Physician Assisted Suicide

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The debate regarding physician assisted suicide largely centers on the patient and the physician and the responsibilities and rights of these two participants. As this ethical debate draws greater attention, it is necessary to look at the responsibilities of other health care providers that may be involved. For example, what professional responsibilities and rights does a pharmacist have? What sources of literature are available to help guide pharmacists? What is the opinion of pharmacists in regards to their involvement in assisted suicide? This paper will examine the attitudes of pharmacy students as well as pharmacists and focus on the role that pharmacists should play in physician assisted suicide.

Many terms are used in the debate surrounding physician-assisted suicide, and an important distinction should be made between two of them in order to alleviate confusion. Euthanasia refers to a physician who directly participates in ending a patient’s life by administering a lethal injection of medication. Physician assisted suicide involves a physician who aids indirectly in the patients death by providing him/her with a lethal dose of medication that he/she administers himself/herself.

The debate surrounding the ethical nature of physician assisted suicide and euthanasia is certainly not a new one. It originated among the medical, ethical and legal communities around 1870 when drugs like chloroform and ether were developed. These drugs could be used at high doses to kill people. Using drugs to execute people proved to have one advantage over hangings or shootings and this was that the drugs did not appear to cause significant suffering. Although it was not successful, the first attempt to legalize euthanasia took place in Ohio in 1906. The discussion of physician assisted suicide and euthanasia slowly evolved in countries all over the world throughout the next seven decades. Great Britain’s attempt to legalize euthanasia began in 1936 but it came to a sudden halt when WWII began with the resultant genocide of the Jews. The debate flared again earlier this year when a House of Lords select committee brought about the "Assisted Dying for the Terminally Ill Bill," a measure that would legalize euthanasia and assisted suicide in Britain. Whether or not Parliament will allow this bill to pass and for euthanasia and physician assisted suicide to be legalized is currently under discussion. A lot of opposition to the bill has recently surfaced and an intense debate is ongoing in this country.

In 1973, the Netherlands became involved in the debate when the Royal Dutch Medical Society was forced to intervene and make a decision about euthanasia when a physician assisted in the death of his terminally ill mother and received nothing more than a slap on the wrist. The medical society feared that this would set a precedent that may bring about similar acts by others and thus they interceded. This practice was eventually legalized in 1993.

The United States became more actively involved in these issues in 1988 when reports surfaced in JAMA of physicians participating in the death of their patients. Currently, physician assisted suicide is illegal in the United States (in all states except Oregon) but numerous cases have gone to court seeking reversals of the laws banning it.
Advocates of physician assisted suicide have challenged several states’ laws banning physician assisted suicide. Two of those states include Washington and New York. In Washington v. Glucksberg, the court found that Washington’s prohibition of physician assisted suicide does not violate the Due Process Clause of the Fourteenth Amendment. In Vacco v. Quill, the court held that the ban on physician assisted suicide did not violate the Equal Protection Clause. The challenges to the New York and Washington laws were successful in federal court of appeals however the U.S. Supreme Court reversed the circuit court decision by holding that there is no federal constitutional right to physician assisted suicide. A challenge to the California law was successful in the district court as well but due to the Supreme Court’s decisions in the cases discussed above, the Ninth Circuit Court of Appeals overturned the district court’s decision.

Oregon is the only state in which physician assisted suicide is legal. In 1994, Oregon citizens, by a narrow margin of 51%, adopted the Oregon Death with Dignity Act which legalized physician assisted suicide for competent, terminally ill patients. After many challenges and an initiative attempting to overturn it, the act was eventually implemented in October 1997. On November 6, 2001, Attorney General John Ashcroft adopted a federal ban on physician-assisted suicide stating that federal drug law prohibits this practice. He interpreted the Controlled Substances Act as stating that regulated drugs may be prescribed only in the course of professional practice or in other words, with a legitimate medical purpose. His directive stated that a doctor could lose his or her federal registration to prescribe controlled substances if that registration is used to prescribe federally controlled substances for assisted suicide. However, the state of Oregon has determined that assisting in a suicide, in strictly defined circumstances, is part of the "course of professional practice," and can be legitimate as a medical practice. Thus, a Federal Judge overturned Ashcroft’s decision. Since that time Ashcroft has filed for several appeals all of which have been denied until that which was filed on November 9, 2004 when he asked the U.S. Supreme Court to review the Ninth Circuit Court’s decision. The Supreme Court agreed to hear the appeal and arguments began in October 2005. A ruling is expected in June 2006.

