-assisted suicide are framed, the practice will be implemented through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, isolated, members of a minority group, or who lack access to good medical care.

- *Devaluation of the lives of the disabled.* A physician's reaction to a patient's request for suicide assistance is likely to depend heavily on the physician's perception of the patient's quality of life. Physicians, like the rest of society, may often devalue the quality of life of individuals with disabilities, and may therefore be particularly inclined to grant requests for suicide assistance from disabled patients.

- *Sense of obligation.* The legalization of assisted suicide would itself send a message that suicide is a socially acceptable response to terminal or incurable disease. Some patients are likely to feel pressured to take this option, particularly those who feel obligated to relieve their loved ones of the burden of care. Those patients who do not want to commit suicide may feel obligated to justify their decision to continue living.

- *Patient deference to physician recommendations.* Physicians typically make recommendations about treatment options, and patients generally do what physicians recommend. Once a physician states or implies that assisted suicide would be "medically appropriate," some patients will feel that they have few, if any, alternatives but to accept the recommendation.

- *Increasing financial incentives to limit care.* Physician-assisted suicide is far less expensive than palliative and supportive care at the end of life. As medical care shifts to a system of capitation, financial incentives to limit treatment may influence the way that the option of physician-assisted suicide is presented to patients, as well as the range of alternatives patients are able to obtain.

- *Arbitrariness of proposed limits.* Once society authorizes physician-assisted suicide for competent, terminally ill patients experiencing unrelievable suffering, it will be difficult, if not impossible, to contain the option to such a limited group. Individuals who are not competent, who are not terminally ill, or who cannot self-administer lethal drugs will also seek the option of physician-assisted death, and no principled basis will exist to deny them this right.

- *Impossibility of developing effective regulation.* The clinical safeguards that have been proposed to prevent abuse and errors are unlikely to be realized in everyday medical practice. Moreover, the private nature of these decisions would undermine efforts to monitor physicians' behavior to prevent mistakes and abuse.