

PHYSICIAN-ASSISTED SUICIDE – A QUALIFIED ENDORSEMENT

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Introduction¹

Most people would like to continue living. Empirical research, done time and again, shows this very clearly. I have visited more than thirty hospitals in Israel, England, Canada, the United States, Australia, New Zealand, the Netherlands and Belgium. Most patients, even in the most dreadful conditions, opt to life. This is more so when patients are Catholic, Jews and Muslims.² This is less so in the Netherlands and Flemish-Belgium.³ But the general picture is clear: We all possess a zeal for life. Therefore, whenever we are unclear about the patients' wishes, the default position we should take is that the patients opt to life.⁴

Only a small minority of patients expressly wish to die. In this article, I first discuss who the patients who wish to die are. Then I speak of the role of the medical profession and whether they should help all who wish to die. I further emphasise the importance of comprehensive palliative care and voice my objection to euthanasia, insisting on a comprehensive system of checks and balances when we wish to come to the patient's aid. My plea is confined to physician-assisted suicide, where the last act is done by the patient and where the control lies with the patient.

I. Who Are the People Who Wish to Die?

Generally speaking, the common denominator of patients who express a desire to die is a strong sense of autonomy. We are unable to control the moment we are born. We are able, to an extent, to control the moment we depart life. These patients insist on having this right. They wish to control the moment of their death. When life lost its appeal for them, they ask to die. Continuous life is perceived to them as agonising. And they approach the medical profession for help because they do not wish to awaken to even more dreadful conditions, in the event that their suicide attempt goes wrong and they will be required to live with the deteriorated consequences. In Oregon, research over the past few years has consistently showed that the most frequently mentioned end-of-life concerns are loss of autonomy, decreasing ability to participate in activities that made life enjoyable, and loss of dignity.⁵

Patients who wish to die are inflicted with degenerative, incurable and painful diseases; sick people who know that death is near, and wish to cease

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¹ All websites were accessed on November 9, 2010.

² Raphael Cohen-Almagor, *The Right to Die with Dignity: An Argument in Ethics, Medicine, and Law*, Piscataway, NJ.: Rutgers University Press 2001.

³ Raphael Cohen-Almagor, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing*, Dordrecht: Springer-Kluwer 2004; 'Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement', *Issues in Law and Medicine* 2009-3, pp. 187-218.

⁴ See *Israel Dying Patient Law*, Chapter C, Section 4 (December 15, 2005).

⁵ *Eighth Annual Report on Oregon's Death with Dignity Act* (March 9, 2006); *Oregon's Death with Dignity Act – 2007*; *2008 Summary of Oregon's Death with Dignity Act*; *2009 Summary of Oregon's Death with Dignity Act*, all documents at <http://www.oregon.gov/DHS/ph/pas/ar-index.shtml>.

fighting against it, cease their bodies and surrender. Weighing the continuation of life against death, they see more advantages in departing life than in maintaining it. In the Netherlands⁶ and Belgium⁷, most of the people who approach physicians with requests for Physician-Assisted Suicide (PAS) and euthanasia are cancer patients. Cancer is a painful disease that inflicts significant suffering.⁸ Many patients do not wish to fight against it for too long.

The liberal state is founded upon the principles of autonomy and individuality. All stems from the individual, and all returns to the individual. The state is perceived as a developed instrument to help sustain our individuality within a just society. The state is far more powerful than a mere individual; it is a tool to enrich individuality, to enable people developing their innate capabilities, to facilitate progress of individuals which, in turn, will yield societal progress. Autonomous people at the end of life may expect liberal society to address their needs and concerns, provided that these needs and concerns do not harm others, are deemed justified and done in *bona fide* manner. The view that holds that we should always preserve life no matter what the patient wants, and that patients who opt to die are not able to comprehend their own interests in a fully rational manner, and that therefore 'we' know what is good for those patients better than they do is morally unjustifiable. This view is morally unjustifiable because it ignores the desires of the patients and does not acknowledge that the preservation of dignity may be valued more by some patients than the preservation of life. We must strive to reconcile the duty of keeping a person alive with her right to keep her dignity, which may also be considered as an intrinsic value. Therefore, the request for assisted dying may be justified; it has a place in the framework of liberal-democracy. Liberal democracy should not turn a blind eye to such appeals. It should not desert its patients and should attempt to accommodate their needs.

⁶ P.J. van der Maas, J.J.M. van Delden, L. Pijnenborg *et al.*, 'Euthanasia and Other Medical Decisions Concerning the End of Life', *Lancet* 1991 (vol. 338), pp. 669-674; P.J. van der Maas, J.J.M. van Delden, and L. Pijnenborg, *Euthanasia and other Medical Decisions Concerning the End of Life*, Health Policy Monographs, Amsterdam: Elsevier 1992; David C. Thomasma, Thomasine Kimbrough-Kushner, Gerrit K. Kimsma and Chris Ciesielski-Carlucci (eds.), *Asking to Die*, Dordrecht: Kluwer Academic Publishers 1998; Paul J. van der Maas, Gerrit van der Wal, Ilinka Haverkate *et al.*, 'Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995', *New England Journal of Medicine* 1996-22, pp. 1699-1705; B.D. Onwuteaka-Philipsen, A. van der Heide, D. Koper, I. Keij-Deerenberg, J.A.C. Rietjens, M.L. Rurup, A.M. Vrakking, J.J. Georges, M.T. Muller, G. van der Wal, P.J. van der Maas, 'Euthanasia and Other End-of-life Decisions in the Netherlands in 1990, 1995, and 2001', *Lancet*, 2003 (vol. 362), pp. 395-399; A. van der Heide, B.D. Onwuteaka-Philipsen, M.L. Rurup *et al.*, 'End-of-life practices in the Netherlands under the Euthanasia Act', *New England Journal of Medicine* 2007-19, pp. 1957-1965.