The Death with Dignity Act, if followed in accordance with the laws, does not constitute suicide. The Act prohibits euthanasia. In order to be eligible to request a prescription from a licensed Oregon physician, several requirements must be fulfilled. The patient must be at least eighteen years of age, a resident of Oregon, considered to be capable and diagnosed with a terminal illness that will ultimately lead to death in the next six months. Capable is defined as the ability to make and communicate health care decisions. An example of a patient who would be considered incapable and thus ineligible from participating in the Act may be a person suffering from Alzheimer’s disease, dementia or has some sort of mental deficiency. In order to receive this prescription several additional requirements must be fulfilled. The patient must make two oral requests to the physician at least 15 days apart followed by a written request that has to be signed in the presence of two witnesses. The prescription may not be written until 48 hours has passed. The time specifications are necessary to give the patient an opportunity to change his/her mind and to give relatives the time they may need to intervene and argue against the assisted suicide if they choose. Two physicians (prescribing and consulting physicians) must review the diagnosis and prognosis and then determine whether the patient is capable of making and communicating health care
decisions. If either physician believes that a psychological or psychiatric disorder is present that may alter the patient’s judgment, the patient will be asked to complete a psychological exam. The prescribing physician is also responsible for providing the patient with alternatives to assisted suicide including palliative pain management and hospice care. Although the patient is not required to comply, the physician must request that the next of kin be notified about the decision the patient has made to end their life.³

An important and perhaps late addition to the law came in 1999 when the Oregon legislature required that pharmacist’s be informed of the medication’s ultimate use. Pharmacists, however, are under no obligation to comply with the request for the medication. As a future pharmacist, I agree with this requirement. It is necessary that the entire health care team (which includes the pharmacist) be involved in this decision seeing that their actions will result in a patient’s death. For some, this act may conflict with their moral and ethical standards and still others will find no conflict with it. Nevertheless, all parties involved in assisting with a patient’s suicide need to be fully informed.

Physicians are also required to notify the Oregon Health Division within seven working days of prescribing the lethal medication and they must provide documentation that all legal requirements have been met. Reporting is not required if the patient begins the request process but never receives a prescription. Every year a report is created based on those who requested assistance for suicide, the motivations for these requests as well as several other factors. Since the laws inception in 1997, 334 patients have received prescriptions. Only 208 persons have used the prescription.⁹ To date, no patients have taken the medication unsuccessfully. The average age of those who used a prescription under the Act was 70.⁹ An article published in JAMA in 2002 complied the most common motivations patients had for requesting assisted suicide as reported by physicians. They include the patient’s loss of autonomy, losing control of bodily functions, and decreased ability to participate in activities that make life enjoyable. Interestingly, the most common reason for requesting assisted suicide was almost never pain or physical suffering.¹¹

