1-1-2019

A Report Of Us Physicians' Beliefs About Physician-Assisted Suicide And A Bioethical Analysis Of The Practice

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A Thesis Submitted to the
Yale University School of Medicine
in Partial Fulfillment of the Requirements
for the Dual Degree of
Doctor of Medicine and Masters of Health Sciences

by

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2019

Abstract

A REPORT OF US PHYSICIANS' BELIEFS ABOUT PHYSICIAN-ASSISTED SUICIDE AND A BIOETHICAL ANALYSIS OF THE PRACTICE.

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The goals of this work were two fold. The first was to assess the beliefs of US physicians about the national legalization of physician-assisted suicide (PAS). The second was to determine the moral permissibility of PAS through a bioethical analysis. For the former, we sent a survey to 1000 randomly chosen physicians from around the US. For the last, we analyzed the permissibility of PAS by examining four common bioethical considerations—role morality, the "slippery slope", doing vs. allowing, and intending vs. foreseeing.

Our survey indicates that 60% of physicians thought PAS should be legal, and of that 60%, 13% answered "yes" when asked if they would perform the practice if it were legal. Next, 49% of physicians agreed that most patients who seek PAS do so because of pain, and 58% agreed that the current safeguards in place for PAS, in general, are adequate to protect patients. With respect to specific safeguards, 60 % disagreed with the statement that physicians who are not psychiatrists are adequately trained to screen for depression in patients seeking PAS, and 60% disagreed with the idea that physicians can predict with certainty whether a patient seeking PAS has 6 months or less to live. Finally, about one-third (30%) of physicians thought that the legalization of PAS would lead to the legalization of euthanasia, and 46% agreed that insurance companies would

preferentially cover PAS over possible life-saving treatments if PAS was legalized nationally. Finally, by examining the bioethical arguments mentioned with respect to PAS, we determined that the practice is not morally permissible

Our survey results suggest several important conclusions about physicians' beliefs of PAS. The first is that there is a discrepancy between belief and practice of PAS. Second, physicians are generally misinformed as to why patients seek PAS, and they are uncertain about the adequacy of safeguards. Third, physicians are still wary of the slippery slope with respect to PAS legalization nationwide. Furthermore, through our bioethical analysis, we show that PAS is morally impermissible.

Acknowledgments

I would like to thank the Office of Student Research and the Department of Bioethics at the Yale School of Medicine for funding this project.

I would like to thank James Nie and Amanda Zhou for their help with all components of the research including survey design, data collection, data analysis, and manuscript editing.

I would like to thank my roommates—Tyler Greenway, Rahil Rojiani, Will Hancock-Cerutti, and Keith Loh—and my family for their undying support during my career at the Yale School of Medicine. This project would not have happened without them.

I would like to thank my thesis committee members, Drs. Mark Mercurio and Julie Rosenbaum for their help, feedback, and support of my thesis.

Finally, and most certainly not least, I would like to thank my thesis advisor, Dr. Lydia Dugdale. She became my very first mentor in medical school during my first year, and since then she has helped and mentored me through my entire career at Yale. Without her support, constructive feedback, and genuine interest in me and my ideas, this thesis would not have been possible. Thank you again Dr. Dugdale.

Table of Contents

Opening Remarks

Physician-assisted suicide (PAS), also known as physician aid-in-dying (AID), is one of the most contentious ethical issues facing medicine today. American Medical Association (AMA) states that, "Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."(1) This practice was first legalized by Oregon through the Death with Dignity Act in 1997.(2) Since then, six other jurisdictions have legalized the practice, and Montana has decriminalized it(3). As a comparison, internationally, physician-assisted suicide *and* euthanasia are legal in Canada, Netherlands, Belgium, Colombia, and Luxemburg.(4) A recent Gallup poll indicates that 67% of the American public support legalization of PAS.(5) Support for the practice among physicians has also risen from 46 % in 2010 and 54 % in 2014 to 57 % in 2016.(6)

Physician-assisted suicide is defined as a physician prescribing a lethal dose of drugs that patients then administer themselves with the intention of ending their lives. This practice is distinct from euthanasia, in which a physician directly administers a drug or drugs with the intention of ending the patient's life. The major distinction between the two is who administers the lethal dose of medication. In the former, the patient administers it. In the latter, the physician is the agent who administers the lethal dose. Although this may seem like a rather small distinction, it makes all the difference. The *patient* is the agent who causes her own death in the first case, while the *physician* is the agent who causes the death of the patient in the latter case.

In the US, there are certain conditions or safeguards that must be met for a patient to successfully obtain a prescription for a lethal dose of barbiturates, which are the drugs

of choice for PAS. Although each state has slightly different conditions, they all closely follow Oregon's Death with Dignity Act, as it was the first state to legalize assisted suicide.

For brevity and clarity, I will explain Oregon's program. First, the patient must be at least 18 years old, a resident of Oregon, and capable of making medical decisions (meaning the patient must be competent). The next condition is that the patient must be diagnosed with a terminal illness that will end her life in 6 months or less. Then, a patient must make two oral requests to her physician that are separated by at least fifteen days. Following this, a patent must provide a written request to her physician that is signed in the presence of two witnesses. The original physician and a consulting physician must then confirm the prognosis and diagnosis of the patient. At this time, they must also assess the patient for competency. If, during this examination, they determine that the patient may be depressed or suffering from any mental illness, they must refer the patient to a psychiatrist for a formal psychological assessment. Once all of these steps have been completed (as necessary), the original physician must inform the patient of alternatives to PAS, such as hospice, comfort care, and pain control, and request (but not require) the patient to inform next-of-kin about her decision to partake in PAS. The physician may then provide the patient a written prescription for a lethal dose of barbiturates that the patient may then ingest at whatever time she thinks is appropriate.(7)

As this practice increasingly becomes an option for patients and their physicians to consider, it is important to understand what the attitudes and perspectives of practicing US physicians are concerning PAS and discuss the moral permissibility of the practice. In Part I of this thesis I will report the findings of a national study looking at perspectives of

US physicians with respect to PAS. In Part II, I will first discuss the moral permissibility of PAS by analyzing four bioethical arguments.

