The Physician-Assisted Suicide Policy Dilemma: A Pilot Study of the Views and Experiences of Connecticut Physicians

Harold I. Schwartz, MD, Leslie Curry, MPH, Karen Blank, MD, and Cindy Gruman, PhD

Development of fully informed public policy regarding physician-assisted suicide (PAS) requires a thorough understanding of the experiences, attitudes, and beliefs of physicians with respect to this issue. This study gathered data on physician characteristics, attitudes toward PAS, factors influencing attitudes toward PAS, and sensitivity to the role of depression in a sample of 397 psychiatrists, internists, and family practitioners in Connecticut. Central considerations included: the influence of religious values, professional discipline and practice patterns, and ability to diagnose depression in a single evaluation. Psychiatrists were significantly more likely to be supportive of PAS than were internists or family practitioners. Most respondents expressed concern regarding the influence of depression on PAS requests. A subset of physicians endorse PAS yet do not share such concern about risks, suggesting substantial challenges for policymakers.

The escalating public debate regarding physician-assisted suicide (PAS) presents an extraordinary challenge to policy-makers. This highly complex issue is shaped by moral and religious values, professional ethics, constitutional guarantees of privacy and due process, medical education, and the evolution of medical technology. Policy decisions speak fundamentally to individual freedom, the value of life, societal values regarding relief from suffering, and the definition of the role of the medical profession. Physicians' moral and ethical beliefs, as well as their attitudes toward and experience with PAS, have emerged as central considerations in these debates. Professional medical societies have developed consensus opinions regarding PAS, yet despite the development of position statements by the American Medical Association, American Psychiatric Association, and American Geriatrics Society, individual physicians' views remain highly varied. Given the scope of physicians' influence

The authors are affiliated with the Braceland Center for Mental Health and Aging, Institute of Living/Hartford Hospital, 400 Washington St., Hartford, CT 06106. Address correspondence to Harold I. Schwartz, MD.

on both legal and public opinion, an understanding of the determinants of individual opinions and behaviors regarding PAS is critical to the design of effective and appropriate public policy.

A number of studies of physicians' attitudes toward PAS have been reported in the literature.[1–4] Both personal and professional characteristics have been found to influence views toward PAS. The data suggest that age is associated with attitudes, in that older physicians are more likely to support PAS.[2,5] There is some evidence that female physicians are more likely to express support for PAS,[4,5] although data are mixed.[1,3] Experience in caring for terminally ill patients has also been found to be significantly associated with views on PAS, with those having less experience expressing greater support.[4,6] Differences have also been noted among medical specialties, with family and general practitioners being more supportive of PAS than internists.[5,7] There is some evidence that psychiatrists[3,4] along with geriatricians and pulmonologists[1] are significantly more likely to approve of PAS than are other physicians.

Although the influence of religion on willingness to participate in PAS has been explored in a few studies, broader issues of religiosity have not been examined in any depth. There is consistent evidence regarding relationships between religious orientation and positions on PAS; Jewish physicians are more likely to support PAS than are Catholics.[1,7] Those opposed to PAS are more likely to report being influenced by religious beliefs than those in favor.[4] Physicians to whom religion is very important are significantly less likely to consider participating in PAS.[6] Frequency of prayer has also been found to be associated with views on PAS; those who never engage in prayer are more likely to be willing to write a lethal prescription.[1]

The importance of psychiatric considerations such as the role of clinical depression in the desire for death in terminally ill patients has been noted.[8] Most of the proposed guidelines for clinical criteria for PAS require a determination that the patient is competent and capable of sound judgment and free of depression or another mental disorder that would impair decisionmaking.[9–11] Despite these requirements for explicit physician assessments, very little research has examined the practitioner's knowledge base in suicide and depression or ability to accurately assess risk around PAS requests. One study found that those with less knowledge about suicide and depression were more likely to support patients' wishes for PAS.[5] Self-reported confidence to recognize depression in a patient requesting PAS is limited. Among a sample of Oregon-licensed physicians, 28 percent indicated they were not confident in their ability to diagnose depression in a patient requesting PAS.[2] A study of psychiatrists found that 94 percent were not very confident that they could, in a single evaluation, determine whether or not a psychiatric disorder was impairing the judgment of a patient requesting PAS.[3] Given the paucity of data regarding the role of religious and professionally based values, as well as the physicians' ability to diagnose depression, this pilot study sought to explore these particular factors

in greater depth. Analysis and discussion of findings focuses primarily on the implications for public policy in this arena.