⁷ Luc Deliens, Freddy Mortier, Johan Bilsen *et al.*, 'End-of-life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey', *Lancet* 2000 (vol. 356), pp. 1806-1811; Jan Jans, 'The Belgian "Act on Euthanasia": Clarifying Context, Legislation, and Practice from an Ethical Point of View', *Journal Of the Society of Christian Ethics* 2005-2, pp. 163-177; Tinne Smets Johan Bilsen, Joachim Cohen *et al.*, 'Reporting of Euthanasia in Medical Practice in Flanders, Belgium: Cross Sectional Analysis of Reported and Unreported Cases', *BMJ* 2010 (vol. 341). See also L. Deliens, G. van der Wal, 'The Euthanasia Law in Belgium and the Netherlands', *Lancet* 2003 (vol. 362), pp. 1239-1240; R. Cohen-Almagor, 'Belgian Euthanasia Law - Critical Analysis', *Journal of Medical Ethics* 2009-7, pp. 436-439.

⁸ Edward Chow and Joav Merrick (eds.), *Advanced Cancer, Pain & Quality of Life*, Hauppauge NY: Nova Science Publishers Inc 2010; Eduardo D. Bruera and Russell K. Portenoy (eds.), *Cancer Pain: Assessment and Management*, Cambridge: Cambridge University Press 2009; 'Cancer Pain Overview, Incidence and Prevalence of Cancer Pain', <http://www.oncolgychannel.com/pain/index.shtml>
<http://www.cancer-pain.org/treatments/treatments.html>.

II. The Role of the Medical Profession

Now, some medical professionals would object to thrusting them with such responsibility. They may say that they are trained to save life, not to bring about its end. They may argue that assisting death negates their conscience, their religious beliefs, and their professional integrity. We should not compel them to carry such an assignment that is contradictory to their system of belief. Coercion *qua* coercion is negative and upsetting. At the same time, these medical professionals should understand that some patients would not like to be compelled to continue living against their will. The same anti-coercion sentiment should help bridge between patients and the medical profession. So while not coercing anybody to do something against her will, there are enough doctors who perceive physician-assisted suicide as a legitimate request and would be willing to assist patients. Respect, dignity, concern, and helping patients assert their individuality are all mentioned as prime drivers for assisting people at the last stage of their lives.

Should medical professionals help *all* who wish to die? The answer is no. First, my plea is restricted to competent patients: adult patients of the age of 18 and older who possess mental capacities and who are able to express an explicit opinion about their wishes, desires, aims, and needs. Thus, demented patients should not be entitled to PAS or euthanasia. Many demented patients express no desire to die. Many seem to be quite content with their lives. In the state of the present knowledge about the human brain, which is limited, it would be irresponsible to assist the death of demented patients, whether or not they left advanced directives and living wills in which they expressed a desire to die upon becoming demented. We should respect the patient we treat, not the patient who some time before expressed a will to die. It would be uncaring to kill someone who seems quite happy with her life, because some time ago she thought that living such a life lacks respect and dehumanises her. The medical staff should respect her as a human being, show that her life is meaningful, worthy of respect and dignity, and contribute to her sense of happiness.

Children and youth constitute a special category of patients. In case of an agonising and incurable disease that torment children, the medical professionals in consultation with the children's parents/guardians, should seek the best ways to relieve their suffering. The children's best interest is the first and foremost consideration, not the best interest of the parents or of other people.

Of course, my plea is restricted to patients afflicted by degenerative and incurable disease rather than to people at large. There were cases of people who wished to die because they were fed up with life, because they were 'tired of life'. They had emotional and mental problems. They were not inflicted by a devastating disease that destroyed their bodies, such as cancer. Those patients should receive therapy, mental help, and appropriate medication. There should be very compelling reasons to move physicians to assist their death. Death is always the last resort. Upon showing these people that they may still find reasons to live, they may opt to life, regain their sense of living, and find some meaning in what they have. Only if a prolonged psychological therapy fails, we may reconsider our avowed opposition to such appeals.

III. Palliative Care

By palliative care is meant the active, comprehensive and total care of patients whose disease is not responsive to curative treatment, where

maintaining that control of pain, of other symptoms, and of psychological, social, and spiritual problems, is paramount.⁹ In other words, palliative care includes all treatments that design to relieve suffering: physical, mental, psychological. Palliative care should be holistic and comprehensive, tailor-made to address individual concerns and afflictions.

As pain is a most important factor in patient's decision to seek death, palliative care is imperative. Surveys carried out among palliative care physicians have shown that most participants do not support euthanasia and assisted suicide.¹⁰ I stress that in the Netherlands and Belgium most of the patients who asked for euthanasia were afflicted with cancer. Prior answering such a request in the positive, those patients should undergo palliative care treatment designed to alleviate their suffering. If the patient persists in the request despite the treatment, we may assume that pain is not the crucial motivation for seeking death.