Part I: A Report of Physicians' Beliefs about and Practices of PAS

Introduction

A recent review of attitudes and practices of PAS in the US, Canada, and Europe concluded that PAS is increasingly becoming legalized, is performed relatively rarely, and is primarily utilized by patients with cancer.(8) A national survey study in 2008 about physicians' attitudes toward PAS also revealed that highly religious physicians are more likely to oppose PAS than those with low religiosity.(9) These data are consistent with previous findings of national surveys of physicians and osteopathic physicians that found that religion was associated with objections to PAS.(10,11) The 2008 study also found that being of Asian ethnicity, of Hindu religious affiliation, and having more experience with end-of-life care were also associated with objecting to the practice of PAS.(9)

Although those are the only national survey studies looking at physician attitudes toward PAS, there have been several institutional and regional studies examining views of physicians, which have shown that physicians' views toward PAS are affected by religion, religiosity, ethnicity, medical specialty, and age. Cohen et al. showed that in Washington State in 1994, oncologists and hematologists were least likely to support PAS, while psychiatrists were most likely.(12) A 1995 study of Michigan oncologists revealed five factors that were important to physicians when considering the approval or disapproval of PAS: global attitudes toward PAS (including ideas like "Does a patient have a right to end his or her life if he or she has an incurable disease," and "Oncologists should have the right to help a patient commit suicide by medical means"), attitudes

toward the acceptability of withholding/withdrawing life-sustaining therapies, philosophical prohibitions toward PAS, concerns of legal consequences of PAS, and beliefs that PAS could be avoided with better end-of-life care.(13) A study of Oregon emergency medicine physicians in 1996 showed that support of legalization of PAS was not influenced by gender, age, or practice location. It did show, however, those without religious affiliations were more likely to support PAS legalization, and Catholic respondents were least likely to support it.(14)

A survey of Connecticut physicians in 2000 showed that views on PAS were strongly associated with religious affiliation, religiosity, ethnicity, and medical specialty.(15) A survey given to Tennessee physicians in 2003 found that factors that influenced beliefs about PAS were ethics, religion, and the role of the physician to relieve pain and suffering.(16) Connecticut internists' attitudes toward PAS in 2004 were significantly influenced by frequency of attendance of religious services and experience providing primary care to terminally ill patients.(17) Another study in Connecticut in 2004 showed that medical house officers from three different internal medicine residency programs were possibly influenced by religious commitments and pressures of training when thinking about the acceptability of performing PAS.(18)

Most recently, a study at a large academic institution found that 63% percent of physicians thought PAS should be legal, but only 22% of that percentage would be willing to participate in the practice.(19) This trend was also observed in Tennessee physicians in 2003—of the physicians who supported PAS, only 25% indicated that they would perform it.(16) This is an important finding that requires further study to be understood more thoroughly. If the practice of PAS is to be continually expanded to more

states without understanding why physicians are generally supportive of PAS but opposed to actually preforming it, it could lead to numerous problems including feelings of dissatisfaction with or mistrust of the profession of medicine by both physicians and patients, poor outcomes surrounding PAS, and a lack of appropriate and effective end-of-life care.

Thus, the aims of this study were threefold. The first was to investigate whether the discrepancy between attitudes about legalization versus willingness to practice PAS holds true nationally. Our hypothesis is that it does. Next, we assessed why this discrepancy between belief and willingness to practice exists. Finally, we aimed to update and expand the understanding of physicians' attitudes toward PAS since the last national study was in 2008. We have included questions regarding the beliefs of physicians on possible economic and social ramifications of PAS legalization and the efficacy of safeguards in place, which to our knowledge have not been previously studied by a national survey.

Methods

Approval

This study was reviewed and approved by the Yale University's Institutional Review Board.

Survey Design

We used an amended version of methods previously described to design our survey.(20) First, we tested eleven questions (see appendix 1) about PAS on fifteen Yale-New Haven Hospital physicians. Each physician received a US$10 gift card for

participating. This first testing step helped us choose appropriate wording and content of questions. Using this data, we then developed our first 37-question survey. To eliminate as much bias as possible, we attempted to ask an equal number of positively and negatively worded questions regarding PAS. This survey was then administered to ten Yale-New Haven physicians (different from the previous 15) in person. The physicians were asked to take the survey and provide feedback in real-time about the relevance, wording, clarity, and effectiveness of each question. Each physician received a US$20 dollar gift card for participation. Following the feedback given to us during the pretest, we designed our final survey. As a final check for survey validity, we sent the finalized survey to three individuals with experience in survey design before administering it.

Survey Content

The final survey can be found in the appendix (appendix 2). We first defined the terms "physician-assisted suicide (PAS)," "physician aid-in-dying (AID)," and euthanasia in a preamble to eliminate possible confusion in terminology. The survey contained six sections. The first was "Legality of PAS/AID" and included the questions "Should PAS/AID be legal in your state?" and "Should PAS/AID be decriminalized in your state?" which could be answered yes or no. The third question asked, "If legal or decriminalized, would you participate in PAS/AID?" which could be answered with yes, possibly, unlikely, or never.

The second section was "Current Practices of PAS/AID", which asked participants to what extent they agreed on a five point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree) with statements about reasons for patients seeking PAS/AID and safety and efficacy of current safeguards in states where the practice is legal. This

section of the survey was designed to assess the knowledge and beliefs of physicians about current practices of PAS/AID. The statements were the following:

- Most patients who seek PAS/AID do so because of physical pain.
- Current PAS/AID laws provide safeguards (patient must be competent, ≥ 18 yo, prognosis ≤ 6 mo, capable of self-administration of medication, request observed by 2 witnesses).
    - These safeguards are adequate to protect patients seeking PAS/AID.
- Current PAS/AID laws require physicians who suspect depression or other mental illness in a patient seeking PAS/AID to consult a psychiatrist.
    - Physicians who are not psychiatrists are sufficiently trained to screen for depression in patients who are seeking PAS/AID.
- Most physicians can predict with certainty whether a patient seeking PAS/AID has 6 months or less to live.

Section three, entitled "Implications of PAS/AID", included statements concerning the social, professional, and economic implications of the national legalization of PAS/AID. Participants were asked to indicate to what extent they agreed with the statements on the same Likert scale. This section was designed to ask physicians questions that they might not normally think about when considering the legalization of PAS. The statements were the following:

- PAS/AID would improve the clinical care of patients at the end-of-life.
- Patients would view the medical profession more negatively.
- Patients would trust their physicians more.
- Racial and ethnic minorities would feel pressure to end their lives.
- Patients with lower socioeconomic status would feel pressure to end their lives.
- Patients with mental or physical disabilities would feel pressure to end their lives.
- PAS/AID would save money for the health care system.
- Health insurance companies would cover PAS/AID over more expensive, possibly life-saving treatments, like chemotherapy.
- PAS/AID would lead to an increased number of medical malpractice suits.
- PAS/AID would lead to an increase in suicides in the community.
- PAS/AID would lead to the legalization of euthanasia.

The next section, "Other Considerations Regarding PAS/AID," included ethical and moral statements about PAS/AID that could be answered using the same Likert scale. The statements were the following:

- Sometimes providing PAS/AID is necessary in order to relieve suffering.
- Sometimes providing PAS/AID is necessary in order to respect patient autonomy.
- There are important ethical distinctions between PAS/AID and withdrawing life-support.
- PAS/AID would be unnecessary if all patients had access to excellent palliative care.
- The medical profession should endorse PAS/AID as a morally valid medical option.
- Physicians who participate in PAS/AID thereby abandon their patients.
- A patient's request for PAS/AID should override the physician's moral objections to performing it.