Methods

An anonymous survey was mailed to all individuals included on the membership roster of the Connecticut Psychiatric Association (n = 920) and a random sample of Connecticut-licensed physicians designated as internists or family practitioners (n = 1,000). A list of licensed physicians was purchased from the Connecticut Department of Public Health Physician Licensure office in 1997. The study was approved by the Hartford Hospital Institutional Research Committee. A self-administered, anonymous questionnaire was mailed, with a follow-up letter and questionnaire to the entire sample mailed four weeks later.

The survey contained 48 forced-choice items regarding: (1) physician characteristics (age, ethnic background, religion, type of physician, practice setting); (2) patient characteristics (age, terminal illness, depression, suicide); (3) attitudes toward various interventions by a physician (withhold or withdraw life-sustaining medical treatment or artificially delivered food and hydration, which may hasten death; prescribe analgesics such as morphine to relieve pain in dosages that may hasten death; write a prescription with the sole purpose of allowing a patient to end his or her life; administer a medication with the sole purpose of allowing a patient to end his or her life); (4) factors influencing attitudes toward PAS (personal factors, beliefs regarding the physician's role, personal experience, potential effects on medical practice, potential risks, palliative care); and (5) sensitivity to depression. Nineteen of the items were drawn from a prior survey, with permission.[2]

Data were analyzed using SPSS software (SPSS Inc., Chicago). Categorical measures in the groups were compared using chi-square tests, while mean values for the continuous variables were compared by t test and one-way analysis of variance. All tests were two-tailed. Univariate and bivariate analyses examined associations between selected physician characteristics and other variables of interest.

Results

Respondent Characteristics Of the 1,920 physicians who were sent a survey, 397 returned completed questionnaires for an overall response rate of 20.7 percent. Response rates by discipline were as follows: psychiatrists, 193/739, response rate 26.1 percent; internists, 119/712, response rate 16.7 percent; family practitioners, 79/469, response rate 16.8 percent. Due to the limited amount of information available in the state licensure database, it was not possible to determine whether survey respondents were representative of all Connecticut-licensed physicians. Age was the only available variable, and it did not differ significantly among the two groups.

One-third of respondents were over age 60, and the majority were male (72%) and white (93%). Primary religious affiliations included Catholic (33%), Protestant (31%), and Jewish (36%). The majority stated their religion was moderately (33%) or very (31%) important to them.

Table 1
Attitudes Toward End of Life Care and Physician-Assisted Suicide

	Strongly Disagree	Disagree	Agree	Strongly Agree
	%	%	%	%
Withhold or withdraw life-sustaining medical treatment, which may hasten death	3	5	28	64
Withdraw artificially-delivered food and hydration, which may hasten death	5	9	31	55
Prescribe analgesics such as morphine to relieve pain in dosages which may hasten death	4	8	31	58
Write a prescription for medication with sole purpose to allow the patient to end his or her life	40	28	23	9
Administer a medication with sole purpose to allow the patient to end his or her life	48	27	18	8

Two-thirds (65%) reported their practice setting as private office-based. Although significance tests precluded consideration of these comparatively small groups, the following religious affiliations were also reported: Moslem, agnostic, atheist, other, and none. Almost half of the respondents (49%) were psychiatrists, 31 percent were internists, and 20 percent family practitioners. Similarly, with regard to medical specialty, 27 respondents indicated a specialty in geriatrics, and 77 indicated another subspecialty (multiple responses were permitted to this item).

Attitudes Toward PAS Respondents were asked to report the degree to which they agreed that a physician should be permitted to engage in a series of end-of-life practices in the case of a competent, terminally ill patient (Table 1). The ability to withhold or withdraw life-sustaining medical treatment was strongly supported by 64 percent of respondents. Over half (55%) strongly agreed that physicians should be permitted to withdraw artificially delivered food and hydration, an action that may hasten death. A slightly higher percentage (58%) strongly agreed that prescription of morphine to relieve pain in dosages that may hasten death should be permissible. There was a major shift in agreement about practices with regard to writing a prescription for medication with the sole purpose of allowing the patient to end his or her life (32% agreed/strongly agreed). Similarly, 26 percent agreed/strongly agreed that physicians should be allowed to administer a medication with the sole purpose of allowing a patient to end his or her life.

