

---

# Physician-Assisted Suicide: A Different Approach

by Linda Emanuel

---

*Most requests for physician-assisted suicide are not due to present suffering. Steps must be designed to uncover the real roots of the desire so that they can be specifically addressed. Examples of such steps are proposed.*

The debate over the justifiability and legalization of physician-assisted suicide has reached a pinnacle of attention with the Supreme Court's recent decision that there is no Federal Constitutional right to physician-assisted suicide. With this decision, several aspects of the debate now have been clarified. Wisely, the Supreme Court did not waste time debating whether physician-assisted suicide ever is, under any circumstances whatsoever, justifiable. In its wisdom, neither did the court give strong direction to the states. Public debate over this issue will not die a premature death. Instead, it now will reach a full and natural resolution as the merits of the arguments play out. Arguments used at the federal level will apply as well as at the state, making enduring state policies in favor of physician-assisted suicide unlikely. However, in keeping with good democratic process, this debate will die only after full deliberation.

Essentially, the Supreme Court said that there is no fundamental right to die. Commentators who had interpreted cases such as *Cruzan*, *Quinlan*, and *Brophy* as right-to-die cases, now must revise those interpretations. In philosophical jargon, they made a category error. That is, they tried to place their reasoning in the wrong framework or category. Instead of a right to die, there is a right to be free of unwanted intervention. These earlier cases upheld the right to be free of such unwanted intervention. This right is deeply rooted in ethics and in law. The right to be free of

unwanted intervention is a fundamental manifestation of autonomy and other principles of bioethics. Violation of bodily boundaries can occur ethically only with one's personal consent or with a higher authorization. It derives from battery law: any violation of one's bodily boundaries is assault and battery. A person has the right to be free of such intervention even if the consequence is death; this is what was upheld for *Cruzan*, *Quinlan*, *Brophy* and others.

By saying "no" to the right to physician-assisted suicide and by affirming simultaneously the more fundamental right to bodily integrity, the Supreme Court has urged society to honor this latter fundamental right more fully and effectively. With these rights, patients should be able to orchestrate a controlled, dignified, compassionate dying process, provided that the medical profession also honors its obligation to provide comfort or palliative care whenever appropriate.

As the debate moves to state levels, it will, I predict, quiet down. But obligations of society and the profession remain. These obligations are to address the root causes of a patient's call for physician-assisted suicide. Just because physician-assisted suicide will not be a widely available legal option does not mean we can forget or suppress the root of the call.

What motivates interest in physician-assisted suicide in our times? The empirical data are illuminating. Among other important findings, it is

clear that among those who are interested in physician-assisted suicide are many people who are depressed. Whether depressed or not, people express the following reasons for their interest: they fear loss of control, indignity, abandonment, being a burden, and eventual physical suffering. Surprisingly, only a small number (five to 11 percent) are motivated by current physical suffering.

---

*Today's culture is affected  
by past decades in which  
death itself has been  
denied.*

---

What does this mean? Most of the motivators toward physician-assisted suicide are fears that are best understood in the psychological and social context of an individual's life. Today's culture is affected by past decades in which death itself has been denied. Desire for a youthful appearance leads middle-aged men and women to replace hair, remove wrinkles, and excise fat, all with considerable psychological, physical, and economic investment (or suffering). The elderly are not revered, and the dying are institutionalized. Death rituals and support for those mourning are underemphasized. Medical science has focused on saving lives and stamping out disease, and has underemphasized the need to provide comfort when cure is impossible. Fears that drive the assisted-suicide debate are very reasonable fears. Our culture makes the ailing feel unwelcome, ashamed, undignified.

An illustration can demonstrate the power of this problem. Suppose I fall ill, start looking like a ghost, and need care from my family for incontinence. If my family and community care for me willingly and lovingly, I will feel dignified and will not feel like a burden or fear abandonment. If, instead, my family cares for me unwillingly and with embarrassment, and if I do not have community support, then I will feel undignified, ashamed, a burden, and will legitimately fear abandonment.

Causes of the call for physician-assisted suicide, then, are not all in the medical sphere. They are rooted in our society. How can this change? Two things that will have the greatest and fastest impact are changing the way we talk about death and dying and the way we plan for it. Most people do not talk about death and dying. When patients and their families come to a physician's office to discuss a life-threatening illness, even those who have been together for decades generally have not talked about dying. They may not know what it means personally, practically, or morally, to themselves or to one another. Death is a taboo topic; society's culture has denied dying a place of respect.

One group in particular can take the initiative here: health care professionals. Physicians and others are trained to structure difficult discussions. We already talk about sexual practices of all varieties; we talk about bowel and bladder habits, and so on. We are trained to pose key questions in unbiased yet directed ways in order to cover the major issues. Discussions about planning for dying can be treated the same way. Unfortunately, medical training for most physicians does not include learning to discuss this key subject with patients.