The fifth section, "Physician Perspectives on Death," contained statements about physicians' own mortality that could be answered using the same Likert scale. The statements were the following:

- I am comfortable talking with patients about death
- My ability to think about my own mortality is relevant to providing good care for patients at the end of life.
- Medical professionals should never intentionally hasten a patient's death at the end of life.

This section also contained a question asking " How often are you faced with end-of-life issues in your daily practice?" that could be answered by selecting one of the following choices: several times a week, every week, nearly every week, two to three times a month, about once a month, several times a year, about once or twice a year, less than once a year, or never. A final question asking, "If you think PAS/AID should be legal or decriminalized but would be unwilling or unlikely to perform it yourself, please explain why," was included in the section and could be answered in a free response manner.

The final section included demographic questions including age, preferred gender identity (answered as free response), ethnicity, race, Veterans Affairs association, percentage of practice involving patients who are underinsured or on Medicaid, and medical specialty.

Survey Administration

We followed validated administration methods already described in the literature.(9,21,22) We chose a random sample of 1000 practicing physicians (age 25-79) from the American Medical Association Physician Masterfile, a database intended to include all physicians in the United States. Five-hundred physicians were chosen at random from all specialties, excluding pathology and radiology, and 500 were chosen from specialties more likely to involve end-of-life care (geriatrics, pediatric critical care, pulmonary and critical care, oncology, physical medicine and rehabilitation, and hospice and palliative medicine). We used the services of the Yale Printing and Publishing for all mailings. Each physician was assigned a number (1-1000), which was included on each survey to maintain confidentiality while recording responses. In order to bolster response rate, we mailed the questionnaire out three times (February 2018, April 2018, June 2018). The final mailing included a note and a US$2 incentive to help bolster response rate.

Data Analysis

Data from hard copy surveys were input into excel files by two different researchers to reduce input error. Answers using the Likert Scale were condensed into “agree” (agree, strongly agree), “neural”, and “disagree” (disagree, strongly disagree). Answers to how often physicians provided end-of-life care were condensed into “often” (several times a week, every week, nearly every week), “sometimes” (two to three times

a month, about once a month, several times a year), and "rarely" (about once or twice a year, less than once a year, never). Age categories ((25-34, 35-44, 45-54, 55-64, 65-75, 75+) were condensed into ≤54 and ≥55 years. Categories for percentages of patients who were underinsured or on Medicaid (0-14, 15-29, 30-44, 45-59, 60-74, 75-89, 90-100) were condensed into <30, 30-74, ≥75%. Regions where physicians practice were determined by the following: Northeast (ME, MA, RI, CT, NH, VT, NY, PA, NJ, DE, MD), Southeast (WV, VA, KY, TN, NC, SC, GA, AL, MS, AR, LA, FL), Midwest (OH, IN, MI, IL, MO, WI, MN, IA, KS, NE, SD, ND), Southwest (TX, OK, NM, AZ), and West (CO, WY, MT, ID, WA, OR, UT, NV, CA, AK, HI). All numerical data are reported as percentages. Answers to the free response questions were coded to identify common themes. In an attempt to account for our sampling method and make our results more generalizable to the general population of US physicians, case weights were assigned to percentages.(23) The case weights were determined by comparing the ratio of specialties in our sample to that of the entire population of US physicians. Italicized percentages reported in the "Results" and "Discussion" sections indicate that they are case weighted.

Results

Survey Response Rate

Of the 1000 physicians who were mailed the survey, 61 came back as undeliverable by the postal service. Those individuals were considered ineligible. At the closure of data collection, we used a method described by Curlin et al. to determine the approximate number of ineligible non-respondents.(21) Thirty respondents and 30 non-

respondents were chosen in alphabetical order. The phone numbers for each were found via a yellow pages Internet search. They were called and asked if they had received the survey. Those who could be reached and did receive the survey were considered eligible. Those who could not be reached or did not receive the survey were deemed ineligible. A calculation was then used to determine approximately how many of the non-respondents were ineligible. We were able to locate 29 out of the 30 (0.97) responders and 26 out of the 30 (0.87) non-responders. We then estimated that 90% (1-[0.97-0.87]) of those who did not respond (751) were eligible. Our estimated response rate of eligible physicians is therefore 22% (188/[188 + 0.90*751]).

Demographics

Demographic information of the respondents is listed in Table 1. Eighty-three (44%) were 54-years-old or under, and 91 (48%) were 55-years-old or older. Sixty (32%) identified themselves as female, 99 (53%) as male, and 29 (15%) did not wish to specify. With respect to ethnicity, 7 (4%) were Hispanic or Latino, and 164 (87%) were not. With respect to race, 1 (1%) was Asian, 8 (4%) were East Asian/Pacific Islander, 6 (3%) were South Asian, 2 (1%) were Other Asian, 8 (4%) were Black/African American, 1 (1%) was American Indian/Alaskan Native, 133 (70%) were White/Caucasian, 7 (4%) were other, and 6 (3%) did not wish to specify. With respect to specialty, 28 (15%) were Internal Medicine, 30 (16%) were Family Medicine/Practice, 24 (13%) were Surgery, 12 (6%) were Psychiatry, 11 (6%) were Obstetrics/Gynecology, 3 (2%) were Neurology, 20 (11%) were Emergency Medicine, 8 (4%) were Anesthesia, 30 (16%) were Pediatrics, and 8 (4) were other. Three (2%) practiced at a Veteran Affairs facility, and 171 (91%) did not. With respect to the percentage of patients in physicians' practices that were on

Medicaid or underinsured, 92 (49%) had less than 30%, 62 (33%) had 30 to 74%, and 13 (7%) had greater than or equal to 75%. Forty (22%) practiced in the Northeast, 52 (28%) in the Southeast, 46 (24%) in the Midwest, 15 (8%) in the Southwest, and 34 (18%) in the West. With respect to how often physicians provided end-of-life care in their practices, 33 (18%) often did, 78 (41%) sometimes did, and 73 (39%) rarely did.

Table 1. Characteristics of the 188 physicians who responded to the survey.

Age	**n (%)[A]**
≤54	83 (44)
≥55	91 (48)
Gender Identity	
Female	60 (32)
Male	99 (53)
Do not wish to specify	29 (15)
Hispanic or Latino	
Yes	7 (4)
No	164 (87)
Race	
Asian	1 (1)
East Asian/Pacific Islander	8 (4)
South Asian	6 (3)
Other Asian	2 (1)
Black/African American	8 (4)
American Indian/Alaskan Native	1 (1)
White/Caucasian	133 (70)
Other	7 (4)
Do not wish to specify	6 (3)
Specialty	
Internal Medicine	28 (15)
Family Medicine/Practice	30 (16)
Surgery	24 (13)
Psychiatry	12 (6)
Obstetrics/Gynecology	11 (6)
Neurology	3 (2)
Emergency Medicine	20 (11)
Anesthesia	8 (4)
Pediatrics	30 (16)
Other	8 (4)
Practice at Veteran Affairs facility	
Yes	3 (2)
No	171 (91)
Percentage of patients in practice that are on Medicaid or underinsured	
< 30	92 (49)
30-74	62 (33)
≥75	13 (7)
Region of practice	
Northeast	40 (21)
Southeast	52 (28)
Midwest	46 (24)
Southwest	15 (8)
West	34 (18)
How often physicians provide end-of-life care[B]	
Often	33 (18)
Sometimes	78 (41)
Rarely	73 (39)

[A]Percentages do not add up to 100 due to incomplete survey data.
[B]Data condensed from 9 to 3 categories.

