Should Assisted Suicide Be Only Physician Assisted?

Kathy Faber-Langendoen, MD, and Jason H.T. Karlawish, MD, for the University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel

Discussions in the media, courts, legislatures, and professional societies generally assume assistance with suicide to be a physician's task; in these venues it is commonly referred to as "physician-assisted suicide." This paper defines both the necessity and the limits of the physician's role in assisted suicide by asking the question: Should assisted suicide be only *physician* assisted? Although physician involvement is necessary, we argue that it is not sufficient to ensure that patients requesting assisted suicide receive the best care. Assisted suicide requires physician involvement, but physicians' limited competence in performing the full range of tasks, the competencies of other professions, and the possibility that other professions could expand their authority in this area suggest that *physician*-assisted suicide is a far too narrow construct of the task. The willingness of other professionals—including nurses, social workers, and clergy—to participate and even take the lead in assisting suicides is critical to meet society's interest that assisted suicide should be humane, effective, and confined to appropriate cases. As long as legislation and guidelines focus exclusively on the physician's role, our laws and regulations will fall short of meeting societal expectations.

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For author affiliations, current addresses, and contributions, see end of text.

Multiple public and professional opinion polls confirm that the right of terminally ill people to have access to legal assisted suicide is gaining acceptance in the United States (1–8). The implementation of Oregon's Death with Dignity Act shows that, in at least one state, public and professional preferences are strong enough to enact a legislated right to assisted suicide for the terminally ill. Numerous failed attempts to convict Jack Kevorkian for assisting with suicides suggest the lack of public sympathy for enforcing laws prohibiting assisted suicide; this sentiment does not extend to euthanasia, however, for which Kevorkian was convicted of murder.

In discussions in the media, courts, legislatures, and professional societies, assistance with suicide is generally assumed to be a physician task, where it is called "physician-assisted suicide." Legislative attempts, Oregon's law, public referenda, and proposed guidelines focus on physician responsibilities and procedures in helping patients end their lives (9).

However, deep, principled division exists in the medical profession as to whether physician-assisted suicide violates professional integrity (10–12). These divisions raise the concern that patients may not have access to physicians with adequate training, certification, or professional support to take the lead in assisted suicide. Among the 23 Oregon patients who received prescriptions for lethal medications in 1998, 6 had consulted multiple physicians before successfully obtaining the prescription (13). Equally important to the issue of access to physicians is the question of whether physicians are the best professionals to take the lead in assisted suicide, because physicians' qualifications in end-of-life care are not unique or even exemplary (14, 15). If society wants access to competent and effective assisted suicide, it ought to consider the extent to which other professions are better suited to assist in a suicide. Key questions include the following: Should assisted suicide be only *physician*-assisted suicide? Could another health care professional replace physicians? (For example, why not have *nurse*-assisted suicide?) Or could a variety of interested health care professionals assume this task?

The point of these questions is not to advance an argument either for or against assisted suicide. Alternatives to assisted suicide exist, including maximal efforts at palliative care, terminal sedation, and refusal of food and fluids, which many consider to be more morally acceptable. However, some find these alternatives inadequate, and Oregonians were sufficiently persuaded to have voted twice to legalize physician-assisted suicide. Although the debate about the morality of legalizing assisted suicide continues, both opponents and proponents have an interest in ensuring that the practice is appropriately restricted, analogous to public policy debates about abortion since the ruling of *Roe v. Wade.* The aim of this paper is to define both the necessity and the limits of the physician's role in assisted suicide by

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asking the question: Should assisted suicide be only *physician* assisted? Our argument is not about the ethics of *whether* to carry out assisted suicide but the ethics of *how* to do it, and our premise is that health care professionals ought not act outside their spheres of professional competence. This paper examines the tasks inherent in assisted suicide and the competence of people in various professions who might be able to do them. The current predominance of physicians in assisted suicide may be misdirected, misleading, and even unnecessary. Although physician involvement is necessary, we argue that it is not sufficient to ensure that patients requesting assisted suicide receive the best care. We will explain our position by examining the nature of assisting a suicide and the potential roles that nonphysician health care professionals could play in assisting suicide.

The Nature of Assisting a Suicide

In most proposed guidelines and regulations for assisted suicide, physicians have key roles. In contrast, other health care professionals are not mentioned or are involved at the physician's discretion (9). Physicians are expected to communicate prognostic information, provide palliative care options, assess depression, and provide the patients with the means to commit suicide. Although a physician's skills are necessary for many of these tasks (such as communicating prognostic information), medical means are not necessary for a person to end his or her life.