In comparison to the structured guidelines set forth by the Oregon law for physician assisted suicide, the Dutch guidelines for both euthanasia and physician assisted suicide seems very lenient. Physicians must abide by “the criteria of due care”. Due care requires that the procedure be carried out in a medically appropriate fashion, that the physician ensures the patient’s suffering to be unbearable and unremitting (although the patient does not have to be terminally ill), that the physician has reached a definitive conclusion with the patient that no reasonable solutions exist and that one other physician has been consulted and agrees with the decision in writing. The “due care” standards go as far as allowing children between the ages of 12 and 16 to request and receive assisted suicide as long as a parent or guardian agrees with this choice. A child, 16 to 18 years old, can request and receive assisted suicide as long as a parent or guardian is aware of this choice but they don’t necessarily have to agree. Is it reasonable to assume that a person less than 18 years old is mature enough to handle the burden of this decision? I don’t believe this is a reasonable assumption. When I was seventeen and graduating from high school I had a difficult time trying to decide which university I wanted to attend. Finally, the law does not prohibit physicians from practicing euthanasia with non-residents.
As with all ethical debates, arguments both for and against assisted suicide exist. Many national professional organizations have addressed their opinion on this issue and some have even been leaders in supporting the ban against it. The American Medical Association (AMA) and The National Hospice Organization (NHO) are two of these organizations that believe physician assisted suicide is wrong and that the U.S. Supreme Court should not overturn states laws banning it. In Washington v. Glucksburg, the court ruling that assisted suicide did not violate the fourteenth amendment was based on the idea that each person has the ability to decide how and when they will die. The AMA has taken the position that the court’s argument rests on an unrealistic assumption regarding the ability of one to control their death. They argue that it is not easy to determine when or how our lives will end and thus it should not be up to the courts to make this determination. Furthermore, physician assisted suicide is not the only way of controlling death. Every patient is granted the autonomy to make decisions about their health care that may ultimately lead to their death. They can request to withdraw or withhold life-sustaining treatments. The greatest example of this is my Great Auntie Leona. At 92 years old, she was diagnosed with terminal lung cancer. She expressed to my family that she had lived a very full life and wanted to pass on peacefully rather than suffer through the intensive therapy. She chose to withhold chemotherapy and radiation treatment. Auntie Leona passed away last week. The AMA holds the belief that what we choose may ultimately determine what our death is like, but in and of themselves our choices do not cause the death. The NHO agrees with the AMA on the concept of autonomy in that there is a difference between taking patients’ lives and allowing the patients to choose not to have something done to them that may or may not hasten their death.

The AMA strongly believes that along with the refusal of treatment, pain management is a fundamental patient right that if properly exercised and protected could possibly deem that physician assisted suicide is never a necessary option. Furthermore, their Code of Ethics holds that physicians have an obligation to provide relief of pain and suffering. The Circuit court’s decision to legalize physician assisted suicide is based on the belief that terminally ill patients, who experience long and painful deaths, face unnecessary torture at the end of their lives. The AMA stresses that this is not the case anymore. Pain control, however still inadequate, has improved greatly. There are effective and evolving medical tools that are being used to improve the patient’s quality of life during their last days and palliative care through symptom management and pain management should be the focus. In addition, the NHO emphasizes that when pain and suffering are alleviated, one can focus on the tremendous growth that occurs at the end of their life which allows for a readiness to accept death. The hospice philosophy focuses on providing terminally ill patients with the best palliative care, a good quality of life and finally death with peace and dignity, none of which they believe to be provided with assisted suicide. NHO claims that patients who have entered into hospice care with the request for assisted suicide have changed their minds once in the program. Thus, possibly illustrating their point that appropriate pain management and emotional support may reduce the pain and suffering which leads patients to seek suicide.

Several national pharmacy organizations have expressed their opinions on the issue of assisted suicide. The American Society of Health-System Pharmacists (ASHP) official position is “to remain neutral on the issue of health professional participation in assisted suicide of patients who are terminally ill. Further, to affirm that the decision to
participate is one of individual conscience and to offer guidance to health-system pharmacists who practice in states in which assisted suicide is legal”. They support the right of the pharmacist to participate or not in morally, religiously or ethically troubling therapies. ASHP endorses certain principles to guide the pharmaceutical care of patients in end-of-life situations. First, pharmacists are responsible for informing and educating patients and their health care providers about the numerous pharmaceutical options. Second, pharmacists should respect each patient’s autonomy and maintain the confidentiality of all patient information, regardless of their own moral and ethical views. Third, pharmacists are responsible for recognizing and addressing the barriers that exist with regards to end-of-life care. Finally, it is the pharmacist’s professional responsibility to ensure that each patient in need has access to palliative care and aggressive pain management through the use of appropriate drug therapy until the end of their life.