Palliative care begins with establishing the goals of care. Outlining realistic and attainable goals assumes an increased importance in the setting of advanced disease, in which treatments intended to cure the disease and prolong life may be more burdensome than beneficial. Whereas the goal for some patients may be to prolong life at any cost, studies suggest the most seriously ill patients want to have their pain and other symptoms relieved, improve their quality of life, avoid being a burden to their families, have a closer relationship with loved ones, and maintain a sense of control.¹¹

Ganzini and colleagues report that as a result of palliative care, some patients in Oregon changed their minds about assisted suicide.¹² Comparing cancer patients with participants receiving usual oncology care, those receiving a nurse-led, palliative care-focused intervention addressing physical, psychosocial, and care coordination provided concurrently with oncology care had higher scores for quality of life and mood.¹³ The medical staff must examine whether it is possible to prevent or to ease the pain by means of medication and palliative care.¹⁴ If it is possible to prevent or to ease the patient's pain, the necessary treatment should be prescribed.

⁹ World Health Organization, *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee*, Geneva, Switzerland: World Health Organization 1990, at p. 11.

¹⁰ Bert Broeckeaert, 'The Attitude of Flemish Palliative Care Physicians to Euthanasia and Assisted Suicide', *Ethical Perspectives* 2009 (16-3).

¹¹ K.E. Steinhauser, N.A. Christakis, E.C. Clipp *et al.*, 'Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers', *JAMA* 2000 (vol. 284), pp. 2476-2482; R. Sean Morrison and Diane E. Meier, 'Palliative Care', *New England Journal of Medicine* 2004-25, pp. 2582-2590.

¹² Linda Ganzini, Heidi D. Nelson, Terri A. Schmidt, Dale F. Kraemer, Molly A. Delorit, Melinda A. Lee, 'Physicians' Experiences with the Oregon Death with Dignity Act', *New England Journal of Medicine* 2000-8, p. 563. See also R. Sean Morrison and Diane E. Meier, 'Palliative Care', *New England Journal of Medicine* 2004-25, pp. 2582-2590.

¹³ Marie Bakitas, Kathleen Doyle, Mark T. Hegel *et al.*, 'Effects of a Palliative Care Intervention on Clinical Outcomes in Patients With Advanced Cancer', *JAMA* 2009-7, pp. 741-749. See also Michael A. Echteld, Luc Deliens, Gerrit van der Wal *et al.*, 'Palliative Care Units in the Netherlands: Changes in Patients' Functional Status and Symptoms', *Journal of Pain and Symptom Management* 2004-3, pp. 233-243.

¹⁴ Directive 7 in *The General Manager Circular*, Israel Ministry of Health, no. 2/96 (January 31, 1996) holds: "Doctors must concentrate their efforts on easing the pain, torment, and suffering of the patient, a subject of highest priority in medical treatment, especially when terminal patients are concerned", p. 12 (Hebrew). For further deliberation on pain control mechanisms and their importance, see Timothy E. Quill, Bernard Lo, and Dan W. Brock, 'Palliative Options of Last Resort', *JAMA* 1997-23, pp. 2099-2104; P. D. Doyle, G. W. Hanks and N. MacDonald (eds.), *Textbook of Palliative Medicine*, New York: Oxford University Press 1998; Timothy E. Quill, Barbara Coombs-Lee and Sally Nunn, 'Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative', *Annals of Internal Medicine* 2000 (vol. 132): pp. 488-493; T.S. Jost and D. Mendelson, 'A Comparative Study of the Law of Palliative Care and End-of-Life

IV. Guidelines for Physician-Assisted Suicide (PAS)

I believe that the right to die with dignity includes the right to live with dignity until the last minute and the right to part from life in a dignified manner. There are competent, adult patients who feel that the preferable way for them to part from life is through physician-assisted suicide. I propose a circumscribed plea for voluntary physician-assisted suicide on their behalf. The following guidelines are pertinent:

Guideline 1. The physician should not suggest assisted suicide to the patient. Instead, it is the patient who should have the option to ask for such assistance. Initiation by the physician might undermine the trust between the patient and the physician, conveying to patients that the doctor is giving up on them and values their lives only to the extent of offering assistance to die. Such an offer might undermine the will to live and to explore further avenues for treatment. Many Dutch researchers and physicians do not see this issue as a significant one.¹⁵ Some of them consider it important to raise the issue when it seems that patients do not dare to initiate it on their own. Undoubtedly, however, all people in the Netherlands are aware of the availability of euthanasia and physician-assisted suicide. Any reluctance shown by patients in regard to this issue should be honoured and respected.

Guideline 2. The request for physician-assisted suicide of an adult,¹⁶ competent patient who suffers from an intractable, incurable and irreversible disease must be voluntary.¹⁷ The decision is that of the patient who asks to die without pressure, because life appears to be the worst alternative in the current situation. The patient should state this wish repeatedly over a period of time.¹⁸ We must verify that the request for physician-assisted suicide does not stem from a momentary urge, an impulse, a product of passing depression. This emphasis of enduring request was one of the requirements of the abolished Northern Territory law in Australia,¹⁹ and is one of the requirements of the Oregon *Death with Dignity Act*,²⁰ as well as of the Dutch

Treatment', *Journal of Law, Medicine and Ethics* 2003 (vol. 31), pp. 130-143; R. Sean Morrison and Diane E. Meier, 'Palliative Care', *New England Journal of Medicine* 2004-25, pp. 2582-2590.

¹⁵ Keith L. Obstein, Gerrit Kimsma and Tod Chambers, 'Practicing Euthanasia: The Perspective of Physicians', *Journal of Clinical Ethics* 2004-3, pp. 223-231. See also David Shalowitz and Ezekiel Emanuel, 'Euthanasia and Physician-Assisted Suicide: Implications for Physicians', *Journal of Clinical Ethics* 2004-3, pp. 232-236.