Legality of PAS

Table 2 shows the number of physicians who thought PAS should be legalized or decriminalized. One-hundred and seven (57, *60*%) physicians thought PAS should be legal [78 (41, *38* %) illegal], and 125 (66, *69*%) thought it should be decriminalized [60 (32, *30*%) not decriminalized] in their respective states (Table 2).

Table 2. The number of physicians who thought PAS should be legalized or decriminalized. "PAS" is an abbreviation for physician-assisted suicide. Italicized percentages are case weighted.

	Yes n (%,%)[A]	**No n (%,%)[A]**
Should PAS be legalized in your state?	107 (57,*60*)	78 (41,*38*)
Should PAS be decriminalized in your state?	125 (66,*69*)	60 (32,*30*)

[A]Percentages do not add up to 100 due to incomplete survey data.

Table 3 shows the number of respondents who answered "yes", "possibly", "unlikely", or "never" when asked if they would perform PAS is it were legal in their state. Fifteen (8, *9*%) indicated "yes", 42 (22, *25*%) replied "possibly", 62 (33, *32*%) were "unlikely" to, and 67 (36, *33*%) would "never" (Table 3).

Table 3. The number of physicians who answered "yes", "possibly", "unlikely", or "never" when asked if they would perform PAS if it were legal in their state. "PAS" is an abbreviation for physician-assisted suicide. Italicized percentages are case-weighted

	Yes n (%,%)[A]	**Possibly n (%,%)[A]**	**Unlikely n (%,%)[A]**	**Never n (%,%)[A]**
Would you perform PAS if it were legal in your state?	15 (8,*9*)	42 (22,*25*)	62 (33,*32*)	67 (36,*33*)

[A]Percentages do not add up to 100 due to incomplete survey data.

Current Practices of PAS

Table 4 shows the number of participants who agreed, disagreed, or were neutral when asked questions about the current practices of PAS in states where it is legal. When asked, "Most patients who seek PAS/AID do so because of physical pain," 81 (43, *49*%) physicians agreed, 40 (21, *24*%) disagreed, and 63 (34, *26*%) were neutral (Table 4). When asked, "Current PAS/AID laws provide adequate safeguards, " 99 (53, *58*%) agreed, 54 (29, *29*%) disagreed, and 30 (16, *13*%) were neutral (Table 4). When asked, "Physicians who are not psychiatrists are sufficiently trained to screen for depression in patients who are seeking PAS/AID," 40 (21, *23*%) agreed, 104 (55, *60*%) disagreed, and 39 (21, *16*%) were neutral (Table 4). When asked, "Most physicians can predict with certainty whether a patient seeking PAS/AID has 6 months or less to live," 31 (16, *18*%) agreed, 114 (61, *60*%) disagreed, and 38 (20, *22*%) were neutral (Table 4).

Table 4. Physicians' responses to questions about the current practices of PAS in states where it is legal. "PAS" is an abbreviation for physician-assisted suicide. "AID" is an abbreviation for aid-in-dying. Italicized percentages are case weighted.

	Agree n (%,%)[A]	**Neutral n (%,%)[A]**	**Disagree n (%,%)[A]**
Most patients who seek PAS do so because of physical pain.	81 (43,*49*)	63 (34,*26*)	40 (21,*24*)
Current PAS laws provide adequate safeguards.	99 (53,*58*)	30 (16,*13*)	54 (29,*29*)
Physicians who are not psychiatrists are sufficiently trained to screen for depression in patients who are seeking PAS.	40 (21,*23*)	39 (21,*16*)	104 (55,*60*)
Most physicians can predict with certainty whether a patient seeking PAS/AID has 6 months or less to live.	31 (16,*18*)	38 (20,*22*)	114 (61,*60*)

[A]Percentages do not add up to 100 due to incomplete survey data.

Implications of PAS Legalization

Table 5 shows the number of participants who agreed, disagreed, or were neutral when asked questions about several professional, social, economic, and legal considerations if PAS were to become legalized nationally. When asked, "PAS/AID would improve the clinical care of patients at the end-of-life," 96 (51, *52%*) agreed, 60 (32, *33%*) disagreed, and 27 (14, *14%*) were neutral (Table 5). When asked, "Patients would view the medical profession more negatively, " 46 (24, *26%*) agreed, 82 (43, *43%*) disagreed, and 55 (29, *32%*) were neutral (Table 5). When asked, "Patients would trust their physicians more, " 43 (23, *24%*) agreed, 64 (34, *35%*) disagreed, and 75 (40, *40%*) were neutral (Table 5).

When asked, "Racial and ethnic minorities would feel pressure to end their lives," 20 (11, *9*%) physicians agreed, 121 (64, *69*%) disagreed, and 43 (23, *23*%) were neutral (Table 5). When asked, "Patients with lower socioeconomic status would feel pressure to end their lives, " 32 (17, *15*%) physicians agreed, 106 (56, *58*%) disagreed, and 46 (24, *25*%) were neutral (Table 5). When asked, "Patients with mental or physical disabilities would feel pressure to end their lives," 50 (27, *24*%) physicians agreed, 89 (47, *49*%) disagreed, and 45 (24, *26*%) were neutral (Table 5).

When asked, "PAS/AID would save money for the health care system," 107 (57, *62*%) physicians agreed, 29 (15, *18*%) disagreed, and 48 (26, *19*%) were neutral (Table 5). When asked, "Health insurance companies would cover PAS/AID over more expensive, possibly life-saving treatments, like chemotherapy," 93 (49, *46*%) physicians agreed, 35 (19, *20*%) disagreed, and 55 (29, *34*%) were neutral (Table 5).

When asked, “PAS/AID would lead to an increased number of medical malpractice suits,” 55 (29, *28%*) agreed, 72 (38, *43%*) disagreed, and 56 (30, *28%*) were neutral (Table 5). When asked, “PAS/AID would lead to an increase in suicides in the community,” 68 (36, *32%*) agreed, 87 (46, *51%*) disagreed, 28 (15, *17%*) were neutral (Table 5). When asked, “PAS/AID would lead to the legalization of euthanasia,” 61 (32, *30*%) physicians agreed, 71 (38, *43*%) disagreed, and 52 (28, *26*%) were neutral (Table 5).

Table 5. Physicians' responses to professional, social, economic, and legal considerations of the national legalization of PAS. "PAS" is an abbreviation for physician-assisted suicide. "AID" is an abbreviation for aid-in-dying. Italicized percentages are case weighted.