Relationships Between Attitudes Toward PAS and Selected Respondent Characteristics A number of personal and professional characteristics were found to be significantly associated with attitudes toward PAS (Table 2). The table displays the percentages of respondents who either agreed or strongly agreed that physicians should be permitted to perform the practices identified in the col-

Table 2
Physician Characteristics Associated with Supportive Views on PAS (% of Those Who Agree/Strongly Agree) $N = 397$

Characteristic	Withhold Life-Sustaining Treatment	Withdraw Food and Hydration	Prescribe Analgesics in Lethal Dose	Write Lethal Prescription	Administer Lethal Prescription
	%	%	%	%	%
Age (years)					
<40	92**	85**	92	18	15
40–49	99	94	90	30	22
50–59	91	86	90	36	26
≥60	87	77	86	32	27
Gender					
Male	92	85	87	32	25
Female	93	87	93	30	24
Years in practice					
1–9	91	88*	91	27	21
10–19	96	91	89	35	27
20–29	94	87	88	34	25
≥30	88	77	87	31	27
Racial background					
White	94****	87****	91****	33*	26
Non-white	62	62	48	11	15
Religion					
Catholic	87*	80	78****	11***	9****
Protestant	93	86	93	21	17
Jewish	96	87	95	52	42
How important is your religion to you?					
Not at all important	98***	93*	95*	50****	36***
Slightly important	98	87	93	47	37
Moderately important	94	87	90	31	25
Very important	84	78	81	15	13
Medical specialty					
Internal medicine	91	82	89	24	28
Family practice	94	91	91	37	19
Psychiatry	91	86	84	34	29
Practice setting[a]					
Private office-based practice	94	87	90	36*	29*
Hospital-based practice	89	81	83	25	18
Community mental health or public setting	95	84	90	40	29
Hospice	100	100	100	50	0
University/Academic	97	90	92	21	15*
HMO	100	100	75	25	13
Nursing home	94	84	84	19	16
Other	94	88	97	40	29

[a] Not mutually exclusive.
*, $p < .05$; **, $p < .01$; ***, $p < .001$; ****, $p < .0001$.

umn headings (responses were made on a four-point scale from strongly agree to strongly disagree and collapsed into two categories for the purpose of these analyses). Older physicians were significantly less likely to support the withholding (χ^2 11.82, $df = 3$; $p < .01$) or withdrawal (χ^2 13.38, $df = 3$; $p < .01$) of treatment, although these differences did not appear with regard to writing a lethal prescription or administering a lethal medication. The most highly significant associations were found with regard to religion, both in terms of religious affiliation and importance of religion. Catholic-affiliated respondents were much more likely to oppose prescribing (χ^2 17.85, $df = 2$; $p < .001$), writing (χ^2 45.87, $df = 2$; $p < .001$), and administering (χ^2 34.55, $df = 2$; $p < .001$) lethal prescriptions than were Protestant or Jewish physicians. Those who reported that religion was very important were significantly less likely to support physician authority to write (χ^2 32.96, $df = 3$; $p < .001$) or administer (χ^2 18.34, $df = 3$; $p < .001$) lethal prescriptions.

There were strong differences in views by medical specialty, but statistical significance was lost in the collapsing of categories as reported in Table 3 (agree with to strongly agree). The following highly significant differences were found when examining the four-point responses. Psychiatrists were less likely to strongly agree with withholding life-sustaining treatment (psychiatrists 54%, internists 78%, family practitioners 69%; χ^2 21.59, $df = 6$; $p < .001$), withdrawing nutrition or hydration (psychiatrists 43%, internists 68%, family practitioners 63%; χ^2 28.93, $df = 6$; $p < .001$), and writing a prescription for analgesics to relieve pain in dosages that may hasten death (psychiatrists 49%, internists 68%, family practitioners 62%; χ^2 15.92, $df = 6$; $p < .05$). There was an interesting shift in views among psychiatrists with regard to the two remaining interventions. Psychiatrists were significantly more likely to be supportive of writing a prescription with the sole purpose of allowing the patient to end his or her life (psychiatrists 13%, internists 6%, family practitioners 6%; χ^2 18.85, $df = 6$; $p < .01$) and administering a medication the sole purpose of which would be to allow the patient to end his or her life (psychiatrists 11%, internists 4%, family practitioners 5%; χ^2 16.88, $df = 6$; $p < .05$). Finally, there were marginally significant differences with regard to practice setting. Physicians in private practice settings or in community mental health settings were more likely to support writing (χ^2 5.99, $df = 1$; $p < .05$) or administering (χ^2 4.92, $df = 1$; $p < .05$) lethal prescriptions.