Fortunately, there is a well-established tool physicians can use to structure death-related discussion: the validated worksheet. As a field of inquiry, psychometrics validates instruments used in eliciting and recording the subjective phenomena of a person's mind, especially instruments used in evaluation and testing. The same approach can be used in developing a worksheet. Once such a validated worksheet is available, physician, patient, and family member or proxy can use it together, penciling in their thoughts in rough. They can get a sense for using scenarios of dying that present decision-making dilemmas, the major issues and the options. They can discover the wishes of the patient. These wishes then can be written formally and filed in the patient's medical record.

Some have used worksheet-guided discussions already; these interactions have been studied and

are well accepted. These studies began as part of the movement toward using living wills and as part of the academic medical studies of how to draft useful documents. However, as is true of so many medical developments, perhaps the most important use for worksheets will be in structuring health care planning discussions.

Anecdotal evidence suggests that when a patient or family member is inclined toward physician-assisted suicide, participation in a structured discussion about values, goals, and options over a range of relevant scenarios can reduce such motivation. Often the request is dropped in favor of a different plan. These different plans can involve withdrawing and withholding of interventions, including nutrition and hydration, and they can include aggressive comfort care, and accommodation of personal goals for concluding the patient's life. But they are less likely to include requests for physician-assisted suicide.

Although not substantiated by large empirical studies (which would be virtually impossible), this observation suggests an important approach for clinicians and medical policy makers regarding end-of-life care. Proponents of physician-assisted suicide have developed guidelines for providing such assistance while guarding against the slippery slope of misuse. Opponents of assisted suicide have advocated a "just say no" approach. Clinicians pursue a third path: developing a protocol for approaching patients and families who already are inclined toward physician-assisted suicide.

Steps involved can be simple and in keeping with well-established medical practice. Consider a patient who requests physician-assisted suicide. That patient should be evaluated for depression, since depression correlates significantly with such requests. If there is clinical depression with disordered thinking, it must be treated.

The patient must also be evaluated for decision-making competence. Medically incom-

petent patients will need a proxy for their decision making.

The key step is that the patient should be engaged in a structured deliberation like that described above. A patient who seeks control can understand how much control is available to them through withdrawing or withholding of interventions and through use of aggressive palliative care. Patients who seek dignity can

---

*Patients who fear  
abandonment can see by  
the very act of planning  
that abandonment need  
not occur, and that caring  
is present.*

---

see how their vision of dignity can be preserved using this range of decisions. Patients who fear abandonment can see by the very act of planning that abandonment need not occur, and that caring is present. Patients who fear being a burden can see how controlled their exit from this world can be without recourse to physician-assisted suicide. For example, a patient with amyotrophic lateral sclerosis can refuse artificial nutrition and hydration. This will allow death to occur in a manner as free from suffering as any we know and within a fairly short time, once dependence on others begins. (This is how I have written my own advance directive in case such a scenario arises.)

By the end of this third step, most patients will have either been excluded from consideration of physician-assisted suicide on grounds of depression or incompetence or will have dropped their request. These steps will have helped to identify and respond to the root causes of the request.

For those who remain firm in their request, the next step requires full disclosure of information on the consequences, risks, and responsibilities

involved in the decision. This informed consent process is standard for all medical decisions. The process should ensure that the patient is free of overt or unacknowledged coercion. It also

---

*Physicians must be secure  
in their ability to structure  
discussions about  
planning for dying and  
secure in their ability to  
obtain comfort care for  
their patients.*

---

should ensure that the patient knows that physician-assisted suicide is not a suffering-free exit from the world. It is a choice with its own existential suffering and risks, one that has consequences for the patient and the bereaved.

If the patient still is requesting physician-assisted suicide, involvement of an ethics committee or consultations are necessary, simply because the decision is a grave one.

If the request continues, at this point it is necessary to decline the request. Throughout this process, and especially in declining a rational request for physician-assisted suicide, whole person comfort care must continue.

Unfortunately, an important empirical study indicates that often the family may be more interested in physician-assisted suicide than the patient. In this case, the professional must evaluate the root causes of the family's request in a set of steps very similar to those taken for patients.

Professionals also must be trained to respond to their own inclinations if they incline toward physician-assisted suicide. The power of transference and the frustration of a highly empowered person facing an "unsaveable" patient can undermine professional judgment. Physicians must be secure in their ability to structure discussions about planning for dying and secure in their ability to obtain comfort care for their patients. Short of this, they must obtain help from colleagues who are secure in these skills.

In summary, the Supreme Court, by ruling as it did against a Federal Constitutional right to physician-assisted suicide, has given society a reprieve. We now have an obligation to elevate the place of dying in society to a healthy one and an obligation to develop the medical art of caring for the dying to a reliable one. Key to this obligation is the ability to talk about and plan for death and dying. Key also is the ability to secure full palliative care for the dying. Neither step is unobtainable, but both are difficult. And the race is on.