

# One Psychiatrist's Perspective on Physician-Assisted Death

Stuart A. Anfang, MD

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In 1991, I was a first-year psychiatry resident in Massachusetts, beginning my interest in law and ethics in psychiatry. The news was full of reports about Dr. Jack Kevorkian, a Michigan pathologist who advocated physician-assisted suicide and euthanasia. Michigan revoked his medical license, but his activities continued. Other physicians took a less dramatic and extreme position, arguing for the role of physicians to support their terminally ill patients in actively taking control of their dying process. In 1991, Dr. Timothy Quill, a palliative care specialist in Rochester, NY, published a seminal article in *The New England Journal of Medicine*.<sup>1</sup> He described his assistance to “Diane,” a 45-year-old leukemia patient whom he provided with a lethal prescription of barbiturates that she self-administered. His actions stirred great debate and controversy, although no legal charges or indictments were brought against Quill.

In 1993, I helped organize a resident forum in Boston about physician-assisted suicide, inviting Dr. Quill to speak to a standing-room audience. In January 1994, during my consult-liaison psychiatry rotation at Massachusetts General Hospital, I did my resident seminar presentation on “Physician-Assisted Suicide: Psychiatric Perspectives.” The discussant, Dr. Ned Cassem, a national figure in consult-liaison psychiatry as well as a Jesuit priest, was gracious in his comments. But Dr. Cassem made crystal clear his position that psychiatrists should never have a role in assisting (or even assessing) patients seeking a physician’s help to end their own lives.

Dr. Quill became an advocate for physician-assisted suicide and a national figure in the “death with dignity” movement. After the state of New York enacted a prohibition against physician-assisted suicide, Dr. Quill and colleagues filed suit, challenging the law’s constitutionality on the basis of equal protection under the Fourteenth Amendment. Quill claimed that if patients have a right to refuse treatment when terminally ill, they have a right to authorize a doctor to assist in ending their lives. Ultimately, the case reached the U.S. Supreme Court in 1997. In *Vacco v. Quill*, a unanimous Court found the New York ban constitutional, concluding that states have a legitimate interest to choose to outlaw assisted suicide and establishing there was no federal constitutional “right to die.”<sup>2</sup>

That same year, Oregon became the first state in the country to legalize physician-assisted suicide, later renamed physician-assisted death (PAD); PAD does not include activities typically considered as current medical practice within standard palliative or hospice care, such as terminal sedation, do-not-resuscitate orders, or withdrawal of life support. The Oregon Death with Dignity Act (DWDA) allows terminally ill Oregon residents to obtain and use prescriptions from their physician for self-administered lethal medications.<sup>3</sup> The DWDA specifically prohibits euthanasia, where a physician or other person directly administers a medication to end another’s life. Amid loud objections inveighing against slippery slopes, Hippocratic oath violations, and potential abuses behind closed doors, Oregon doctors quietly began to get referrals for PAD, evaluate and manage these cases, and provide data to the state health authority.

More than 20 years later, Oregon maintains the largest and most comprehensive database regarding PAD in a U.S. state, publishing annual statistics.<sup>4</sup> As

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Dr. Anfang, MD is Vice Chair for Clinical Services, Department of Psychiatry, Baystate Health, Springfield, MA. Address correspondence to: Stuart A. Anfang, MD. E-mail: stuart.anfang@baystatehealth.org.

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of the January 2020 report, more than 2,500 people since 1997 have received prescriptions under the DWDA, and 1,657 people (66%) have died from ingesting the medications. Three quarters of patients had cancer, followed by neurological disease (11%, most commonly amyotrophic lateral sclerosis) and respiratory disease (6%). Patients most commonly cite end-of-life concerns about quality of life, loss of autonomy, and loss of dignity. Since 1997, 66 patients (4%) had been referred for psychiatric evaluation by their physician (with only one patient in 2019). Referral for psychiatric evaluation for questions of decisional capacity or underlying psychiatric illness is at the discretion of the treating physician. Oregon does not publish data regarding patients who were referred for psychiatric evaluation and found ineligible or who ultimately did not receive a prescription for lethal medication under DWDA. As the state with the longest experience with PAD, Oregon is the context for most of the published medical literature describing the experience of U.S. physicians, psychiatrists, and patients (e.g., work by psychiatrist Linda Ganzini, MD,<sup>5</sup> and epidemiologist Katrina Hedberg, MD, MPH<sup>6</sup>).