¹⁶ Most bill proposals to legislate PAS in the United States specify that the age of the consenting patient must be 18 or older to qualify for the procedure. Russell Korobkin, 'Physician-assisted Suicide Legislation: Issues and Preliminary Responses', *Notre Dame Journal of Law, Ethics & Public Policy* 1998-2, p. 454; R. Cohen-Almagor, *Euthanasia in the Netherlands: The Policy and Practice of Mercy Killing*, Dordrecht: Springer-Kluwer 2004, pp. 1-20.

¹⁷ See the Dutch requirements of careful practice, in John Griffiths, Alex Bood and Heleen Weyers, *Euthanasia and Law in the Netherlands*, Amsterdam: Amsterdam University Press 1998, p. 66. See also Chap. II. Article 3 of the Belgian Euthanasia Law at: <http://www.kuleuven.ac.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23>

¹⁸ Many bill proposals to legislate PAS in the United States required a waiting period of 14 or 15 days. Cf. Russell Korobkin, 'Physician-assisted Suicide Legislation: Issues and Preliminary Responses', *op. cit.*, p. 468.

¹⁹ Section 7, *Rights of the Terminally Ill Act (1995)* (NT).

²⁰ In Australia, the law required a 'cooling off' period of nine days. In Belgium, the law requires a 'cooling off' period of one month. In Oregon, the Act requires a waiting period of fifteen days. I do not wish to suggest an arbitrary time period of waiting, saying instead that the patient should state her wish several times 'over a period of time'. I concur with Miller and colleagues who think that a fifteen days waiting period may be highly burdensome for patients who are suffering intolerably and may preclude access to assisted death for those who request it at the point when they are imminently dying. Franklin G. Miller, Howard Brody and Timothy E. Quill, 'Can Physician-Assisted Suicide Be Regulated Effectively?', *Journal of Law, Medicine & Ethics* 1996 (vol. 24), p. 226. See also Oregon *Death with Dignity Act*, *Oregon Revised Statutes*, (1998 Supplement) vol. 8, at 982.

legal guidelines.²¹ It should be ascertained with a signed document that the patient is ready to die now, rather than depending solely upon directives from the past. Section 2 of the Oregon Act requires that the written request for medication to end one's life be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest to the best of their knowledge and belief that the patient is capable, is acting voluntarily, and is not being coerced to sign the request.²²

Individuals may express general attitudes regarding end of life in an informal discussion made in a social setting, possibly saying that they would not want to live if they were unable to function alone and had to depend on the mercy of others. However, such hypothetical observations do not constitute reliable evidence of a patient's current desires once an actual illness is in progress. This is especially true if the wish was stated when young and healthy. The younger people are and the further they are from serious disease, the more inclined they are to claim that in a hypothetical state of pain, degradation and hopelessness, they would prefer to end their lives. On the other hand, there is a tendency to come to terms with suffering, to compromise with physical disabilities, and to struggle to sustain life. This tendency grows as the body weakens. Many people change their minds when they confront the unattractive alternatives, preferring to remain in what others term the 'cruel' world, and continue the Sisyphean struggle for their lives.

Guideline 3. At times, the patient's decision might be influenced by severe pain. The Oregon *Death with Dignity Act* requires the attending physician to inform the patient of all feasible alternatives, including comfort care, hospice care and pain control.²³ Bill proposals to legislate PAS in Illinois, Hawaii, Maine, Michigan, Vermont, Washington and Wisconsin explicitly required the attending physician to review options for palliative care with the patient, including hospice and/or pain control options.²⁴ If it is possible to prevent or to ease the patient's pain, then the patient's request for assisted suicide should not be fulfilled; instead, the necessary treatment should be prescribed. This is provided that the educated patient (i.e., a patient who was advised by the medical staff about the available palliative care options) does not refuse to take the painkillers, and that when the pain subsides so does the motive (or one of the main motives) for assisted suicide. If the patient insists on denying all medication, then doctors must first try to find the reasons for this insistence before they comply with the request.²⁵

Coping with pain and suffering can drain all of the patient's emotional strength, exhausting the ability to deal with other issues. In cases of competent patients, the assumption is that the patient understands the meaning of the decision. A psychiatrist's assessment can confirm whether the patient is able to make a decision of such ultimate significance to the patient's life and whether the decision is truly that of the patient, expressed

²¹ *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002*, at: [http://www.academiavita.org/english/AltriDocumenti/org_int/OLANDA/Testo%20legge%20olan dese%20eutanasia\[1\].pdf](http://www.academiavita.org/english/AltriDocumenti/org_int/OLANDA/Testo%20legge%20olan dese%20eutanasia[1].pdf).

²² *Oregon Death with Dignity Act, Oregon Revised Statutes*, (1998 Supplement) vol. 8, at 980.

²³ 13 Or. Rev. Stat. § 3.01 (1998). See R. Cohen-Almagor and Monica G. Hartman, 'The Oregon Death with Dignity Act: Review and Proposals for Improvement', *Journal of Legislation* 2001-2, pp. 269-298.

²⁴ Russell Korobkin, 'Physician-assisted Suicide Legislation: Issues and Preliminary Responses', *op. cit.*, p. 469.

²⁵ J.V. Lavery, Joseph Boyle, Bernard M. Dickens, Heath Maclean and Peter A. Singer, 'Origins of the Desire for Euthanasia and Assisted Suicide in People with HIV-1 or AIDS: A Qualitative Study', *Lancet* 2001-9279, pp. 362-367. See also Anthony L. Back and Robert A. Pearlman, 'Commentary: Desire for Physician-assisted Suicide: Request for a Better Death?', *Lancet* 2001-9279, pp. 344-345.

consistently and of his/her own free will. The Northern Territory *Rights of Terminally Ill Act* required that the patient meet with a qualified psychiatrist to confirm that the patient was not clinically depressed.²⁶ It is worthwhile to hold several such conversations, separated by a few days. The patient's loved ones and the attending physician should be included in at least one of the conversations.