Factors Influencing Views on PAS

The next section of the survey explored a number of factors that may influence physicians' views on PAS. The majority of respondents (62%) indicated the amount of pain the patient could be expected to experience during the remainder of life was a very important factor. Nearly half also rated expected mental condition (46%) and right to self determination (44%) as very important. Resource and family considerations did not have substantial influence on respondents' views toward PAS. The following physician/practice factors were reported to have a

Table 3
Factors and Concerns About Potential Risks Influencing Views on Physician-Assisted Suicide

	Not At All		Slightly		Moderately		A Great Deal	
	Write and administer	All others	Write and administer	All others	Write and administer	All others	Write and administer	All others
Factors	%		%		%		%	
Patient's expressed wishes, irrespective of terminal condition*	25	43	20	20	28	18	28	18
Patient's expected quality of life***	0	23	7	14	32	26	62	38
Life expectancy with treatment***	5	27	20	16	41	30	38	26
Expected pain or discomfort***	0	22	1	6	12	18	87	54
Expected mental condition***	2	26	4	10	28	25	65	39
Financial burdens**	30	53	36	24	24	19	10	4
Use of scarce resource**	25	46	37	29	27	18	11	7
Right to self determination***	1	20	8	14	24	30	67	36
Wishes of patient's family**	22	42	39	27	27	25	12	6
Age of patient***	21	51	41	23	29	21	9	5
Potential risks								
Administering a nonfatal overdose**	23	46	41	27	23	18	13	10
The risk that an accurate determination of the patient's future quality of life cannot be made*	89	12	31	19	40	35	22	35
The risk that allowing PAS might open the door to involuntary euthanasia***	28	13	29	12	22	28	21	47
The risk that PAS might be misused with certain disadvantaged groups***	23	10	23	13	29	28	24	48
The risk that reversible mental illness, such as depression, might be contributing to a patient's request for PAS***	1	6	25	6	36	27	37	61

*, $p < .05$; **, $p < .01$; ***, $p < .001$.

great deal of influence on physicians' views: physician's role in relieving pain and suffering (73%), beliefs regarding ethics in medicine (68%) and patient self-determination (55%), and personal moral convictions (54%). A number of potential risks were frequently identified as moderately or greatly affecting perceptions regarding PAS. More than half (56%) of respondents stated that the risk a reversible mental illness (such as depression) might be contributing to a patient's request for PAS greatly influenced their view. A sizable percentage (43%) expressed a great deal of concern that PAS might be used with certain disadvantaged groups. One-third (33%) of physicians said that their belief that current palliative care options are inadequate or underutilized had a moderate or great impact on attitudes toward PAS.

Confidence in Assessing Psychiatric Disorders in the Context of a Request for PAS Respondents were asked to assess their confidence level in assessing psychiatric disorders that might impair the judgment of a patient requesting PAS. Nearly half (48%) reported that they are not at all confident that within the context of a single evaluation they could assess whether a psychiatric disorder was influencing the patient's decision. The majority (64%) indicated that, given a long term relationship with the patient, they could make an accurate assessment. The last item inquired about the likelihood that a patient seeking PAS might suffer from an occult depression which, if treated, might cause the patient to change his or her mind. Over one-third (39%) felt this was very likely.