Suicide can be committed by using a variety of nonmedical methods, such as a gun, carbon monoxide, and asphyxiation (16). Unfortunately, these methods can be violent, messy, variably effective, socially isolating, or repugnant. In addition, a person could voluntarily decide to stop eating and drinking, dying by means of dehydration (a method that, although probably legal, is also morally controversial) (17). This process, however, takes a great deal of resolve on the part of the patient and caregivers and may take several days to weeks. The use of lethal doses of prescription medications has been advocated because it is quick; appears to be more humane, effective, and peaceful; and allows the person to die in the presence of loved ones.

The tendency to medicalize assisted suicide as a last resort for competent terminally ill patients bears more than a passing resemblance to the medicalization of capital punishment in the second half of this century (from hanging and firing squad to lethal injection). Physicians appear to be the most efficient and skilled professionals to effectively and humanely end a life. As is the case with capital punishment, physician expertise may be called upon in two areas: in the process of assessment before ending a life and in the provision or administration of the means (18). Although physicians have a key role in the assessment process (evaluating prognosis, providing palliative care options, and assessing depression), the provision of medical means per se need not be done only by physicians, as has been the case with capital punishment, if physicians determine that assisting suicide is incompatible with their professional values (19).

Moreover, even if physicians accept assisted suicide, they may not be the only or even the best professionals to implement humane and effective assisted suicide. The physician's skills in this area might even be surpassed by those of other health care professionals. In light of the medical profession's ambivalence about accepting this role, the predominant role that physicians have been assigned needs careful scrutiny.

Potential Roles of Physicians and Nonphysicians in Assisted Suicide

As society legalizes assisted suicide, it maintains interests in confining suicide to appropriate cases by using methods that are effective but not violent, and in protecting patient and family privacy. To meet these interests, we suggest that assisted suicide by prescription of lethal medication should require, at the minimum, the following steps:

1. Assessing the request for assisted suicide
2. Preparing the person for dying
3. Providing the means
4. Providing support as requested during administration of the medications and while the patient is dying
5. Managing complications
6. Reporting the assisted suicide
7. Coordinating and overseeing the overall process

Examining the competency of various professionals who might have a role in an assisted suicide shows that these seven steps are not the exclusive domain of physicians.

Assessing the Request for Assisted Suicide

The initial assessment of a request for assisted suicide is clearly within the physician's expertise. Physicians generally assume primary responsibility for communicating information about diagnosis, prognosis, and the full range of treatment options; ensure that every reasonable attempt to provide palliative care has been made; and assess concomitant factors, such as depression, that may adversely influence a patient's decision. The task of assessing requests for assisted suicide is an effort to help patients consider all alternatives, often with the

hope that they will find an acceptable option to suicide (20).

Some might argue that a physician's involvement in assessing a request for assisted suicide involves an unacceptable level of moral complicity with an intended suicide. However, we believe that the physician's role in this process is analogous to the role of a psychiatrist who is opposed to the death penalty and is called upon to offer an opinion of a defendant's mental competence to stand trial for a capital offense, or the role of a physician consulted by the Social Security Administration to provide a medical assessment of whether a patient is too disabled to work. The physician contributes important information about the patient's diagnosis, prognosis, and response to treatments, but others decide whether the patient is incompetent or disabled and act upon the consequences of that decision. Assessment of a request need not imply moral agreement with the final outcome, be it the death penalty, disability determination, or assisted suicide.

Preparing the Person for Dying

Other critically important tasks are far outside physician expertise and can be accomplished only through the expertise of others (21). For many patients, spiritual issues are a part of confronting death (22), and contemplating suicide raises spiritual questions of control, the meaning of suffering, and final destiny. Because spiritual concerns translate into religious beliefs for many Americans, physicians are often ill-equipped to deal with such issues: They tend to be less religious, less likely to believe in God, and less likely to believe in prayer than the general population (23–26). In addition, patients choosing assisted suicide merit maximal efforts at relieving physical and mental distress. Experience in hospice shows that skilled nurses effectively provide this with physician support. Finally, there is the need to assess whether potential coercive factors are unduly influencing the person's request. Factors such as family dynamics and economic pressures are best confronted by those who are expert in the psychosocial aspects of care. Addressing issues of coercion, spiritual concerns, and symptom control clearly requires expertise beyond that of physicians and is often better provided by nurses, social workers, and clergy or other spiritual advisors. Physician involvement alone is insufficient.

Providing the Means

Public and legislative debates continue to focus on the task of prescribing lethal drugs for assisted suicide (27), and state regulations currently grant physicians exclusive prescribing authority for medications commonly used for assisted suicide. Although nurses and physician assistants are generally prohibited from prescribing schedule II drugs, such as secobarbital or morphine, many states already grant limited independent prescribing authority to nonphysician health care professionals (28). Physicians need not be the only ones who can prescribe drugs commonly used for assisted suicide. Nurse practitioners or physician assistants could be granted independent prescription authority to exercise after a physician certifies that a patient meets the prognostic and diagnostic criteria for assisted suicide and is competent to make the decision to commit suicide. Expansion of prescribing authority may improve access to assisted suicide if few physicians are willing to assist (13); however, it also makes it possible to bypass physician involvement. This is a risk that may be unacceptable considering the necessity of physician involvement in assessing diagnosis, prognosis, and the full range of treatment options.