	Agree n (%,*%*)[A]	**Neutral n (%,*%*)[A]**	**Disagree n (%,*%*)[A]**
PAS/AID would improve the clinical care of patients at the end-of-life.	96 (51,*52*)	27 (14,*14*)	60 (32,*33*)
Patients would view the medical profession more negatively	46 (24,*26*)	55 (29,*32*)	82 (43,*43*)
Patients would trust their physicians more.	43 (23,*24*)	75 (40,*40*)	64 (34,*35*)
Racial and ethnic minorities would feel pressure to end their lives.	20 (11,*9*)	43 (23,*23*)	121 (64,*69*)
Patients with lower socioeconomic status would feel pressure to end their lives.	32 (17,*15*)	46 (24,*25*)	106 (56,*58*)
Patients with mental or physical disabilities would feel pressure to end their lives.	50 (27,*24*)	45 (24,*26*)	89 (47,*49*)
PAS would save money for the health care system.	107 (57,*62*)	48 (26,*19*)	29 (15,*18*)
Health insurance companies would cover PAS over more expensive, possibly life-saving treatments, like chemotherapy.	93 (49,*46*)	55 (29,*34*)	35 (19,*20*)
PAS/AID would lead to an increased number of medical malpractice suits.	55 (29,*28*)	56 (30,*28*)	72 (38,*43*)
PAS/AID would lead to an increase in suicides in the community.	68 (36,*32*)	28 (15,*17*)	87 (46,*51*)
PAS would lead to the legalization of euthanasia.	61 (32,*31*)	52 (28,*26*)	71 (38,*43*)

[A]Percentages do not add up to 100 due to incomplete survey data.

Other Considerations Regarding PAS

Table 6 shows the number of participants who agreed, disagreed, and were neutral when asked questions about ethical considerations regarding the national legalization of PAS. When asked "Sometimes providing PAS/AID is necessary in order to relieve suffering," 120 (64, *65%*) agreed, 49 (26, *28%*) disagreed, and 16 (8, *6%*) were neutral

(Table 6). When asked, “Sometimes providing PAS/AID is necessary in order to respect patient autonomy,” 107 (57, *58%*) agreed, 50 (27, *29%*) disagreed, and 28 (15, *12%*) were neutral (Table 6).

When asked, “There are important ethical distinctions between PAS/AID and withdrawing life-support,” 146 (78, *78%*) agreed, 22 (12, *11%*) disagreed, and 15 (8, *10%*) were neutral (Table 6). When asked, “PAS/AID would be unnecessary if all patients had access to excellent palliative care,” 64 (34, *38%*) agreed, 80 (43, *45%*) disagreed, and 38 (20, *18%*) were neutral (Table 6).

When asked, “The medical profession should endorse PAS/AID as a morally valid medical option,” 89 (47, *49*%) physicians agreed, 66 (35, *32*%) disagreed, and 29 (15, *17*%) were neutral (Table 6). When asked, “Physicians who participate in PAS/AID thereby abandon their patients,” 16 (9, *13%*) agreed, 144 (77, *76%*) disagreed, and 23 (12, *10%*) were neutral (Table 6). When asked, “A patient’s request for PAS/AID should override the physician’s moral objections to performing it,” 37 (20, *20%*) agreed, 123 (65, *68%*) disagreed, and 25 (13, *15%*) were neutral (Table 6).

Table 6. Physicians' responses to ethical considerations of the national legalization of PAS. "PAS" is an abbreviation for physician-assisted suicide. "AID" is an abbreviation for aid-in-dying. Italicized percentages are case weighted.

	Agree n (%,*%*)[A]	**Neutral n (%,*%*)[A]**	**Disagree n (%,*%*)[A]**
Sometimes providing PAS/AID is necessary in order to relieve suffering.	120 (64,*65*)	16 (8,*6*)	49 (26,*28*)
Sometimes providing PAS/AID is necessary in order to respect patient autonomy.	107 (57,*58*)	28 (15,*12*)	50 (27,*29*)
There are important ethical distinctions between PAS/AID and withdrawing life-support.	146 (78, *78*)	15 (8,*10*)	22 (12,*11*)
PAS/AID would be unnecessary if all patients had access to excellent palliative care.	64 (34,*38*)	38 (20,*18*)	80 (43,*45*)
The medical profession should endorse PAS/AID as a morally valid medical option.	89 (47,*49*)	29 (15,*17*)	66 (35,*32*)
Physicians who participate in PAS/AID thereby abandon their patients.	16 (9,*13*)	23 (12,*10*)	144 (77,*76*)
A patient's request for PAS/AID should override the physician's moral objections to performing it.	37 (20,*20*)	25 (13,*15*)	123 (65,*68*)

[A]Percentages do not add up to 100 due to incomplete survey data.

Physician Perspectives on Death

Table 7 shows the number of participants who agreed, disagreed, and were neutral when asked questions concerning their personal beliefs about death and its relevance to the practice of medicine. When asked, "I am comfortable talking with patients about death," 156 (83, *83%*) agreed, 13 (7, *6%*) disagreed, and 16 (9, *10%*) were neutral (Table 7). When asked, "My ability to think about my own mortality is relevant to providing good care for patients at the end of life," 155 (82, *81%*) agreed, 12 (6, *11%*) disagreed, and 18 (10, *8%*) were neutral (Table 7). When asked, "Medical professionals should never intentionally hasten a patient's death at the end of life," 74 (39, *43*%) physicians agreed, 80 (43, *41* %) disagreed, and 30 (16, *15* %) were neutral (Table 7).

Table 7. Physicians' responses to questions concerning their personal beleifs about death and its relevance to the practice of medicine. Italicized percentages are case weighted.

	Agree n (%,*%*)[A]	**Neutral n (%,*%*)[A]**	**Disagree n (%,*%*)[A]**
I am comfortable talking with patients about death.	156 (83,*83*)	16 (9,*10*)	13 (7,*6*)
My ability to think about my own mortality is relevant to providing good care for patients at the end of life.	155 (82,*81*)	18 (10,*8*)	12 (6,*11*)
Medical professionals should never intentionally hasten a patient's death at the end of life.	74 (39,*43*)	30 (16,*15*)	80 (43,*41*)

[A]Percentages do not add up to 100 due to incomplete survey data.

Crosstabulations

Table 8 shows the crosstabulation of those who thought PAS should be legal or decriminalized and how likely they would perform PAS if it were legal or decriminalized in their state. Of those who thought PAS should be legal, 16 (15%) would, 40 (37%) "possibly" would, 38 (36%) were "unlikely" to, and 13 (12%) would "never" perform it (Table 8). Of those who thought PAS should be decriminalized, 16 (13%) would, 40 (32%) "possibly" would, 47 (37%) were "unlikely" to, and 23 (18%) would "never" perform it (Table 8).

