

To: Secretary Alex Azar, U.S. Department of Health and Human Services
From: Madeline Klineman, Georgetown University, Washington, DC
Re: Federal Implementation of Physician-Assisted Suicide Legislation
Date: 3 April 2018

CALL TO ACTION:

To develop stronger and more varied end-of-life treatment care plans, end stigmatization of death, and strengthen the economic stability of healthcare in America, it is imperative that the Department of Health and Human Services adapt the Washington State Death with Dignity Act 70.245 RCW to the national level, legalizing and increasing regulations for physician-assisted suicide in the United States.

STATEMENT OF PROBLEM:

Currently in the United States, healthcare spending is at an all-time high and costs the country \$3.3 trillion dollars annually. It is imperative to reduce spending while also increasing the choice that patients have in their care. One major sector of healthcare spending is end-of-life care and according to the Kaiser Family Foundation, “63% of those who say their own health is only fair or poor...say most people in the U.S. have too little control” (Hamel, et. al, 2014). Per the same report, over 75% of Americans support “having Medicare cover discussions between doctors and patients about end-of-life treatment options” (Hamel, et. al, 2014). One treatment that is not discussed is physician-assisted suicide (referred to in this proposal as PAS). This is because at the federal level, PAS is illegal and unsupported in the medical community. Dr. Atul Gawande, executive director of Ariadne Labs and professor at Harvard School of Public Health argues that “Congress need[s] to incentivize healthcare systems...by initiating...changes that are more likely to make a difference” (Gawande). It is critical to the aging population of America to be able to discuss freely their medical decisions regarding palliative and end-of-life care with their medical providers. To solve this financial, restrictive, and ethical challenge posed to the American people and government, United States Congress and the Department of Health and Human Services must implement new regulations, following the design of Washington’s Death with Dignity Act, to legalize and strongly regulate PAS across the country.

RATIONALE FOR POLICY RECOMMENDATION:

In attempt to recreate end-of-life care in the United States, it is imperative to provide patients access to more choices for their treatment. By legalizing and implementing further regulations on PAS, Congress will increase the ability to have truthful conversations with care givers and loved ones about palliative treatment and reduce overall stigma towards death. When taking this direction ethicists and the general population alike argue that PAS revokes a patient’s autonomy. I will dispute this, among other bioethical theories to prove that under ethical analysis, PAS is sound.

Kant’s universal law categorical imperative is paramount to the discussion of PAS and while many take the stance that if everyone can commit suicide then it will be detrimental to society

and law, but I refute this concept by arguing the implementation of regulations together with the federal legalization of PAS to prohibit this from occurring. In adapting the Washington State Death with Dignity Act Chapter 70.245 RCW to the federal level, you will prohibit everyone from pursuing “death with dignity.” Further, Chapter 70.245 RCW outlines that one must be “competent” and able “to make and communicate an informed decision” and also be terminally ill with less than six prognosticated months of life remaining (Chapter 70.245, 2009). Another aspect of Kant’s categorical imperatives used to argue against PAS is the second formulation: Humanity as an End in Itself. This says that any being should be treated “not merely as a means” but be “regarded at the same time as an end” (Vaughn 60-1). In this way, opponents of PAS argue that by killing a patient they are only a means to death, not an end. That said, by removing their pain and respecting their personhood and autonomy, you are treating them as both an end and a being. Which brings me to my final Kantian ethical rationale of implementing PAS regulations nationally. While some argue that PAS revokes a physician’s autonomy, in the same way that doctors can refuse to provide certain treatments, a doctor can refuse to provide PAS. While John Arras argues that “physicians are being called upon to do the killing,” regulations and legalization would result in no duty on the physician to do so (Vaughn 630, Arras qtd. in Vaughn 665). But in legalizing PAS, the nation will respect the autonomous choices of the patient in their end-of-life care and that of the physician to provide said care. The legalization would create a difference in moral responsibility and would define the meaning of death reducing the stigmatization and argument of PAS opponents nationally.

Many believe that according to the Hippocratic Oath, which physicians take upon entrance to medical school, physicians must “Do no harm,” but that statement, among others, is not written in the Oath at all. Many argue that PAS is a direct violation of the Hippocratic Oath including John D. Arras. He writes, “the imposition of medical treatment against one’s will represents a violation of personal autonomy and physical integrity totally incompatible with the deepest meaning of our traditional respect for liberty” (Arras qtd. in Vaughn 671). This statement is rooted in the values instilled by the Hippocratic Oath, none of which are violated due to PAS. The key rationale here is that when utilizing PAS, no physician is imposing medical treatment against one’s will. Based on Chapter 70.245.070 of the Washington State Death with Dignity Act, informed consent is a necessary criterion for being eligible for PAS. Not only does this support the Hippocratic oath, but it also supports theories of beneficence, utility, and respecting the ends of medicine.