General practitioners in the Netherlands express discomfort about their competence to perform palliative care adequately. There is a clear need to involve palliative care consultants so as to enhance the general knowledge and experience of physicians in palliative care.²⁷

Guideline 4. The patient must be informed of the situation and the prognosis for recovery or escalation of the disease, with the suffering that it may involve. There must be an exchange of information between doctors and patients.²⁸ Bearing this in mind, we should be careful to use neutral terms and to refrain from terms that might offend patients and their loved ones.²⁹

Guideline 5. It must be ensured that the patient's decision is not a result of familial and environmental pressures. At times, patients may feel that they constitute a burden on their loved ones. It is the task of social workers to examine patients' motives and to see to what extent they are affected by various external pressures (as opposed to a truly free will to die). A situation could exist in which the patient is under no such pressure, but still does not wish to be a burden on others. Obviously, we cannot say that the feelings of patients toward their loved ones are not relevant to the decision-making process.³⁰

Guideline 6. The decision-making process should include a second opinion in order to verify the diagnosis and minimise the chances of misdiagnosis, as well as to allow the discovery of other medical options. A specialist, who is not dependent on the first doctor, either professionally or otherwise, should provide the second opinion.³¹ A recent Dutch study reveals that the nature of

²⁶ Section 7, *Rights of the Terminally Ill Act (1995)* (NT).

²⁷ Annemieke Kuin, Annemie M. Courtens, Luc Deliens et al., 'Palliative Care Consultation in the Netherlands: A Nationwide Evaluation Study', *Journal of Pain and Symptom Management* 2004-1, pp. 53-60, at 57. See also R. Cohen-Almagor, 'Dutch Perspectives on Palliative Care in the Netherlands', *Issues in Law and Medicine* 2002-1, pp. 111-126; Jan L Bernheim, Reginald Deschepper, Wim Distelmans and Arsène Mullie, 'Development of Palliative Care and Legalisation of Euthanasia: Antagonism or Synergy?', *BMJ* 2008 (vol. 336), pp. 864-867.

²⁸ On this issue, see Oregon *Death with Dignity Act*, Section 3, Attending physician responsibilities. Many bill proposals to legislate PAS in the United States specified certain information that must be communicated by the physician to the patient before honouring her request. Cf. Russell Korobkin, 'Physician-assisted Suicide Legislation: Issues and Preliminary Responses', *op. cit.*, p. 468. See also Chap. II, Article 3 of the Belgian Euthanasia Law; R. Cohen-Almagor, 'Belgian Euthanasia Law - Critical Analysis', *Journal of Medical Ethics* 2009-7, pp. 436-439.

²⁹ R. Cohen-Almagor, 'Language and Reality at the End of Life', *Journal of Law, Medicine and Ethics* 2000-3, pp. 267-278. See also S.E. Bedell, T.B. Graboys, E. Bedell and B. Lown, 'Words That Harm, Words That Heal', *Arch Intern Med.* 2004-13, pp. 1365-1368.

³⁰ R. Cohen-Almagor, 'The Patients' Right to Die in Dignity and the Role of Their Beloved People', *Annual Review of Law and Ethics* 1996(vol. 4), pp. 213-232, and *The Right to Die with Dignity: An Argument in Ethics, Medicine, and Law*, Piscataway, NJ.: Rutgers University Press 2001, chap. 6; John Hardwig, 'Families and Futility: Forestalling Demands for Futile Treatment', *Journal of Clinical Ethics* 2005-4, pp. 28-337; David J. Casarett, *Last Acts: Discovering Possibility and Opportunity at the End of Life*, NY: Simon and Schuster 2010.

³¹ Most bill proposals to legislate PAS in the United States required that the treating physician refer the patient to a second consulting physician to verify the terminal nature of the disease. The Massachusetts bill required a third confirming opinion. Cf. Russell Korobkin, 'Physician-assisted Suicide Legislation: Issues and Preliminary Responses', *op. cit.*, p. 453. See also Chap. II, Article 3 of the Belgian Euthanasia Law, and R. Cohen-Almagor, 'Euthanasia Policy and

the relationship with the consultant in the euthanasia decision-making process was sometimes unclear. The consultant was reported to have been an unknown colleague (39%), a known colleague (21%), otherwise (25%), or not clearly specified in the report (24%). Review committees relatively often scrutinised the consultation process (41%).³² The patient's attending physician, who supposedly knows the patient's case better than any other expert, must be consulted, and all reasonable alternative treatments must be explored. The Oregon *Death with Dignity Act* requires that a consulting physician shall examine the patient and his/her relevant medical records and subsequently confirm, in writing, the attending physician's diagnosis that 'the patient is suffering from a terminal disease'. Furthermore, the consulting physician must verify that the patient is capable, is acting voluntarily, and has made an informed decision.³³ The Northern Territory *Rights of Terminally Ill Act* required that a physician who specialised in treating terminal illness examine the patient.³⁴

Guideline 7. It is advisable for the identity of the consultant to be determined by a small committee of specialists who will review the requests for physician-assisted suicide. This is in order to avoid the possibility of arranging deals between doctors ("you will consult for me regarding Mr. Jones, approving my decision, and I will consult for you regarding Ms. Smith, approving your decision").³⁵

Guideline 8. Some time prior to the performance of physician-assisted suicide, a doctor and a psychiatrist are required to visit and examine the patient so as to verify that this is the genuine wish of a person of sound mind who is not being coerced or influenced by a third party. The conversation between the doctors and the patient should be held without the presence of family members in the room in order to avoid familial pressure. A date for the procedure is then agreed upon.³⁶ The patient's loved ones will be notified so that they can be present right until the performance of the act, making the day an intimate, family occasion.