Table 8. The self-reported likelihood of physicians who thought PAS should be legal or decriminalized performing PAS. "PAS" is an abbreviation for physician-assisted suicide.

	If PAS were legal or decriminalized, would you participate in it?			
	"Yes" **n (%)**	***"Possibly"*** **n (%)**	***"Unlikely"*** **n (%)**	***"Never"*** **n (%)**
Should PAS be legal in your state?	16 (15)	40 (37)	38 (36)	13 (12)
Should PAS be decriminalized in your state?	16 (13)	40 (32)	47 (37)	23 (18)

Table 9 shows the crosstabulation of those who thought PAS should be legal and their responses to two questions concerning the ethics of PAS. Of those who thought PAS should be legal, 84 (81%) agreed, 4 (4%) disagreed, and 16 (15%) were unsure when asked, "The medical profession should endorse PAS/AID as a morally valid medical option" (Table 9). Of those who thought PAS should be legal, 28 (27%) agreed, 66 (63%) disagreed, and 11 (10%) were unsure when asked, "Medical professionals should never intentionally hasten a patient's death at the end of life" (Table 9).

Table 9. Physicians', who thought PAS should be legal, responses to two ethical questions regarding national PAS legalization. "PAS" is an abbreviation for physician-assisted suicide.

	Agree n (%)	**Neutral n (%)**	**Disagree n (%)**
The medical profession should endorse PAS/AID as a morally valid medical option.	84 (81)	16 (15)	4 (4)
Medical professionals should never intentionally hasten a patient's death at the end of life.	28 (27)	11 (10)	66 (63)

Beliefs and Practices of PAS

Table 10 shows the free responses answers of physicians who were asked to explain why they thought PAS should be legal or decriminalized but would be unwilling or unlikely to perform the practice. The single most common reason given was lack of training/expertise (47%) (Table 10). Other, less common themes were religious/spiritual teachings (11%), should be an option for patients (8%), legal implications/hurdles (7%), ethical/moral opposition to the practice of PAS (5%), PAS is rarely ever truly indicated (5%), and could not personally perform PAS due to its inherent severity (4%) (Table 10). Themes endorsed by only one respondent were the following: inadequate safeguards in place, "great subtleties and greater responsibility involved in performing PAS/AID, "[I] would favor smaller # physicians involved to ensure expertise in assessing

appropriateness of PAS rather than general medical practitioners uniformly authorized to do so," and "I am afraid patient may have a scary face when dying" (Table 10).

Table 10. Free responses answers of physicians who were asked to explain why they thought PAS should be legal or decriminalized but would be unwilling or unlikely to perform the practice. "PAS" is an abbreviation for physician-assisted suicide. "AID" is an abbreviation for aid-in-dying.

	%
Lack of training/expertise	47
Spiritual/religious teachings	11
Should be option for patients	8
Legal implications/hurdles	7
Ethical/moral opposition to the practice of PAS	5
PAS is rarely every truly indicated	5
Could not personally perform PAS due to its inherent severity	4
Inadequate safeguards [A]	1
"Great subtleties and greater responsibility involved in performing PAS/AID" [A]	1
"I am afraid patient may have scary face when dying" [A]	1
"[I] would favor small [number of] physicians involved to endure expertise in assessing appropriateness of PAS rather than general medical practitioners uniformly authorized to do so." [A]	1

[A]Answer given by only one physician

Discussion

Legality, Beliefs, and Practices of PAS

This study shows that 60% of US physicians believe that PAS should be legalized, which is consistent with previous Gallup poll results (57%) (Table 2).(6) We also found that 69% of US physicians think the practice should be decriminalized, which is a new finding (Table 2). With legalization, there would not be *any* penalties attributed to the act of PAS. While, decriminalization of PAS would mean that there would no longer be any *criminal* penalties of performing the act. Additionally, only 9% of respondents indicated that they would unequivocally perform PAS if it were legal (Table 3). Of those who thought PAS should be legalized or decriminalized, only 15 and 13% indicated that they would unequivocally be willing to perform the practice if it were legal

or decriminalized, respectively, (Table 8). Furthermore, of those who thought PAS should be legalized or decriminalized, 12% and 15% would "never" perform PAS, respectively (Table 8). This discrepancy between the belief that PAS should be legalized and the actual willingness to practice it if it were legal is consistent with findings in the literature and our previous survey data from a large academic institution.(16,19)

In order to assess why this discrepancy persists, we asked those physicians who thought PAS should be legal but would be unwilling to perform it to explain why in a free response text box. The single most common response (47%) was a lack of training or expertise with respect to PAS since it was outside the scope of their practice (Table 10). The next most common themes were religious/spiritual teachings (11%), should be an option for patients (8%), legal implications/hurdles (7%), ethical/moral opposition to the practice of PAS (5%), PAS is rarely ever truly indicated (5%), and could not personally perform PAS due to its inherent severity (4%) (Table 10).

Several conclusions can be inferred from these responses. The first is that religion/spiritual teachings play a role in physicians' decisions about performing PAS, which has been consistently shown to be the case in the literature.(11,21) The second is that ethics and morals are important in physicians' decisions. Several respondents invoked the Hippocratic oath and "do no harm" as to why they would not perform PAS. This is not surprising as one of the oldest and most consistently used arguments of those opposed to PAS is that it goes against the physician credo of "to do no harm."(24) Next, some physicians are unlikely to perform PAS due to fear of legal action taken against them should they perform the practice. The fourth and arguably most interesting conclusion can be drawn from the answers indicating PAS being outside the scope of

physicians' practices, its inherent severity, and that it should be an option for patients. It is clear from these responses that physicians think that patients should have the option to choose PAS; however, the doctors would be unwilling to perform it because it is outside the scope of their practice. On the one hand, this unwillingness could be due to a lack of training or expertise with respect to PAS. Perhaps if some of these physicians had specific training in performing PAS, they would be more willing to perform it, which some respondents did explicitly state. Our sample also had a large percentage of pediatricians, which likely lead to an increase in this reason since PAS is never a consideration for their practice in the US. On the other hand, it could simply be an indication that physicians think patients should have the option to PAS without any real internal exploration of why they think it should be an option for patients but would not personally want to perform it. It is easier to simply say that it is outside their scope of practice than it would be to address a potential internal discrepancy between belief and willingness to practice.

Underlying many of these "outside of specialty" responses is likely a feeling toward the inherent severity of PAS, which 5% of respondents explicitly identified. This feeling is explained quite well by Robert Burt when he writes about "ambivalence" toward death. He argues that although it is conceivable that death can be a moral good or at least morally neutral in some cases, there exists a pervasive sense that death is wrong or a "moral error."(25) Burt writes, "We cannot readily erase a persistent contrapuntal conviction that death…is inherently wrong."(25) Our data seem to suggest that physicians today generally want their patients to have control over their deaths, but physicians remain uncertain about their own participation.(19) This ambivalence is

further supported by the finding that of those who thought PAS should be legal, 27% agreed that, "Medical professionals should never intentionally hasten death at the end of life" (Table 9).