Those Who Would Both Write and Administer Lethal Prescriptions Because much of the concern about PAS revolves around the potential "slippery slope" between PAS and euthanasia, the relationship between attitudes about writing lethal prescriptions and attitudes about administering lethal medications is important to examine. There was a highly significant relationship ($p > .001$) between views on writing and administering lethal prescriptions. While 39 percent of the sample strongly disagreed with either measure, a notable percentage (24%) agreed or strongly agreed with both writing and administering a lethal prescription. This subgroup was not distinguishable from the rest of the respondents by age, sex, or years of practice. However, there were significant differences with regard to the percentage of patients in one's practice over the age of 65 (20% for those who would both write and administer versus 31% for all others, $F(1,373) = 12.67$; $p < .001$). There were marginally significant differences among the two groups in terms of the number of patients in their practice who had died during the last year ($F(1,360) = 3.6$; $p = .059$). Of note, members of this subgroup acknowledge having already written lethal prescriptions with significantly greater frequency than the rest of the sample (9.0% of those who would both write and administer versus 3.4% of all others; χ^2 4.83, $df = 1$; $p < .05$). Since this subgroup might be thought of as those most likely to engage in voluntary active euthanasia as well as PAS, their attitudes, experience, and concerns were analyzed with reference to all

other respondents as a comparison group (Table 3).

In considering the decision to write a lethal prescription for a patient, those who would both write lethal prescriptions and administer lethal medication place greater importance on the patient's expressed wish for PAS, irrespective of terminal condition (χ^2 10.98, $df = 3$; $p < .05$), the patient's expected quality of life (χ^2 34.54, $df = 3$; $p < .001$), the patient's life expectancy with proper treatment (χ^2 19.33, $df = 3$; $p < .001$), expected pain and discomfort (χ^2 37.3, $df = 3$; $p < .001$), and the age of the patient (χ^2 27.38, $df = 3$; $p < .001$). These individuals also place greater importance on the patient's expected mental condition (χ^2 33.03, $df = 3$; $p < .001$), potential financial burdens on the patient or family (χ^2 16.14, $df = 3$; $p < .01$), and the potential use of scarce medical resources by the patient (χ^2 13.01, $df = 3$; $p < .01$). Although they are more concerned with the patient's right to self-determination (χ^2 35.35, $df = 3$; $p < .001$), they also place more emphasis on the importance of the wishes of the patient's family (χ^2 13.96, $df = 3$; $p < .05$). Finally, this subgroup was less concerned about the risks that: a reversible mental illness, such as depression, might be contributing to a patient's request for PAS (χ^2 35.82, $df = 3$; $p < .001$); PAS could be misused with disadvantaged groups (χ^2 22.08, $df = 3$; $p < .001$); PAS might lead to involuntary euthanasia (χ^2 34.32, $df = 3$; $p < .001$).

Discussion

This study examined the practices and attitudes of Connecticut physicians with regard to PAS. There are several limitations to note. The response rate is lower than in many other mailed surveys to physicians, typically around 50 percent,[12] including other studies of physician attitudes regarding PAS in the literature.[2–7] There are two possible methodologic reasons for this low response rate. First, there was only one follow-up contact to encourage replies from non-respondents to the first-wave mailing. Second, assurances of anonymity may not have been as compelling as we would have wished, since the cover letter was printed on the research team's institutional letterhead (as opposed to the university letterhead). The level of concern and motivation to respond among physicians in Connecticut may also be lower than in the other states in which studies have been conducted, since there is presently no major legislative initiative or court case to raise awareness about PAS. Most prior empirical research has been conducted in states where legalization of PAS was undergoing extensive public debate. Information regarding non-respondents was very limited, as the state licensure database contains only the age of a physician. While the sample is representative of Connecticut-licensed physicians in terms of age, non-respondents may differ in other important characteristics. Further, findings of a survey of Connecticut-licensed physicians may not be generalizable to other states. Finally, the forced-choice response design limited the detail conveyed by respondents regarding views and experiences. Nevertheless, these pilot data provide important insights regarding the potential challenges to policy-makers

as they begin to consider legislation in this area.