Guideline 9. The patient can rescind at any time and in any manner. This provision was granted under the Australian Northern Territory Act³⁷ and under the Oregon *Death with Dignity Act*.³⁸ Chapter III, Article 4 of the

Practice in Belgium: Critical Observations and Suggestions for Improvement', *Issues in Law and Medicine* 2009-3, pp. 187-218.

³² Hilde Buiting, Johannes van Delden, Bregje Onwuteaka-Philipsen et al., 'Reporting of Euthanasia and Physician-assisted Suicide in the Netherlands: descriptive study', *BMC Medical Ethics* 2009 (vol. 10), p. 18.

³³ Oregon *Death with Dignity Act*, Oregon Revised Statutes, (1998 Supplement), vol. 8, at 981-982. The American Medical Association's council on ethical and judicial affairs suggests the participation of consultants to facilitate discussions that would help the parties reach a course of action. AMA strongly objects to PAS. See Fred Charatan, 'AMA Issues Guidelines on End of Life Care', *BMJ* 1999 (vol. 318), p. 690.

³⁴ Section 7, *Rights of the Terminally Ill Act* (1995) (NT).

³⁵ In this context, for further discussion see Reginald Deschepper et al., 'Communication on end-of-life decisions with patients wishing to die at home: the making of a guideline for GPs in Flanders, Belgium', *British Journal of General Practice* 2006 (vol. 56), pp. 14-19, at: <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1828069>.

³⁶ Proposals to legislate PAS in Illinois, Massachusetts and Maine required that a patient seeking PAS obtain a consultation with a mental health professional in order to insure that the patient can pass the 'impaired judgment' standard. Cf. Russell Korobkin, 'Physician-assisted Suicide Legislation: Issues and Preliminary Responses', *op. cit.*, p. 456. This Guideline is somewhat similar to the guidelines of the Swiss EXIT protocol.

³⁷ Andrew L. Plattner, 'Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It', *DePaul Journal of Health Care Law* 1997 (vol. 1), p. 648.

³⁸ 13 Or. Rev. Stat. § 3.07 (1998).

Belgian Euthanasia Law says that patients can withdraw or adjust their euthanasia declaration at any time.³⁹

Guideline 10. Physician-assisted suicide may be performed only by a doctor and in the presence of another doctor. The decision-making team should include at least two doctors and a lawyer, who will examine the legal aspects involved. Insisting on this protocol would serve as a safety valve against possible abuse. Perhaps a public representative should also be present during the entire procedure, including the decision-making process and the performance of the act. This extra caution should ensure that the right to die with dignity does not become a duty. It will contribute to reporting of cases. The experiences of both the Netherlands and Belgium raise alarm bells as many end-of-life cases have not been reported. In Belgium, only one out of two euthanasia cases is reported to the Federal Control and Evaluation Committee.⁴⁰ The doctor performing the assisted suicide should be the one who knows the patient best, having been involved in the patient's treatment, taken part in the consultations, and verified through the help of social workers, nurses and psychologists that PAS is the true wish of the patient.

Guideline 11. Physician-assisted suicide may be conducted in one of three ways, all of them discussed openly and decided upon by the physician and the patient together: (1) oral medication; (2) self-administered, lethal intravenous infusion; (3) self-administered lethal injection. Oral medication may be difficult or impossible for many patients to ingest because of nausea or other side effects of their illnesses. In the event that oral medication is provided and the dying process is lingering on for long hours, the physician is allowed to administer a lethal injection.⁴¹

Guideline 12. Doctors may not demand a *special fee* for the performance of assisted suicide. The motive for physician-assisted suicide is humane, so there must be no financial incentive and no special payment that might cause commercialisation and promotion of such procedures.

Guideline 13. There must be extensive documentation in the patient's medical file, including the following: diagnosis and prognosis of the disease by the attending and the consulting physicians; attempted treatments; the patient's reasons for seeking physician-assisted suicide; the patient's request in writing or documented on a video recording; documentation of conversations with the patient; the physician's offer to the patient to rescind her request; documentation of discussions with the patient's loved ones; and a psychological report confirming the patient's condition. This meticulous documentation is meant to prevent exploitation of any kind – personal, medical, or institutional. Each report should be examined by a coroner following completion of the physician-assisted suicide.⁴²

³⁹ Chamber of the Representatives of Belgium, *Government Bill Related to Euthanasia* (November 5, 2001), Doc 5014488/001, project transmitted by the Senate. At: <http://www.kuleuven.ac.be/cbmer/viewpic.php?LAN=E&TABLE=DOCS&ID=23>

⁴⁰ Timme Smets, Johan Bilsen, Joachim Cohen *et al.*, 'Reporting of Euthanasia in Medical Practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases', *BMJ* 2010 (vol. 341). See also Michael Cook, 'Steep rise in official Dutch euthanasia', *BioEdge Report* (November 13, 2010).