Current Practices of PAS

When asked about current practices of PAS in states where it is legal, only 24 % of physicians disagreed (49% agree; 26% neutral) that the most common reason for patients seeking PAS is physical pain (Table 4). The data about the practice of PAS in Oregon from Oregon's Death with Dignity Act indicate that most patients who seek PAS do so because of loss of autonomy and being less able to engage in activities that make life enjoyable and *not* because of physical pain.(26) In fact, physical pain is not even in the top five reasons why patients seek PAS. This finding suggests that physicians in general are misinformed as to why patients seek PAS at the end of life.

When asked about current safeguards, most physicians (59%) agreed that they are adequate (Table 4). This is a larger percentage than previously reported in the literature. A study from Oregon found that only 37% of emergency medicine physicians thought that the Oregon initiative had adequate safeguards.(14) When asked about specific safeguards, however, physicians were less sure. Sixty percent of respondents disagreed that a physician other than a psychiatrist could effectively screen a patient seeking PAS for depression (Table 4). Furthermore, 60% disagreed that most physicians can adequately predict if a patient seeking PAS has 6 months or less to live (Table 4).

These results have important implications. First, physicians in general doubt that doctors who are not psychiatrists can adequately screen patients seeking PAS for depression. Most patients who ask for PAS have a diagnosis of terminal cancer.(26) A

study of cancer patients showed that of those who had a desire to die, 59% had depressive syndromes. Of those patients who did not have a desire to die, only 8% had depressive syndromes.(27) Thus, there is evidence to suggest that many patients with terminal cancer who seek death have depression. The data from Oregon, however, indicate that less than five percent of patients seeking PAS are evaluated by a psychiatrist.(26) If the majority of patients seeking PAS have terminal cancer, and most terminal cancer patients desiring death have signs of depressive syndromes, then more than five percent of patients seeking PAS should be evaluated by psychiatrists. It seems that physicians who responded to this survey are right to doubt the effectiveness of this specific safeguard. Indeed, a study from Oregon has found that of those patients who received a lethal medical for terminal illness, 1 in 6 had clinical depression.(28)

The second implication of these findings is that prognosis as a safeguard is fraught with inadequacies. Respondents in general disagree that most physicians can accurately predict if a patient seeking PAS has 6 months or less to live. These opinions are supported by the literature. Physicians are generally hesitant to provide life-expectancies to patients because they think they are challenging to predict because it is "difficult" and "stressful".(29) Furthermore, a recent study found that only 57% of physicians were accurate when predicting a patient had six months or less to live.(30) Taken together, it is clear that both the opinions of physicians and the literature support the ineffectiveness of current safeguards used to protect patients with mental illness and longer prognoses who are seeking PAS.

It should be noted as well that prognosis is dependent on the willingness of a patient to accept treatment. A patient with insulin-dependent diabetes mellitus who

refuses insulin will be dead in less than six months. Though this patient is not "terminal" in the classic sense, she would qualify for PAS under the current laws. This is a large loophole in arguably the most important safeguard of current PAS laws.

Implications of PAS Legalization

A slight majority (52%) of physicians thought PAS legalization would improve the clinical care of patients at the end of life, while a third (33%) thought it would not (Table 5). Respondents were more likely to disagree when asked if the medical profession would be viewed more negatively (26% agreed, 43% disagreed, 32% neutral) and if patients would trust their physicians more (24% agreed, 35% disagreed, 40% neutral) if PAS were legalized (Table 5).

Most physicians disagreed that patients of lower socioeconomic status, racial or ethnic minorities, and those with mental or physical disabilities would feel pressure to end their lives through PAS (58, 69, 49%, respectively) (Table 5). These opinions are supported by at least one study, which found that there was no heightened risk for abuse of PAS in populations based on race/ethnicity, income, and disabilities.(31) Though there is evidence supporting the unbiased nature of the practices of PAS, it is still important to continue monitoring for bias in states where it is newly legalized. The data for the aforementioned article comes from Oregon, which is a predominately white state. Patients have historically been discriminated against based on race throughout the history if the practice of medicine, and there is no reason to assume that PAS would be any different than other practices in medicine.(32) Furthermore, those in the disability community have consistently been vocal about their fears of abuse with respect to

PAS.(33) These concerns must be heard and routinely evaluated to ensure safe practices of PAS.

With respect to economic ramifications of legalization of PAS, most physicians (62 %) thought it would save the healthcare system money. This is consistent with findings from a recent article published in Canada that suggested that the Canadian healthcare system could save as much as 140 million dollars through the use of PAS.(34) Additionally, nearly half of physicians (46%) thought that the legalization would lead to health insurance companies preferentially covering the cost of PAS over more expensive, life-saving treatments like chemotherapy (Table 5). The US desperately needs to control its healthcare spending. Indeed, in 2010, one quarter of all Medicare spending was attributed to the last year of life.(35) It is apparent that any practice that effectively shortens the length of end-of-life care will likely decrease the cost of healthcare nationwide.

The question, however, is how medicine as a profession wants to cut spending. Do we set the precedent of providing the means for patients to kill themselves by legalizing PAS to lower costs with the possibility of creating an environment where insurance companies favor paying for PAS rather than more expensive treatments? Or do we strive for an intellectually more difficult and laborious process of examining how we as a profession view death and dying in order to create an environment where death is not a crisis from which a patient must be rescued?(36)

When asked about legal concerns, the majority of respondents (43%) disagreed that the legalization of PAS would lead to an increase of medical malpractice suits (Table 5). This is logical as the current PAS laws have protections for physicians against

malpractice suits. A majority disagreed (51%, 32% agreed) that the national legalization of PAS would lead to increased number of suicides in the community. This is the opposite of what is reported in the literature. The Werther effect, also known as copycat suicide, is the phenomenon that a widely publicized suicide increases the rate of suicides thereafter.(37) A recent study examined this effect with respect to PAS legalization and found a 6.3% increase in statewide suicide rates (assisted and non-assisted) in states where PAS has been legalized.(38) The association is correlative and not causative, but it is an important consideration nonetheless when thinking about the legalization of PAS.

The last question in this section assesses what physicians think about the "slippery slope" argument, which will be explained in detail in Part II of this thesis. A slight majority (43%) disagreed that the legalization of PAS would lead to the legalization of euthanasia, while about a third (30%) agreed (26% neutral) (Table 5). The respondents seem to be relatively split on this topic, which is similar to the climate in the US in general. There are many who proclaim that the slippery slope will never happen in America, while others use it as strong justification against the legalization of PAS.(39) Indeed, many physicians refer to countries like Belgium and the Netherlands where both PAS and euthanasia have been legalized as realization of the slippery slope argument.(40) There was a motion recently bought up in the Oregon Senate to allow individuals identified by a power of attorney to administer the lethal drugs to the terminally ill patient if that patient no longer had the capacity to administer it themselves.(41) Furthermore, on January 15, 2019, a bill was introduced in the New Mexico house entitled the "Elizabeth Whitefield End of Life Option Act." This would make PAS legal in New Mexico and expand the inclusion criteria. The bill does not

require a patient to "self-administer" and allows patients with mental illnesses to request PAS.(42) This is certainly evidence that the slippery slope argument does have merit in the US and must be considered.