The United States Supreme Court, in both *Washington v. Glucksberg*[13] and *Vacco v. Quill,*[14] has thrust the evolution of public policy regarding PAS into the arena of state legislatures. As of August 1998, 37 states had statutes prohibiting PAS, 6 states criminalized PAS by common law, and there was no applicable law (or the law was unclear) in 6 additional states.[15] At the time of this writing, PAS is legal in only one state (Oregon). Since 1995, 17 states have considered some form of PAS legislation.[15] The issues relevant to state legislators as they consider such legislation are legion and extend beyond the formidable ethical considerations, which have been debated extensively in the literature.[16–22]

The views of state citizens regarding legalization of assisted suicide are of central importance. A poll of Connecticut residents[23] found that 70 percent of respondents would favor PAS if it were closely regulated, which is consistent with other public opinion polls[6, 15, 24, 25] and the passage by public referendum of the Oregon Death With Dignity Act.[26] Further, the views of physicians licensed in a particular state will play a critical role in the development of and compliance with legislation, particularly in terms of statutory safeguards. The prevalence of writing or administering lethal prescriptions for the purpose of PAS, despite its current legal status, is of particular interest. Would legalization (essentially decriminalization) enhance the practice through regulation or open the door to abuse of the elderly, the incompetent, the disadvantaged, and other groups?

Professional medical organizations, including the American Medical Association,[27] the American Psychiatric Association,[28] the American Nurses Association,[29] and the American Geriatrics Society[30] have taken positions opposing legalization. In a letter to the United States Supreme Court, The New York Academy of Medicine expressed its concern about the unintended consequences of legalization and predicted that "... the logical and predictable consequences of legalization of physician-assisted suicide will be its extension to voluntary euthanasia."[31] This slippery slope is generally regarded to mean: (1) the risk of extension of PAS, intended for individuals with terminal illness, to individuals with non-terminal conditions; and (2) the movement from PAS to active voluntary euthanasia and even to involuntary euthanasia.[32] Indeed, concern that legalization of PAS will encourage a slippery slope toward euthanasia has been a central component of the PAS debate.[19–20, 33, 34] It is worthy of note that the slippery slope debate about PAS and euthanasia practices in the Netherlands rages unabated despite years of experience and multiple studies.[35–40]

There are various clinical, economic, social, and even legal factors that may predispose to the expansion and extension of PAS.[41–43] Will legalization of PAS facilitate a process of acculturation through which physicians will come to feel increasingly comfortable with an expanded role in ending patients' lives? Ganzini[44] suggests just such an explanation for the finding that the majority of psychiatrists in the Netherlands have

come to endorse PAS for intractable (but non-terminal) mental disorders.[45]

A small number of physicians acknowledged currently writing prescriptions intended to be lethal in accordance with patients' requests. The 4 percent acknowledging this practice in this study is similar to the 3.3 percent reported in a recent national survey[1] and is less than the 7 percent reported in a survey of Oregon physicians[2] and in two surveys of oncologists.[24, 46] Consonant with other reported studies, the willingness of physicians in this study to participate in PAS would increase significantly were it to be legalized.

The participation of physicians in active voluntary euthanasia is less clear. In the survey by Meier,[1] the prevalence of physicians ever having provided a lethal injection was 4.7 percent. These injections were given mostly to patients predicted to be within 24 hours of death, a situation leading to confusion about the intent to relieve suffering as compared with the intent to hasten death.[47] Our survey gathered data about concerns that might deter respondents from moving down the slippery slope toward euthanasia. Respondents identified a number of risks that influence their attitudes toward PAS, including the risk that a reversible mental illness might be contributing to a PAS request (56%), that PAS might be used with certain disadvantaged groups (43%), and that current palliative care options are inadequate (33%). Almost 40 percent of the sample believed it likely that a patient requesting PAS might suffer from occult depression which, if treated, might cause the patient to change his or her mind. Each of these concerns or beliefs may be inferred to reflect caution on the respondent's part toward both PAS itself and its extension to euthanasia.

Of concern, however, are the attitudes of the subset of respondents (24%) who would both write and administer a lethal prescription and who currently participate in PAS at a significantly higher rate than the rest of the sample. This group is also less concerned about a variety of risks that may be inferred to reflect caution on the part of physicians contemplating participation in these practices. They place importance on the patient's expressed wish for PAS, irrespective of the patient's condition, suggesting that the presence of a terminal illness may not be viewed as a central requirement for PAS by this group. They place importance on the financial burden the patient may be creating for his family and the patient's use of scarce medical resources, suggesting that social factors may be considered in addition to the patient's wishes. At the same time, they are less concerned about the misuse of PAS in disadvantaged groups. They are less concerned that a reversible mental illness (depression) may be contributing to the PAS request and less concerned that PAS could lead to involuntary euthanasia. These findings suggest a subgroup of physicians, not previously identified, who may be more willing to engage in PAS and possibly in voluntary, active euthanasia but who are less concerned with a variety of clinical, social, and ethical considerations that are generally viewed as critical to the boundary between PAS and euthanasia.

