

## VIEWPOINT

# The Challenge of New Legislation on Physician-Assisted Death

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Related article

By the end of 2016, more than 80 million people in the United States and Canada will live in a jurisdiction allowing physician-assisted death. As such, this practice can no longer be considered a quirky experiment in a few states. The North American experience with physician-assisted death began in 1994, when voters in Oregon approved a ballot measure, the Death With Dignity Act, allowing a physician to prescribe a lethal dose of a medication that a patient voluntarily self-administers. Oregon stood alone for 14 years until Washington (2008), Vermont (2013), and now California (2015) approved similar laws. As of January 2016, the effective date of the California law, known as the End of Life Option Act, is uncertain. These laws are in general very similar, with safeguards that include requirements for a waiting period and that eligible patients be mentally competent, not mentally ill, and have a life expectancy of less than 6 months. In 2009, the Montana Supreme Court removed prohibitions against physician-assisted death for competent patients. There are no reporting requirements in Montana, so little is known about the actual practice of physician-assisted death in that state. In 2015, the Canadian Supreme Court unanimously reversed a federal law that prohibited physician-assisted death and gave the government until June 2016 to establish mechanisms for access to such assistance.<sup>1,2</sup>

In Europe, laws and practice about physician-assisted death differ considerably from those in the United States. In the Netherlands, Belgium, and Luxembourg, the most common practice is euthanasia for competent patients who request it; the legal requirements focus on a physician's assessment of a patient's unbearable suffering without prospect of improvement. The Netherlands and Belgium, which legalized physician-assisted death in 2001 and 2002, respectively, have expanded access for adolescents, persons who have not made explicit requests, and patients with mental but not necessarily physical illness.<sup>2</sup>

In Switzerland, assisted suicide has been legal since 1942 and is available for noncitizens. Swiss law specifies that assisting suicide is punishable only if done for "selfish reasons." At the request of a right-to-die organization, physicians prescribe lethal medications; a physician-patient relationship is not required. Patients must be competent and have an incurable though not necessarily terminal illness. The lethal medication can be administered intravenously, but the administration must be under the patient's control. One right-to-die organization, Dignitas, offers assisted suicide almost exclusively to nonresidents; between 2008 and 2012, the group helped 611 noncitizens, predominantly from the United Kingdom and Germany, to die.<sup>2,3</sup>

In the United States, despite predictions about a "slippery slope," the state laws allowing physician-

assisted death are rarely used. Data from Oregon show a modest increase in physician-assisted death, from 0.6 in 1000 deaths in 1998 to 3 in 1000 deaths in 2014.<sup>1</sup> Concerns that legalization of physician-assisted death would undermine efforts to develop and improve palliative care programs and target vulnerable groups, such as the elderly population, the uninsured, and the poor, have not been realized. In fact, in Oregon and Washington the availability of hospice and palliative care has expanded substantially, though the increased availability cannot necessarily be attributed to legalization of physician-assisted death. Compared with people with other causes of death, Oregon residents who have died after taking a prescription for a lethal medication have more years of education and are more likely to be white.<sup>1</sup> It is unclear if these traditional measures of privilege confer greater interest in physician-assisted death or more success in obtaining a prescription for a lethal medication. The most worrisome finding is from a 2008 study<sup>4</sup> that showed that patients in Oregon with depression have obtained prescriptions for lethal medications; it is not known whether treatment for depression would have changed their outcomes.

In contrast with the United States, the number of physician-assisted deaths is increasing rapidly in the European nations where the practice is legal. A survey conducted in Flanders, the part of Belgium where Dutch is spoken, reported 46 cases of euthanasia per 1000 deaths in 2013.<sup>5</sup> This compares with 2 physician-assisted deaths per 1000 deaths in Washington and Oregon the same year.<sup>1,2</sup>

In this issue of *JAMA Internal Medicine*, Bossard and colleagues<sup>6</sup> report a survey of assisted suicide in Switzerland that found an incidence of 11 per 1000 deaths in 2013, compared with 3 in 1000 deaths in 2001. Although part of the increase in assisted suicide in Switzerland is likely due to "suicide tourism," the survey also shows a very small, yet measurable, practice of illegal euthanasia and of ending life without the patient's explicit request. Continuous deep sedation increased from 4.7% of all deaths in 2001 to 17.5% in 2013. Data from Europe should be compared with data from the United States with caution. In Oregon and Washington, every case of legal physician-assisted death must be reported to the state or the physician is not eligible for the legal protections that the laws provide. Neither state, however, has recent, high-quality data on the prevalence of continuous deep sedation or euthanasia.