⁴¹ Cf. Johanna H. Groenewoud, Agnes van der Heide, Bregje D. Onwuteaka-Philipsen *et al.*, 'Clinical Problems with the Performance of Euthanasia and Physician-assisted Suicide in the Netherlands', *N. Eng. J. Med.* 2000-8, pp. 551-556.

⁴² Directive 6 in *The General Manager Circular*, Israel Ministry of Health, no. 2/96 (January 31, 1996) states: "The decision to respect a patient's objection to a life prolonging treatment shall be documented in the medical statutes, expressing maximum reasons for the decision and the

Guideline 14. Pharmacists should also be required to report all prescriptions for lethal medication, thus providing a further check on physicians' reporting.⁴³

Guideline 15. Doctors must not be coerced into taking actions that contradict their conscience or their understanding of their role. This was provided under the Northern Territory Act.⁴⁴

Guideline 16. The local medical association should establish a committee, whose role will be not only to investigate the underlying facts that were reported but also to investigate whether there are 'mercy' cases that were not reported and/or that did not comply with the Guidelines.

Guideline 17. Licensing sanctions will be taken to punish those health care professionals who violated the Guidelines, failed to consult or to file reports, engaged in involuntary termination of life without the patient's consent or with patients lacking proper decision-making capacity. Physicians who failed to comply with the above Guidelines will be charged and procedures to sanction them will be brought by the Disciplinary Tribunal of the Medical Association. The maximum penalty for violation of the Guidelines will be the revoking of the physician's medical license. In the event that this penalty proves insufficient in deterring potential abusers, there will be room to consider further penalties, including heavy fines and prison sentences.⁴⁵

Conclusion

My plea is restricted to PAS. I object to euthanasia not because I believe euthanasia is immoral; instead, I fear abuse. There is a fine line between moral consideration and the implementation of a policy. Research conducted in the Netherlands and Belgium does not convince that both countries have been able to properly address abuse concerns. Many patients are still killed involuntarily. Until we can be sure that euthanasia is not abused on policy level, control should remain with patients, not with physicians.

However, with regard to patients who are unable to swallow medication, euthanasia is the only solution. With regard to such patients, a category that includes Amyotrophic Lateral Sclerosis (ALS)⁴⁶ and locked-in syndrome⁴⁷

discussions with the patient", p. 12 (Hebrew). See also Israel *Patients' Rights Law* (1996), 1591, Chapter E: medical documentation and medical information, p. 331. See also J.J.H. Suyver, *Regional Euthanasia Review Committees: 2009 Annual Report* (The Hague, May 2010), at: <http://www.euthanasiecommissie.nl/en/review-committees/annualreport/default.asp>

⁴³ For further deliberation, see Johan Bilsen, Marc Bauwens, Jan Bernheim *et al.*, 'Physician-Assisted Death: Attitudes and Practices of Community Pharmacists in East Flanders, Belgium', *Palliative Medicine* 2005 (vol. 19), pp. 151-157.

⁴⁴ Andrew L. Plattner, 'Australia's Northern Territory: The First Jurisdiction to Legislate Voluntary Euthanasia, and the First to Repeal It', *op. cit.*, p. 648.

⁴⁵ For further deliberation, see Arthur L. Caplan, Lois Snyder and Kathy Faber-Langendoen, 'The Role of Guidelines in the Practice of Physician-Assisted Suicide', *Annals of Internal Medicine* 2000 (vol. 132), pp. 476-481; S. Frileux, C. Lelièvre, M.T. Muñoz Sastre, E. Mullet, and P. C. Sorum, 'When Is Physician Assisted Suicide or Euthanasia Acceptable?', *Journal of Medical Ethics* 2003-6, pp. 330-336.

⁴⁶ Amyotrophic lateral sclerosis (ALS), sometimes called Lou Gehrig's disease, is a rapidly progressive, invariably fatal neurological disease that attacks the nerve cells (*neurons*) responsible for controlling voluntary muscles. The disease belongs to a group of disorders known as *motor neuron diseases*, which are characterised by the gradual degeneration and death of motor neurons. See 'What is amyotrophic lateral sclerosis?' at: http://www.ninds.nih.gov/disorders/amyotrophiclateralsclerosis/detail_amyotrophiclateralsclerosis.htm.

⁴⁷ Locked-In syndrome is a condition in which a patient is aware and awake, but cannot move or communicate due to complete paralysis of the body. It is the result of a brain stem stroke in which the ventral part of the brain stem is damaged. It results in quadriplegia and inability to speak in otherwise cognitively intact individuals. Those with Locked-In syndrome may be able to

patients, we should insist on strict safeguards that confirm that the patients truly wish to die, and that their wish is voluntary and free-willed.

As human life is at stake, all cases of PAS and euthanasia should be scrutinised, examined, monitored, and studied carefully. We should learn from the experiences of countries that practice end-of-life mechanisms: in Europe, the Netherlands, Belgium (especially the French side which is quite obscure at present), Switzerland⁴⁸ and Luxemburg,⁴⁹ and – in the U.S.A. – the states of Oregon⁵⁰ and Washington.⁵¹ During the learning process, we should insist on inserting corrective mechanisms whenever applicable.