American Pharmacists Association (APhA) policies were reviewed in 2004. The review committee amended the 1997 policy which now states, “APhA supports informed decision making based upon the professional judgment of the pharmacists, rather than endorsing a particular moral stance”. It seems that the neutral position the organization has taken supports the pharmacist’s decision as long as it was made with the best interest of the patient in mind. APhA “opposes laws and regulations that mandate or prohibit the participation of pharmacists in physician-assisted suicide”. Furthermore, APhA upholds the Pharmacist Conscience Clause expressing that every pharmacist has the “right to exercise conscientious refusal” however, you must “ensure patient’s access to legally prescribed therapy”. In other words, if you choose not to dispense a medication, you should provide the patient with alternatives for getting their prescriptions filled. The principles that exist within the APhA Code of Ethics can help guide pharmacists in determining their responsibility when caring for patients who choose assisted suicide. A pharmacist must “respect the autonomy and dignity of every patient” and “promote the right of self-determination and recognize individual self-worth by encouraging patients to participate in decisions about their health. In all cases, a pharmacist respects personal and cultural differences among people”. Another responsibility within the code of ethics is that a pharmacist must “act with honesty and integrity in professional relationships”. For example, the value systems that exist in a particular practice should always be discussed before beginning new employment. If the pharmacist does not morally or ethically agree with these value systems then he/she should not practice in that environment. That would be neither in the pharmacist’s nor the patient’s best interests.

Pharmacists play an integral part in physician assisted suicide in terms of dispensing the medications used in the death of patients. It is important to recognize how pharmacists feel about the role they may choose to play and the role pharmaceutical agents should play in assisted suicide. I evaluated a survey published in the American Journal of Hospital Pharmacy as well as the results of my own survey to establish the beliefs and attitudes held by both pharmacy students and pharmacists.

I surveyed seventy-eight pharmacy students at Wayne State University. The demographics of the study were as follows. The average age of students participating in this study was twenty four. Six students were in their second year, sixty-six were in their third year, and six were in their fourth year of the program. Of those surveyed, sixty currently intern in a community setting, five in a hospital setting and eight stated that they
do not work. The students were asked specific questions regarding their ethical beliefs surrounding physician assisted suicide in which they responded with either “yes”, “no” or “undecided”. Although many variables including age, gender and religious beliefs were not largely controlled, the survey gives an estimation of the attitudes of a younger generation of soon to be graduated pharmacists.

The survey conducted by the American Society of Health System Pharmacists (ASHP) was published in 1994 and surveyed more than five-hundred pharmacists licensed in the United States. Most of the participants were males and the average age was forty-two years old. The following are the opinions revealed by both the student pharmacists and the licensed pharmacists.

- 62% of students believed that physician assisted suicide should be legalized
- Similar percentages of students and pharmacists believed that patients are justified in wanting to end their own lives, 69% and 72.6% respectively.
- 81% of students believed that prescription drugs are an appropriate way for a physician to assist in a patient’s suicide and only 11% disagreed; 71% of pharmacists surveyed agreed
- 77% of students and 67% of pharmacists felt that it would be inappropriate for a physician not to notify and obtain consent from the pharmacist who would be involving in the assisted suicide
- 73% of students and 54% of pharmacists wanted to know if a medication that they were going to dispense was going to be used to assist in a suicide
- Interestingly, 51% of students versus 34% of pharmacists stated that they would knowingly participate in an assisted suicide; 27% of students said that they would not participate while 22% were undecided

These two surveys analyzed side by side seem to indicate that while pharmacists believe patients are justified under certain circumstances to want to end their own lives, they are more unsure of their role in the assisted suicide than the pharmacy students. A majority of the students surveyed agreed with the legalization and would participate in physician assisted suicide. A larger percentage of students over pharmacists indicated that they wanted to be more involved in the practice by being informed about the patient’s situation via the prescribing physician. One reason to account for the difference in opinions between students and licensed pharmacists is the year in which these surveys were conducted. The pharmacist survey was completed more than ten years ago. In 1994, there was an increase in media attention due to the pending legalization of physician assisted suicide in Oregon and as a result many citizens of the United States were introduced to this practice for the first time. For others who were familiar with it, like health care professionals, there was at least an increased awareness about the practice and it prompted many to take a more intense look at the ethical debate. It is possible that because the idea of legalization of physician assisted suicide in the United States was a new one, people were more likely to err on the side of caution. Since it has been legal in Oregon since 1997, we have evidence of how the practice has evolved since its legalization and maybe physician assisted suicide has become a more acceptable practice. Another reason for the difference is the basic generational gap between the two groups.
studied and with this gap comes obvious attitude differences. Finally, pharmacists have an advantage over students in that they actually have practical experience that may affect the way in which they respond to the questions. For example, when I asked my pharmacist her opinion on physician assisted suicide, her first concern was the liability associated with it. When considering my opinions, liability was never even a thought.