Providing Support as Requested during Administration of the Medications and while the Patient Is Dying

One of the arguments advanced for legalizing assisted suicide is that legalization allows people to die in the presence of those who care for them, without fear of putting these people at risk for prosecution. Patients and families may choose to have others present to lend emotional support and monitor the dying process. Such assistance could be provided by a variety of health care professionals, including nurses, physicians, social workers, and clergy. Whereas a physician ought to be available should complications arise, the physician is unlikely to be the key player in attending to the patient's and family's needs during the dying process.

Managing Complications

The problem of how to manage a failed assisted suicide attempt presents a task unlike any previously assumed by health care professionals. When assisted suicide is attempted but the patient does not die, who should take further steps, if any, to end the person's life? Although physicians clearly have the medical means to end life under these circumstances, there is likely to be even greater professional resistance to this scenario than prescribing lethal drugs for self-administration.

Exact data on the incidence of this problem are difficult to obtain, given the illegality of assisted suicide in most jurisdictions. Anecdotes exist of assisted suicides gone awry, with patients vomiting the drugs or the doses being insufficient, so that family members or others eventually ended the person's life by asphyxiation with a pillow or plastic bag (29). One could argue that these cases result from "amateur" attempts and that such events are far less likely to occur in the hands of properly trained

experts. Although the Dutch practice in ending patients' lives generally proceeds by the use of intravenous sedation followed by intravenous paralytic agents (and thus falls under the category of euthanasia), some Dutch data about the use of oral drugs for assisted suicide are available (30, 31). If sufficient quantities of barbiturates are ingested without vomiting, most patients die within 1 hour; approximately 25% survive up to 5 hours, and a few survive up to 24 hours. Of the 75 reported cases that involved oral medications, 77% of the patients died without further intervention. However, 20% of the patients died only after additional administration of intravenous paralytic agents, suggesting that oral medication alone may be insufficient or unacceptably slow for a substantial minority of patients wishing to end their lives (30, 31). These data suggest that failed attempts happen.

Although dealing with failed attempts at suicide falls far outside the physician's traditional duty, someone (whether physician, family, nurse, or others) will have to attend to such complications. Regulations that do not anticipate this outcome and specify who will take action are shortsighted and will not serve patients well. Expanding the capacity and authority to complete failed attempts to other competent and willing health care professionals may protect patients' abilities to have their lives ended humanely, but it will extend medical practice from assisted suicide to euthanasia, a development that many will find unacceptable.

Reporting the Assisted Suicide

In Oregon and according to most guidelines, completed assisted suicides must be reported. This step is of little importance to the individual but is important for the public, health care professionals, and those who may seek assisted suicide in the future because it provides a way to monitor the practice of assisted suicide. Although such a report cannot correct mistakes in a particular suicide, it can help to ensure that future assisted suicides meet established procedural safeguards. In general, physicians report on a death by completing death certificates. This practice leads one to assume that physicians should also be the ones to report on an assisted suicide, as Oregon law stipulates. But if other professionals serve key roles in the steps that lead up to an assisted suicide, then they should also report on their involvement in assisted suicide. Perhaps the most sensible model for reporting is that all professionals who participate in the assisted suicide should jointly report on it. This broad documentation assures the public that patients will receive the best possible multidisciplinary care and that all professionals who participate will account for their role.

Coordinating and Overseeing the Overall Process

Assisted suicide requires a sequence of complex and important tasks. Rarely will a single health care professional be expert in all of these tasks, and several of the essential components can and perhaps should be done by professionals other than physicians. Yet, the Oregon Death with Dignity Act assigns physicians the role of total oversight and coordination, which probably reflects physicians' traditional lead in orchestrating medical care, particularly in the diagnosis or treatment of disease. But assisted suicide involves tasks and skills that extend beyond a physician's abilities. Even in areas that do fall under the physician's domain, such as pain and symptom management, actual practice is often shamefully inadequate (15).

If no single health care profession has all of the skills needed, perhaps the best model is the type of multidisciplinary care practiced in rehabilitation and hospice. When patients die under the care of a hospice, it is often the hospice nurse who coordinates the care and ensures that emotional, financial, relational, and medical issues are addressed, while the physician retains a key role in prescribing medications and, at times, providing compassionate support to the patient and family. The traditional hierarchies of authority in the health care professions, as well as physician-oriented methods of reimbursement, might make the orchestration of assisted suicide seem to be a physician-led task. But this responsibility could just as well be assigned to a nurse or other health care professional, or it could even be assigned to someone outside the health care profession, such as clergy. In a model of an assisted suicide with a nonphysician health care professional overseeing and coordinating the process, a physician might assess the request and a multidisciplinary team, led by a nurse, might perform the other steps. Although this team could include a physician, it would not need to be led by a physician.