Some 115 Britons who wanted to decide the time of their death had to leave their country, their home (which is their castle), and travel to Switzerland where they were helped to die. The British authorities are embarrassed. They understand that this death-tourism is the result of insufficient legal instruments to enable sick people, at the end of their lives, to seek help at home. A change is in need. Polls consistently show that between seventy and eighty percent of the population support physician-assisted suicide but the British legislature has been hesitant.⁵²

Things should change also on the Swiss side. I never liked the idea that anyone can perform assisted suicide in Switzerland. The assistant is not obliged to be a physician.⁵³ The scrutiny mechanisms are lax. In 2009, the British conductor Edward Downes and his wife Joan travelled to Switzerland to end their lives with the help of the local end-of-life organisation, Dignitas. Unlike his wife, Sir Edward did not suffer from an intractable, deadly disease.⁵⁴ Indeed, Ludwig Minelli, the founder of Dignitas, urged in a recent

communicate with others by coding messages by blinking or moving their eyes, which are not affected by the paralysis. See http://the-medical-dictionary.com/locked_in_syndrome.htm.

⁴⁸ Stephen J. Ziegler, 'Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process', *Journal of Law, Medicine and Ethics* 2009, pp. 318-330; Amelia Gentleman, 'Inside the Dignitas House', *The Guardian* November 18, 2009, at: <http://www.guardian.co.uk/society/2009/nov/18/assisted-suicide-dignitas-house>.

⁴⁹ Euthanasia: a continent divided, *BBC News* February 11, 2009, at: <http://news.bbc.co.uk/go/pr/fr/-/1/hi/world/europe/7322520.stm>.

⁵⁰ Death with Dignity Act Annual Reports, at: <http://www.oregon.gov/DHS/ph/pas/ar-index.shtml>; R. Cohen-Almagor and Monica G. Hartman, 'The Oregon Death with Dignity Act: Review and Proposals for Improvement', *Journal of Legislation* 2001-2, pp. 269-298.

⁵¹ Clare Dyer, 'Washington follows Oregon to legalise physician assisted suicide', *BMJ* 2008 (vol. 337), at 2480; 'Autonomy, not pain, was concern for Washington's first assisted suicides', *BioEdge* March 6, 2010, at: http://www.bioedge.org/index.php/bioethics/bioethics_article/8887/

⁵² David Smith and Sarah-Kate Templeton, 'Public in strong backing for right to assisted suicide', *The Sunday Times* December 14, 2008, at:

http://www.timesonline.co.uk/tol/life_and_style/health/article5337761.ece; 'Dying with dignity', *The Guardian* December 6, 2004; Jamie Doward, 'Revealed: full scale of euthanasia in Britain', *The Observer* September 19, 2004; 'Killing by kindness', *The Independent* July 12, 2004, at: <http://www.independent.co.uk/news/uk/crime/killing-by-kindness-552889.html>. See also <http://www.euthanasia.cc/stats.htm>.

⁵³ Samia A. Hurst and Alex Mauron, 'Assisted Suicide and Euthanasia in Switzerland: Allowing a Role for Non-physicians', *BMJ* 2003 (vol. 326). See also Meinrad Schaer, 'The Practice of Assisted Suicide in Switzerland', at: http://www.finalexit.org/dr_schaer_switzerland_1996-97_report.html; Derek Humphry, 'Swiss Assisted Suicide Branching Out', August 2, 2001, at: http://www.finalexit.org/swiss_assisted_suicide_branching_out.html; G. Bosshard, S. Fischer and W. Bar, 'Open Regulation and Practice in Assisted Dying – How Switzerland Compares with the Netherlands and Oregon', *Swiss Medical Weekly* 2002 (vol. 132), pp. 527-534.

⁵⁴ Matthew Weaver, 'British conductor dies with wife at assisted suicide clinic', *The Guardian* July 14, 2009, at: <http://www.guardian.co.uk/society/2009/jul/14/assisted-suicide-conductor-edward-downes>; Jull Lawless, 'Conductor Edward Downes And Wife Joan Die In Swiss Suicide Clinic', *The Huffington Post* July 14, 2009, at: http://www.huffingtonpost.com/2009/07/14/conductor-edward-downes-a_n_231204.html; Steve Doughty and Tom Kelly, 'They held hands as they lay down

interview that a person whose terminally ill partner commits suicide should also be given help to die – even if he or she is perfectly healthy.⁵⁵ For me, more should have been done to highlight to Sir Edward and spouses in a similar situation that life can still be meaningful and worthwhile. We should never rush decisions to end life. And no money should transfer hands for the conduct of PAS. Dignitas currently charges at least 6000 Euros for the assisted-suicide service.⁵⁶ Not a bad business.

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and waited for death”: Son tells how he watched his parents die at Swiss suicide clinic’, *Mail Online* July 15, 2009, at: <http://www.dailymail.co.uk/news/article-1199550/Famous-British-conductor-Sir-Edward-Downes-wife-die-assisted-suicide-clinic-Dignitas-Switzerland.html>.

⁵⁵ ‘Let the distraught partners of terminally ill who commit suicide die too, says Dignitas boss’, *Mail Online* October 19, 2010, at: <http://www.dailymail.co.uk/news/article-1321547/Dignitas-Ludwig-Minelli-Let-partners-terminally-ill-commit-suicide-die-too.html#>.

⁵⁶ Culturekiosque Staff, ‘The Suicide Tourist: Frontline Investigates Assisted Suicide in Switzerland’, *Culturekiosque News* March 2, 2010, at: http://www.culturekiosque.com/nouveau/news/suicide_tourist_dignitas472.html; Amelia Gentleman, ‘Inside the Dignitas House’, *The Guardian* November 18, 2009, at: <http://www.guardian.co.uk/society/2009/nov/18/assisted-suicide-dignitas-house>. See also: <http://www.youtube.com/watch?v=MeZvM34H5so>; <http://www.pointgreyimages.com/suicide%20tourist/synopsis.htm>; <http://www.youtube.com/watch?v=bxQYTFIZi8A>.