

Physician-assisted suicide and euthanasia – who are the vulnerable?

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The most widely voiced concern about physician-assisted suicide (PAS) and euthanasia is the risk that they pose to the wider community and the vulnerable, if legalised. No matter how well intentioned are the creators of the initial safeguards of PAS or euthanasia, there seems to be no sustainable way to maintain restrictions on them. It is pertinent, then, to examine the ways in which the legalisation of PAS or euthanasia, in their ever-broadening scope, might increase vulnerability to suicide and decrease the safety of members of a community.

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A lonely, elderly patient of mine was in severe pain and losing independence from a herniated lumbar disk. Afraid of surgery, she said to me quite earnestly: 'Can't you rather just give me a strong injection of morphine? I'm past my sell-by date.' I replied that I would prefer her to be around a bit longer, pain free, and to enjoy the rest of her life with the best quality possible for her. She gave my hand a squeeze, and did well after surgery. It is important to explore how the legalisation of physician-assisted suicide (PAS) or euthanasia could impact such a patient.

The meaning of vulnerability

Battin *et al.*^[1] investigated the possibility of abuse of people in 'vulnerable groups', such as the elderly, women, the uninsured, people with low educational status, the poor, the physically disabled and others. The intention was to determine whether people in these categories had a heightened risk of PAS compared with background populations. The authors concluded: 'Where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.'

This type of study does not ask the pertinent questions regarding vulnerability to PAS or euthanasia. It is important to determine to what extent *all* people to whom PAS is presented as an option are rendered more vulnerable and unsafe – not dependent upon their previous or current disadvantaged social or socioeconomic sub-grouping. It can be expected that individuals who have the most to lose would feel these pressures more intensely.

Chochinov^[2] has developed a model of dignity-conserving care and dignity psychotherapy that aims to conserve the dignity of dying patients. He has noted: 'Many patients, over the course of their cancer illness, experience occasional and fleeting thoughts that not awakening to another day might offer the kind of escape and comfort they perceive life can no longer provide. People tire of pain,

disability, changing roles, mounting losses and fewer prospects for remediation [...] thoughts can become overwhelming. Conversely, in response to appropriate palliation and the rallying of a community, of support, thoughts about the wish to die can dramatically recede.' According to physicians, loss of a sense of dignity is the most highly cited reason why patients request and receive assistance hastening their death.^[2]

Chochinov^[2] examined 213 terminal cancer patients with a life expectancy of <6 months. They were asked to rate their sense of dignity. For 7.5% (16 patients), loss of dignity was a significant concern. These patients also 'were far more likely to have significantly increased pain, decreased quality of life, difficulty with bowel functioning, heightened dependency needs (bathing, dressing, incontinence), loss of will to live, increased desire for death, depression, hopelessness and anxiety. The issue of appearance seemed to highly correlate with perceptions of personal dignity. For those near the end of life, the notion of appearance extended beyond mere looks, and included their own perception of how they were seen by others.'^[2,3]

Thus poorly controlled symptoms led to requests for hastened death. In this sense, a wish to die should not be seen as an expression of autonomy but an expression of a lack of autonomy.

This last point in Chochinov's findings on the perceptions of personal dignity is highly significant:^[2,3] those of us working in palliative care know all too well the sense that people develop, as they become more frail and dependent on others, that they are becoming a burden on their friends and family. Chochinov's work provides the insight that in this setting, an expression of a wish to die is often more a question than a statement. 'Am I of any worth?' 'Am I in the way?' Patients are looking for the picture of themselves in the eyes of their beholders. If the answer is returned that they should be helped to die, it is an affirmation of what they suspected – that others now see them as worthless.

Thus vulnerability to suicide increases in all types of individuals where the opportunity for PAS or euthanasia is opened, especially in settings that lead to a loss of sense of dignity.

Increase in the range of suicide

It was previously thought that PAS might reduce the non-assisted or overall suicide rate. In testing this, Jones *et al.*^[4] found in the USA that after the legalisation of PAS, there was an increase in suicides in states where PAS was legalised relative to other states. PAS was associated with a 6.3% increase in total suicides (including assisted suicides). There was no decrease in non-assisted suicides.^[4]

Legalising PAS could lead to honouring the idea of suicide, and a change in the way a community values human life.

A related concern is that once legalised, the initial restrictions related to PAS and euthanasia inevitably fall away, thereby exposing more categories of people to pressure toward PAS or euthanasia.

To describe the 'slippery slope' argument by making it seem as if those who are concerned about a 'slippery slope' are concerned that the procedure might lead to involuntary or unlawful euthanasia against patients' wills, without their consent or with coercion, is merely to create a misleading perception or caricature. The real pertinent observed concern is that, once legalised, there is no sustainable way to maintain restrictions on PAS or euthanasia.

One of many examples where this can be observed is in the Netherlands, where euthanasia was legalised in 2002, and increased from 1.7% of deaths in 2005 to 4.5% in 2015.^[5] It has become acceptable to euthanase people for psychiatric illness, including dementia. In September 2019, a doctor was acquitted of any wrongdoing after she got family members to hold down a patient living with dementia, as the doctor actively euthanased her against her will while she struggled to get free. She had changed her mind since her previous request years before, but this did not count to protect her.^[6]

Van Loenen^[7] has documented the changes in Dutch culture that have coincided with the legalising of euthanasia in the Netherlands. This change was encapsulated in the shift from an understanding of dignity as something inherent or intrinsic, to something that is merely felt or perceived.^[7]

If autonomy is the overriding principle and subjective suffering the reason, there is no argument that can justify restricting euthanasia only to certain categories of people. A challenge to the legal framework may lead the judicial authorities to conclude that it is unjust to allow suffering for some classes of people and not for others – and the gate opens wider.

Any legal framework that restricts euthanasia to a limited category of people places the state in a position where it must define those categories of people as being of less worth, as the state has to decide which types of people may have their 'autonomous' request for death accepted and which may not. Elliot has stated:

'The physical criterion in any form violates the equality of respect and moral status of a large class of people [...] insinuating that

their lives – but crucially, not other people's – are "objectively" the sort of thing they might reasonably want to dispose of; and 'it would be reckless to behave as though the physical criterion did not inflict a degrading evaluative judgement on those to whom it is applicable. By taking one group of human beings to be disposable in a way no one else is, assisted suicide violates the equal moral status and respect which they are owed.'^[8]

Conclusion

Vulnerability to suicide increases in all categories of individuals to whom the opportunities for PAS and euthanasia are opened, especially in settings that lead to a loss of sense of dignity. Frameworks attempting to regulate the 'safe' legalisation of PAS or euthanasia have proven to be unsustainable, and intrinsically 'inflict a degrading evaluative judgement'^[8] on those to whom they are applicable.

No country that has legalised euthanasia thus far has set in place any effective measure to determine how not to euthanase people who feel as if they are a burden on others. In the end (so to speak), we are all vulnerable.

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