In 2008, Washington became the second state to legalize PAD, subsequently followed by Vermont (2013), California (2015), Colorado (2016), the District of Columbia (2017), Hawaii (2018), New Jersey (2019), and Maine (2019).<sup>7</sup> In 2009, a Montana Supreme Court ruling (*Baxter v. Montana*) legalized PAD in that state.<sup>8</sup> More than half of U.S. states have seen proposed legislation to legalize PAD, and several state supreme courts have considered the question of a constitutional right to PAD. In the United States, PAD statutes have all been restricted to patients with terminal illness, typically defined as an irreversible illness likely to lead to death within six months. Euthanasia is expressly prohibited. Internationally, countries such as The Netherlands, Belgium, Canada, and Luxembourg have extended PAD to non-terminally ill patients and also allow direct medical assistance in dying (i.e., euthanasia).

Seventy million Americans live in jurisdictions allowing PAD. It is thus important to consider the role of psychiatry in this process. I had the privilege of chairing a task force of the American Psychiatric Association (APA) Council on Psychiatry and Law to prepare an APA Resource Document on Physician-Assisted Death, approved in 2017.<sup>9</sup> As stated in the document, the goal was “to provide background and

relevant information to APA members regarding PAD. As policy makers consider proposed PAD laws, APA members, state associations, and district branches will likely play an important role in the legislative process . . . . This resource document should not be interpreted as stating an official APA position on PAD” (Ref. 9, p 2). In 2016, the APA adopted a position statement on medical euthanasia stating that a psychiatrist “should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death” (Ref. 10, p 1). The APA does not currently have an official position on PAD, although APA members are bound by the American Medical Association (AMA) Principles of Medical Ethics.

The AMA has long held that PAD is “fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks” (Ref. 11, p 1). This position was re-affirmed in June 2019 by the AMA House of Delegates (in a 360–190 vote) after an updated report from its Council on Ethical and Judicial Affairs.<sup>12</sup> Several state and local medical societies have taken a neutral stance on PAD, and several national organizations (e.g., American Public Health Association, American Medical Women’s Association, and American Medical Students Association) support PAD.<sup>7</sup>

I disagree with the AMA’s position. After nearly 25 years of PAD in the United States, now in multiple jurisdictions, the data do not support a conclusion that it would be difficult or impossible to control. Some opponents may question the accuracy or completeness of data collected in a particular state, but the consistency of data across multiple years and several jurisdictions do not substantiate that this is impossible to control. Oregon is not the only state reporting data. In California (with a population close to 40 million), lethal prescriptions had been written for fewer than 2,000 people between June 2016 and December 2019, with two thirds actually dying from ingesting the medication.<sup>13</sup> Of the deaths, more than 85 percent were already receiving hospice or palliative care. There are no clear data substantiating widespread abuse or misuse.

The slippery slope argument, often pointing to euthanasia of non-terminally ill patients in Europe, has not been borne out after more than 20 years of PAD in the United States. For a variety of cultural, social, historical, and political reasons, I personally doubt that the United States would ever reach the more

liberal positions of Belgium and The Netherlands. It is hard to locate the proof of the “serious societal risks” the AMA warns against. In an era of fundamental health care challenges in the United States (e.g., unequal access, poor preventive care, and middling mortality outcomes despite enormous expenditures, not to mention the current COVID pandemic), the involvement of doctors in fewer than 10,000 reported PAD deaths over 22 years does not rank high on the scale of serious societal risk.

There are also the ethics arguments that physicians should “first do no harm.” I will defer to others for a detailed parsing of the ethics and philosophical arguments for physician involvement in assisted death. I think comparison can be made to physician involvement in other life-changing situations with complex ethics. Personally, I have no objection to a woman’s right to choose to terminate an unwanted pregnancy, and no objection to a physician’s active participation (indeed, we want to avoid the pre-1973 world of dangerous and sometimes fatal clandestine abortions). I would, however, respect an individual physician’s personal religious or ethics conviction not to participate, presuming that the patient can be referred to another physician who can provide the necessary medical service. Saying that it is ethical to participate directly in an abortion does not mean it is unethical to not participate directly. Some would argue that it is unethical for a forensic psychiatrist to participate in a competency evaluation (or treatment for competency restoration) that may ultimately lead to capital punishment, but that is not the position of the American Academy of Psychiatry and the Law or the APA. To find it ethically acceptable for a psychiatrist to be involved in PAD as currently authorized in the United States (most likely as an evaluator for decisional capacity and potential confounding psychiatric illness) does not make it unethical for a different psychiatrist to refuse involvement. Indeed, when studies show that PAD referrals for psychiatric consultation are relatively few (i.e., 4–5% by most estimates), there may well be more concern that cases of treatable depression or decisional incapacity are being missed.<sup>9</sup>

Seventy million Americans live in states allowing PAD. More states will surely follow. Psychiatrists do more harm by not sharing their wisdom and expertise. We are the experts at assessing decisional capacity,

evaluating depression and other psychiatric illness, and skillful interviewing, assuring that terminally ill patients are seeking PAD because they desire a more humane death and not because they fear burdening family or cannot access appropriate end-of-life care. PAD is here to stay. It’s time for psychiatry to be there for these patients. One day, we may be these patients.

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