The ethical theory of beneficence is critical in medical ethics and PAS is practicing exactly that while also aligning to meet with theories of Preference Utilitarians. In reducing the harm for a patient via PAS, the physician respects patient autonomy and also reduces harm for others due to the burden of losing a family member and their intense pain and suffering in their last moments of life (Vaughn 630). According to the Kaiser Family Foundation, over 85 percent of Americans believe that patients and their families should have a greater say in which treatment options to pursue for patients who are seriously ill and nearing the end of life (Hamel, et. al 2017). Further, this aligns with preference utilitarian views because it is imperative to meet an individual’s preferences, most notably in their healthcare. Finally, PAS respects the ends of medicine. Much of the care provided throughout a person’s life occurs in their last month. This concept shows that providing care during that time is not necessarily useful and extremely costly. Not only does this show that PAS would be within the ends of medicine to alleviate pain, but it will also give

economic relief towards the draining system of health care in America, for the government as well as individuals and families.

According to a 2017 study directed by the Kaiser Family Foundation researching what people around the world and in the United States look for in their health care, “just over half (54 percent) say that making sure their family is not burdened financially by their care is ‘extremely important’” (Hamel, et. al, 2014). “In 20 percent of cases, a family member had to quit work or make some other major lifestyle change; almost one-third of these families lost all of their savings; and just under 30 percent lost a major source of income” (Covinsky et al., 1994). It is important to recognize that “the lives of our loved ones can also be devastated just by having to *pay* for health care for us” (Hardwig 93). While the legalization of PAS will contribute to the financial well-being of families of terminally ill patients, the regulations will ensure that this is not the reason patients are looking to obtain PAS. The Washington State Death with Dignity Act outlines the assurance of zero-coercion in requesting and obtaining PAS (Chapter 70.245, 2009).

Moreover, allowing insurance companies to cover PAS will save the government money in the end-of-life care as well as aligning with the general population’s support for “plac[ing] responsibility [for end-of-life care] on the government (42 percent)” (Hamel, et. al, 2014). Given the support from the government in allowing PAS, families will be able to discuss death more openly without government-supported stigmatization, and both families and patients will see the ultimate benefit of allowing PAS. While arguably morbid, it is important to recognize that “there are...times when death comes too late because *others*...would be better off...overall, despite the loss of a loved one” (Hardwig 91).

BACKGROUND INFORMATION AND POLICY IMPLICATIONS:

The recommendation to adapt the Washington Death with Dignity Act 70.425 RCW to the federal level would include all the criteria of the terminally-ill patient to qualify to receive aid-in-dying drugs from their physicians. These include, but are not limited to, a competent adult suffering from a terminal illness (prognosticated to die within six months) who provides voluntary expression of wishes and has been given informed consent (Chapter 70.245.020).

The political implications of these laws and the proposal of a national piece of legislation overturning the Assisted Suicide Funding Restriction Act of 1997 and legalizing physician-assisted suicide would be met with opposition, but a majority of the country has shifted towards its support in recent years. Atul Gawande argues that we must shift focuses in end-of-life care because “we don’t ask what priorities people have...besides living longer” (Gawande). Moreover, more than 85 percent of patient’s state that it is “more important for doctors to be completely honest even if there is little chance of recovery” (Hamel, et. al, 2014). By implementing a new policy, the conversation between patients and their physicians will be more open and honest and terminally-ill patients will have more options for their end-of-life care.

BACKGROUND OF PROBLEM:

Due to the intrinsic reaction to *killing* in the United States and around the world, the concept of physician-assisted suicide is met with much opposition. However, it is important to recognize the

independent nature of those requesting the aid-in-dying prescriptions for a peaceful and dignified death. While “passive euthanasia is legal and officially endorsed by the medical profession,” PAS is not (Vaughn 626). This is because passive euthanasia is used for someone considered brain dead. As of 2014, “Americans ages 65 and up made up 15 percent of the total U.S. population” and it is projected that by 2030 that percentage will be closer to 20 (Hamel, et. al, 2014, Ortman, Velkoff, and Hogan, 2014). The important aspects of health for that population according to a study conducted in 2014 by the Kaiser Family Foundation is “making sure their wishes for medical care are followed” (Hamel, et. al, 2014). While 49 percent of respondents felt this way respectively, only 23 percent felt that “living as long as possible is extremely important to them,” whereas 71 percent hope to “die without pain, discomfort, and stress” (Hamel, et. al, 2014).