The divergence in the rate and growth of physician-assisted death between the United States and Europe defies easy explanation. On the surface, the differences in the process of care are striking: whereas a study<sup>7</sup> from 2000 reported that 18% of Oregonians who made

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an explicit request for physician-assisted death received a prescription for a lethal medication, 77% of requests for euthanasia were granted in Belgium, according to a recent survey.<sup>8</sup> Palliative care clinicians have expertise well suited to helping patients find alternatives to physician-assisted death, but disparities in access to palliative care services do not account for the differences in rates. Palliative care services preceded euthanasia in 74% of cases of physician-assisted death in Belgium; in Oregon, 90% of people who received physician-assisted death were enrolled in hospice.<sup>1,5</sup> It is unclear whether these distinctions reflect variation in laws, medical judgments, cultural expectations, or institutional barriers. Nonetheless, the limited understanding of the differences underscores the importance of a process for ongoing monitoring. Continued monitoring should include public reporting of the incidence of physician-assisted death, and demographics, disease characteristics, and the access to palliative care of those who pursue it. Such robust monitoring should enable clinicians, citizens, and policymakers to understand if the legal status of physician-assisted death in an increasing number of jurisdictions reasonably serves the small proportion of patients who wish to pursue it.

Recent developments in California and Canada present new challenges: How can access to physician-assisted death expand in a clinically responsible way to 38 million people in California and 35 million people in Canada? To date, much of the clinical work in the United States has been done by a small number of physicians, other clinicians, and volunteers in the relatively small states where the practice has been legal. In Oregon and Washington, nonprofit advocacy organizations provide counselors to enable patients to navigate the process. This is important because some medical systems and hospices with religious af-

filations prohibit their staff from participating and even ask patients not to discuss their interest in physician-assisted death with their employees.<sup>1</sup> The counseling system, however, relies on volunteers. Some large medical systems have devised policies and programs of care to help, such as assigning an advocate to educate and assist the patient, family, and clinicians; locating physicians who are willing to participate, screening for mental disorders; and ensuring compliance with the law.<sup>9</sup>

Patients considering physician-assisted death should have ready access to palliative care services and hospice, but the current shortage of palliative care physicians and nurses may limit the involvement of expert clinicians.<sup>10</sup> Moreover, physicians who receive requests for physician-assisted death should have sophisticated communication skills. Beneath the surface of a request may be hidden issues, such as fears of pain and dependency; such issues should be addressed regardless of whether a prescription is eventually written. Very few physicians in the United States and Canada have had the needed communication skills training.

In short, the time has come for an international call to action about physician-assisted death. Professional societies, academic medical centers, medical groups, and health care systems should ensure high-quality care by (1) expanding access to palliative care, especially earlier in the trajectory of illness before interest in physician-assisted death is expressed; (2) providing high-quality training to physicians and other clinicians in the communication skills needed to sort out a patient's fears, wishes, and values; and (3) advocating for continued and comprehensive public reporting systems about physician-assisted death. Physician-assisted death should remain an end-of-life practice of last resort for those who have made an informed choice and meet the legal criteria.

#### ARTICLE INFORMATION

**Published Online:** February 29, 2016.  
doi:10.1001/jamainternmed.2016.0047.

**Conflict of Interest Disclosures:** None reported.

**Funding/Support:** This work was supported with resources and the use of facilities at the VA Portland Health Care System.

**Role of the Funder/Sponsor:** The VA Portland Health Care System had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

**Disclaimer:** The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

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