Whether this model would better ensure that the multiple facets of a request for assisted suicide were attended to is unknown, but it is a matter that could be subjected to empirical scrutiny, much as the Dutch have examined their practices of assisted suicide and euthanasia. On a principled level, having other professionals oversee the process of assisted suicide both emphasizes the critical participation of nonphysician health care professionals and recognizes the physician's limited expertise in the various tasks involved.

Discussion

The debate over assisted suicide is overly focused on the physician's role. Assisted suicide requires

physician involvement, but several factors, such as the limited competence of physicians in performing all of the tasks, the competencies of other professions, and the possibility that other professions could expand their authority in this area, suggest that *physician*-assisted suicide is a far too narrow construct of the process. The need for a multidisciplinary approach to assisted suicide is precisely the same need that led to the formation of hospice programs that attend to the dying and their families, a model that may apply to assisted suicide. The federal government, through Medicare regulations, will certify only those hospices that provide physician, nursing, social work, and spiritual services. Regulations for assisted suicide could also be written to ensure that those persons seeking assisted suicide should have access to a skilled and multidisciplinary group of experts. A physician may need to be part of, but not necessarily the leader of, that group.

Statements from nonphysician health care professional organizations demonstrate that, just like physicians, they are still defining their willingness to attach their professions to assisted suicide. The American Nurses Association and Oncology Nursing Society have published statements against assisted suicide; the Oregon State Nurses' Association has an ambivalent statement regarding nurses' involvement (32–34). The American Association of Physician Assistants has an ambiguous statement regarding physician assistant involvement, although it does state that physician assistants may act if they are following physician's orders (35). Social workers are encouraged by the National Association of Social Workers to explore alternatives to assisted suicide with patients. This association states that social workers ought to be free to support patients and families during an assisted suicide, although the policy cautions social workers against assisting with administration of lethal medications, adding "it is inappropriate for social workers to . . . personally participate in the commission of an act of assisted suicide" (36). The 1994 Code of Ethics of the American Pharmacists Association does not directly address physician-assisted suicide. Recent surveys show that approximately half of pharmacists support physicians or other health care professionals assisting in suicide and that a sizable minority would agree to dispense drugs for this purpose (37).

The range of opinion regarding the morality of assisted suicide suggests that no health care profession is likely to unequivocally embrace the provision of lethal medications for assisted suicide as part of their profession or to take the lead in coordinating the care of patients wishing to end their lives. However, that same ambivalence and variation in opinion suggest that sufficient support may exist for developing a new health care structure (analogous to hospice) derived from multiple health care disciplines that is willing to provide assisted suicide. This new structure, which could include physicians, nurses, clergy, social workers, and pharmacists, would be united by the common goal of defining the standards and training required to fulfill a person's request for assisted suicide. State laws and regulations could be rewritten to grant this multidisciplinary structure the authority to provide assisted suicide.

Conclusion

Stipulations that assisted suicide must be *physician* assisted may ensure society a level of review and an exploration of alternatives that may not occur if assisted suicide remains a private, illegal act. But physician-assisted suicide is far too narrow a construct to meet the public's expectation that some persons should have access to humane and effective assisted suicide. Physician assistance, which may be necessary, is insufficient to ensure that assisted suicide is restricted to appropriate cases and occurs in an appropriate manner. This is most likely to be the case if assisted suicide becomes more widely legal because the average physician is arguably ill-prepared to lead assisted suicide. The willingness of other health care professionals—including nurses, social workers, and clergy—to participate and even take the lead in assisting suicides is critical to meet society's interest that assisted suicide should be humane, effective, and confined to appropriate cases. As long as legislation and guidelines focus exclusively on the physician's role, our laws and regulations will fall short of meeting this assurance.

From SUNY Health Science Center, Syracuse, New York; and University of Pennsylvania, Philadelphia, Pennsylvania.

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Requests for Single Reprints: Lois Snyder, JD, Center for Bioethics, University of Pennsylvania Health System, 3401 Market Street, Suite 320, Philadelphia, PA 19104-3308; e-mail, lsnyder@mail.acponline.org.

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Current Author Addresses: Dr. Faber-Langendoen: Program in Bioethics, SUNY Health Science Center, 750 East Adams Street, Syracuse, NY 13210.
Dr. Karlawish: University of Pennsylvania, Institute on Aging, 3615 Chestnut Street, Philadelphia, PA 19104.

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