Surveys to date about physicians' atti-

tudes toward PAS and active voluntary euthanasia reveal extremely divergent views. Attitudes are influenced by age, sex, years in practice, religion, and medical specialty. It is reassuring that most physicians endorse PAS for voluntary, competent patients only if legalized and in regulated settings. It is also comforting to know that most physicians are concerned about issues such as involuntary euthanasia and the influence of depression or other mental disorders on PAS requests. In our opinion, the presence of a subset of physicians who endorse both procedures, who currently practice PAS more frequently than others, and who do not share these concerns about risks calls for extensive physician education around these issues and, if PAS is to be legalized, regulation sufficient to address the potential transition from PAS to euthanasia.

References

1. Meier DE, Emmons CA, Wallenstein S, Quill T, Morrison RS, Cassel CK: A national survey of physician-assisted suicide and euthanasia in the United States. N Engl J Med 338:1193–1201, 1998
2. Lee MA, Nelson HD, Tilden VP, Ganzini L, Schmidt TA, Tolle SW: Legalizing assisted suicide: views of physicians in Oregon. N Engl J Med 334:310–15, 1996
3. Ganzini L, Fenn DS, Lee MA, Heintz RT, Bloom JD: Attitudes of Oregon psychiatrists toward physician-assisted suicide. Am J Psychiatry 153:1469–75, 1996
4. Cohen JS, Fihn SD, Boyko EJ, Jonsen AR, Wood RW: Attitudes toward assisted suicide and euthanasia among physicians in Washington state. N Engl J Med 331:89–94, 1994
5. Duberstein PR, Conwell Y, Cox C, Podgorski CA, Glazer RS, Caine ED: Attitudes toward self-determined death: a survey of primary care physicians. J Am Geriatr Soc 43:395–400, 1995
6. Bachman JG, Alcser KH, Doukas DJ, Lichtenstein RL, Corning AD, Brody H: Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. N Engl J Med 334:303–9, 1996
7. Shapiro RS, Derse AR, Gottlieb M, Schiedermayer D, Olson M: Willingness to perform euthanasia: a survey of physician attitudes. Arch Intern Med 154:575–84, 1994
8. Chochinov HM, Wilson KG, Enns M, *et al*: Desire for death in the terminally ill. Am J Psychiatry 152:1185–91, 1995
9. Baron CH, Bergstresser C, Brock DW, *et al*: A model state act to authorize and regulate physician-assisted suicide. Harv J Legis 33:1–34, 1996
10. Miller FG, Quill TE, Brody H, Fletcher JC, Gostin LO, Meier DE: Regulating physician-assisted death. N Engl J Med 331:119–23, 1994
11. Quill TE, Cassel CK, Meier DE: Care of the hopelessly ill: proposed clinical criteria for physician-assisted suicide. N Engl J Med 327: 1380–4, 1992
12. Asch DA, Jedrziewski MK, Christakis NA: Response rates to mail surveys published in medical journals. J Clin Epidemiol 50:1129–36, 1997
13. Washington v. Glucksberg, 521 U.S. 702 (1997)
14. Vacco v. Quill, 521 U.S. 793 (1997)
15. Lenzer A: Assisted suicide: now a critical state issue. Presented at the 51st Annual Meeting of the Gerontological Society of America, Philadelphia, PA, Nov 1998
16. Beauchamp TL: Intending death: The ethics of assisted suicide and euthanasia. Upper Saddle River, NJ: Prentice-Hall, 1996
17. Capron AM: Legalizing physician-aided death. Camb Q Healthc Ethics 5:10–23, 1996
18. Fins JJ, Bacchetta MD: The physician assisted suicide and euthanasia debate: an annotated bibliography of representative articles. J Clin Ethics 5:329–40, 1994
19. New York State Task Force on: Life and the Law. When death is sought: assisted suicide and euthanasia in the medical context. Albany, NY: Health Research, 1994
20. Brock DW: Voluntary active euthanasia. Hastings Center Report 22:10–22, 1992
21. Vaux KL: The theologic ethics of euthanasia. Hastings Center Report 19:19–22, 1989
22. Stone TH, Winslade WJ: Physician-assisted suicide and euthanasia in the United States: legal and ethical observations. J Legal Med 16:481–507, 1995
23. Poll finds tentative conditional support for