In my survey, I asked students to evaluate several scenarios that they may encounter in their professional practice. They were asked to indicate one of three answers based upon scenarios ranging from a pharmacist being presented with prescriptions for questionable medications by patients whom he/she had never met to close family members. The answers that were available included, a.) fill the prescription as is, b.) call the doctor to verify the prescription and then fill it (assuming the physician approved it), or c.) never fill the prescription. The specific scenarios and results are as follows:

- What would you do if you were presented with a prescription for drug X (a medication and dose known to be used in assisted suicides) but you did not know the person whom the prescription was written for?
  - 35% stated that they would fill it as is, 50% said they would call the doctor to verify but then fill it, leaving only 15% that would never fill it

- Would your answer change if the prescription for drug X was for a patient whom you have known for many years and have developed a good professional relationship?
  - 81% stated their answer would not change in this scenario

- What would you do if you were presented with a prescription for drug X by a family member who has terminal cancer and states that the pain in unbearable and he/she wants to spend their last days with their family in the comfort of their own home?
  - 69% said they would fill the prescription as is, 19% stated that they would call the doctor to verify but then fill it, leaving only 12% that said they would never fill the prescription

- What would you do if you were presented with a prescription for Alprazolam 2 mg #120 and Vicodin ES #120 for a patient who has never had prescriptions filled at your pharmacy and will be paying cash?
  - Interestingly, none of the students responded that they would never fill the prescriptions, and 69% expressed that they would fill the prescriptions after verifying them with the physician

- What would you do if you were presented with a prescription for Vicodin ES #120 for a patient whom you have known for many years and who has recently confided in you that he is suffering from depression and has nothing left to live for?
  - 50% said that they would fill the prescription after verification, 19% would fill it as is and 31% stated that they would never fill the prescription
As a follow-up to the last two questions, I asked what, if any, concerns would the student have with dispensing the medications? I was specifically looking to see if any of the students would question whether the medications could be used by a patient to commit suicide even though they may not necessarily be a medication prescribed by a physician for this purpose. Only 12% expressed concern that the unknown patient with Vicodin and Alprazolam would use the medication for this purpose whereas 31% expressed concern about the depressed patient using the medication to commit suicide. It is important that as pharmacists we recognize that all medications have the potential to be used for suicide. Pharmacists need to take advantage of this counseling opportunity to explore how their patients are feeling and whether or not they are receiving the appropriate care they need. Obviously, pharmacists cannot practice everyday with the overwhelming feeling that their patients may use their medications to commit suicide but it is definitely something to be aware of.

Is physician assisted suicide morally and ethically acceptable, and so ought it be legally permissible, for a physician to assist the competent, terminally ill patient in taking his or her own life? Clearly this question has no concise answer and both sides arguing it have valid points. Following the argument of autonomy, I believe that individuals should be able to have complete control over decisions relating to their health care and this includes the option of ending their life by assisted suicide. I think that this practice should be legalized but only under strict provisions. It is obviously a practice not to take lightly and thus sufficient safeguards need to be built into a legalized system that would prevent abusing it. The Oregon Death with Dignity Act seems to be well thought out and maybe could be used as the basis of legalization in other states. As a future pharmacist, I see that my responsibilities are to ensure that every patient considering this option is fully educated and has spent a sufficient amount of time considering all the alternatives available to them. I will not push my beliefs on any patient and furthermore I don’t think that any health care professional possesses that right. Ultimately, we need to focus on acting in the best interest of each patient which encompasses discussing their feelings and respecting the decisions that they make.

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