As seen by the aforementioned statistics, most of those nearing death would prefer a peaceful, painless death to living as long as possible. Because of this, much of the government healthcare spending is on care that the patients do not want. Moreover, until 2015 patients were not able to have these conversations about end-of-life care with their physicians because insurance did not cover them. By implementing further regulations on PAS and ensuring the meeting of criteria, and legalizing PAS nationally, the United States could save on unnecessary care while also improving the health relations between physicians and patients nearing end-of-life.

RELEVANT STAKEHOLDERS AND PERSPECTIVES:

Many groups have a stake in the problem of physician-assisted suicide. This is because it is a very controversial topic in the government as well as medically. The American Medical Association denounced physician-assisted suicide arguing that it is against the Hippocratic oath to not save lives. In 2008, out of 2,000 respondents, 69 percent objected PAS, but only 5 percent objected withdrawing life support (Curlin, 2008). Because of the moral responsibility and illegality of PAS many do not support it. But in these two examples, the effect is the same. According to the American Medical Association, “it would be difficult or impossible to control” PAS if it were legal (Family Law). Similar to that of the American Medical Association, the Vatican supports withdrawing life support. However, in 2015, “nearly seven in 10 Americans (68%) say doctors should be legally allowed to assist terminally ill patients in committing suicide” (Dugan). In this way, one can see that the perception of PAS is changing.

LEGISLATIVE CONTEXT:

In November of 1990, Congress passed the Patient Self-Determination Act, allowing patients the autonomy to refuse any and all medical treatment. What followed was political activism surrounding patient rights in respectful and dignified death. In 1994, Oregon was the first state to pass a law legalizing physician-assisted suicide. Oregon’s Death with Dignity Act of 1994 allowed terminally-ill patients to request aid-in-dying drugs at a lethal dose. The law “allow[s] qualified mentally competent, terminally-ill adults to request prescription medication from their physician for... hastening death” (Death with Dignity National Center, 2018). In 1997, President Bill Clinton signed the Assisted Suicide Funding Restriction Act of 1997 which prohibits the use of federal funds for aid-in-dying treatments (Family Law). Washington followed Oregon’s lead in 2008 by passing their own Death with Dignity Act 70.425 RCW. Since 2008, three more

states have passed Death with Dignity laws including Vermont, California, Colorado, and most recently the District of Columbia in 2017 (Death with Dignity National Center, 2018). Per the Death with Dignity National Center, 30 states considered death with dignity laws in 2017.

According to Franklin Miller, “physician-assisted suicide currently exists in secret” nationally (Miller). Because of this, the illegality of PAS “compromises the professional integrity of physicians and undermines respect for the law” (Miller). In this way, the current legislation in place is not effective to stop the act of PAS and by implementing a federal law the regulations can be monitored and followed more closely. In recent years, there have been movements toward legalization of PAS and in 2015 “Medicare announced that it would pay for conversations about end-of-life care” (Hamel, et. al, 2014). This is a time where the political window for legislation is open.

OVERVIEW OF PROS AND CONS AND RAMIFICATIONS:

In the United States, as previously mentioned, healthcare costs are consistently rising. With the implementation of a new piece of legislation legalizing physician-assisted suicide, the likelihood of decreased costs in palliative care is certain. While the average life reduction from PAS is “less than 3.3 weeks,...forgoing [only] four weeks of life and using hospice care at the end of life...[can] produce a savings of [approximately] \$336 million” (Emanuel and Battin, 1998). Not only will the decreased costs be beneficial to the United States economy but legalizing PAS will have personal benefits for various stakeholders as well.

Physicians who are not accepting of providing illegal care, but support PAS will be able to give quality care to those who they serve without having to do so in secret. Unfortunately, it is possible that physician malpractice insurance will increase due to the fatal nature of the prescription. Further, there may be setbacks by those who are religiously affiliated and those who oppose PAS. That said, according to a study by The Economist, only 50 percent of Americans said that “religion played a ‘major role’ in their thinking about end-of-life care” (Final Months, Economist). There is a possibility that the general public will disagree with the choice to legalize PAS, in a 2013 study “67 percent of Americans were against physician-assisted suicide;” however, this data did not include any respondents from Oregon or Washington, two states who have already legalized PAS (Colbert). And in recent years, many more are in favor of legalization. Finally, for those strongly connected to the terminally-ill they will have an ease of care-taking as “continuing to live takes...a toll on the lives of those connected” to them (Hardwig 93). In conclusion, the United States Congress and the Department of Health and Human Services must move forward to pass legislation adapting and federally legalizing Washington State’s Death with Dignity Act.

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