assisted suicide. The Hartford Courant, April 12, 1998, p B5
24. Emanuel EJ, Fairclough DL, Daniels ER, Clarridge BR: Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public. Lancet 347:1805–10, 1996
25. Meier DE: Doctors' attitudes and experiences with physician-assisted death: a review of the literature, in Physician-Assisted Death: Contemporary Issues in Biomedicine, Ethics, and Society. Edited by Humber JM, Almeder RF, Kasting GA. Totowa, NJ: Humana Press, 1993
26. The Task Force to Improve the Care of Terminally Ill Oregonians: The Oregon Death With Dignity Act: A Guidebook for Health Care Providers. Portland, OR: Center for Ethics in Health Care, Oregon Health Sciences University, 1998
27. Council on Ethical and Judicial Affairs of the American Medical Association: Decisions near the end of life. JAMA 267:2229–33, 1992
28. Council on Ethical and Judicial Affairs, American Medical Association: Physician-assisted suicide, in Ethics Newsletter (American Psychiatric Association Ethics Committee) 11(2):1–5, 1995
29. American Nurses' Association: Position Statement on Assisted Suicide. Washington, DC: ANA, 1994
30. American Geriatrics Society Ethics Committee: Physician-assisted suicide and voluntary active euthanasia. J Am Geriatr Soc 42:579–80, 1995
31. Barondess JA: Letter to William H. Rehnquist, Chief Justice of the U.S. Supreme Court, Dec 2, 1996
32. Handing H, Rutenfraus C, Zylicz Z: Physician assisted suicide and euthanasia in the Netherlands: lessons from the Dutch. JAMA 227: 1720–2, 1997
33. Dixon N: On the difference between physician-assisted suicide and active euthanasia. Hastings Center Report 28:25–9, 1998
34. Task Force on Physician-assisted Suicide of the Society for Health and Human Values: Physician-assisted suicide: toward a comprehensive understanding. Acad Med 70:583–90, 1995
35. Angell M: Euthanasia in the Netherlands—good news or bad? N Engl J Med 335: 1676–8, 1996
36. Onwuteaka-Philipsen BD, Muller MT, van der Wal G, van Eijk JTM, Ribbe MW: Attitudes of Dutch general practitioners and nursing home physicians to active voluntary euthanasia and physician assisted suicide. Arch Fam Med 4:951–5, 1995
37. Battin MP: Euthanasia: the way we do it, the way they do it. J Pain Symptom Manage 6: 298–305, 1991
38. van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN: Euthanasia and other medical decisions concerning the end of life. Lancet 338:669–74, 1991
39. van der Maas PJ, van der Wal G, Haverkate I, *et al*: Euthanasia, physician-assisted suicide, and other medical practices at the end of life in the Netherlands, 1990–1995. N Engl J Med 335:1699–1705, 1996
40. Pijnenborg L, van Delden JJM, Kardaun JWPF, Glerum JJ, van der Maas PJ: Nationwide study of decision concerning the end of life in general practice in the Netherlands. Br Med J 309:1209–12, 1994
41. Marshall B. Kapp, Old folks on the slippery slope: elderly patients and physician-assisted suicide. 35 Duquesne L Rev 35:443–53 (1996)
42. Kapp MB: Annotated bibliography on physician-assisted suicide. J Ethics Law Aging 3:45–50, 1997
43. Donovan GK: Physician-assisted suicide. JAMA 274:1911, 1995
44. Ganzini L, Lee MA: Psychiatry and assisted suicide in the United States. N Engl J Med 336:1824–6, 1997
45. Groenewond JH, van der Mass PJ, van der Wal G, *et al*: Physician assisted death in psychiatric practice in the Netherlands. N Engl J Med 336:1795–1801, 1997
46. Doukas DJ, Waterhouse D, Gorenflo DW, Seid J: Attitudes and behaviors on physician-assisted death: a study of Michigan oncologists. J Clin Oncol 13:1055–61, 1995
47. Quill TE: The ambiguity of clinical intentions. N Engl J Med 329:1039–40, 1993