Other Considerations Regarding PAS

Sixty-five percent agreed that PAS is sometimes necessary to relieve suffering, and 58% agreed that it is sometimes necessary to respect patient autonomy (Table 6). The former finding is similar to previous data at a large academic institution, which found that 73% of physicians agreed that it is sometimes necessary to hasten death through PAS to relieve suffering.(19) The latter supports the conclusion mentioned above that in general physicians think that patients should have the right to choose to end their lives through PAS.

Seventy-eight percent agreed that there are important ethical distinctions between PAS and withdrawing life support (Table 6). This accords with current practice and ethics of end-of-life care in the US, which acknowledges this distinction to be true. Furthermore, most (68%) disagreed that a patient's request for PAS should override the physician's moral objections to performing it (Table 6). This is in agreement with the understanding in medicine that physicians are moral agents, and society and patients must respect this.(43) Interestingly, physicians were more undecided than expected when asked if the medical profession should endorse PAS as a morally valid medical option. Forty-nine percent agreed, 32% disagreed, and 17% were unsure (Table 6). Once again, a discrepancy is present—although 60% think PAS should be decriminalized, only 49% think it is a morally valid medical option (Table 1, Table 6). Furthermore, of those who

thought PAS should be legal, 81% agreed that PAS should be endorsed by the medical profession as a morally valid option (Table 9). Nineteen percent disagreed or were unsure if the medical profession should endorse PAS, but they still think it should be legal.

The vast majority of respondents (76%) disagreed that physicians who participate in PAS abandon their patients (Table 6). They were split when asked if PAS would be unnecessary if patients had access to excellent palliative care (38% agreed, 45% disagreed) (Table 6). The latter question was asked because it could be argued that if patients had access to the best palliative care, which would include biological, social, spiritual, and psychological care, a practice like PAS would never be needed—or at least *rarely* needed. Since most concerns of patients seeking PAS are existential, if time was taken to work through those thoughts, feelings, and preparations, perhaps patients would not need a practice like PAS.(26)

Physician Perspectives on Death

This section was given to respondents to get a sense of how important they thought talking and thinking about death was in their daily practices. Eighty-three percent agreed that they were comfortable talking with patients about death, and 81% agreed that their ability to think about their own mortality was relevant to providing good care for patients at the end of life (Table 7). These are promising findings. In order to be able to actively and effectively talk with patients about death, one must be able to think about and discuss their own mortality with his or herself.

The final result, which was briefly mentioned above, further supports the existence of an inconsistency in physicians' beliefs and practices. Respondents were almost exactly split down the middle when asked if medical professionals should never

intentionally hasten a patient's death at the end of life (43% agreed, 41% disagreed) (Table 7). When this data was correlated with data about legality of PAS, it revealed that 27% of those that thought PAS should be legal agreed that medical professionals should never intentionally hasten death (Table 9).

Strengths and Limitations

The strength in our study lies in the breadth and novelty of the questions in our survey tool. We also sent the survey to a generous sample (1000) of random physicians from around the US.

Our analysis is limited by the survey tool used, low response rate, and small n. Although the specific questions were vetted for clarity and simplicity, it is likely that some of the questions could have been interpreted in more than one way decreasing the accuracy of our analysis. This has indeed been shown to be the case in the literature specifically with surveys based on physicians' attitudes surrounding assisted suicide.(44) Our response rate is lower than the average for surveys of physicians (54%); thus, it is likely that there is a degree of non-respondent bias.(45) Although non-respondent bias is likely less important than other sources of bias, 22% is a low response rate, which will inevitably engender some non-respondent bias. It is unclear why our response rate was this low as we used a validated survey administration technique that routinely produced response rates of around 60%.(9,21,22) Possible explanations could be the length of this survey and the use of a $2 incentive instead of the reported $20 in the final survey mailing. Our small n decreases the overall generalizability of our study, although randomization and case weights were used to counter this.

Conclusion

Our results suggest that there are several important aspects of physicians' perspectives surrounding the national legalization of PAS. The first is that there is a discrepancy between belief and willingness to practice PAS. Although the majority of physicians agreed that it should be legalized, only a small portion of those would unequivocally perform the practice if it were legal. Furthermore, our data indicate that this incongruity between belief and practice could be attributed to 1) a general misunderstanding on the part of physicians as to why patients seek PAS, 2) a lack of training or expertise with PAS, and 2) an inherent discomfort with the practice due to its intimate relationship with death. A second finding is that physicians believe the current safeguards protect patients, but when asked about the specific aspects of these safeguards, they question their adequacy. Most notably, 60% of respondents thought that physicians could not adequately determine if a patient seeking PAS had 6 months or less to live, which is arguably the most important safeguard in place. Third, physicians are still wary of the proverbial "slippery slope." Not only do about a third of the physicians think that PAS legalization would lead to euthanasia, but nearly half believe that health insurance companies would preferentially cover PAS over more expensive, potentially life-saving treatments like chemotherapy.

Part II: Bioethical Analysis

Introduction

Physician-assisted suicide (PAS), also known as aid-in-dying, is currently legal in seven states, decriminalized in one, and illegal in forty-two. As it is increasingly becoming an option for physicians and patients, it is important to determine if this is something that is morally permissible for physicians to offer. In this paper, I will provide an argument against the legalization of PAS by showing that it is morally impermissible according to four commonly invoked bioethical considerations: role morality, the "slippery slope," doing vs. allowing, and foreseeing vs. intending.

PAS is defined as a physician prescribing a lethal dose of drugs that patients may then administer themselves with the intention of ending their lives. This practice is distinct from euthanasia, in which a physician directly administers a drug or drugs with the intention of ending the patient's life. I will only be addressing PAS in this paper.

Role Morality

I will first use role morality arguments to justify my position against the national legalization of PAS. In order to provide a robust argument, I will use David Luban's formulation to show that a physician's role morality precludes a physician from participating in PAS.

Before tackling the formulation, it is beneficial to describe role morality. Briefly, it is the idea that when one holds a certain role, such as a lawyer, physician, or engineer, one will be granted a different set of moral oughts/obligations/codes than the common

morality of the general public. For example, due to the physician's role, she has a different obligation to disclose confidential information than someone from the general public. While one would ordinarily be required by law to disclose pertinent information about someone in a criminal trial, a physician, asked to disclose similar information that she obtained in her professional role, would be obligated to non-disclosure by the sanctity that the medical profession puts on the physician-patient relationship. But from where does role morality come? How is it built? And, what are its limits? Luban provides some answers.

Luban describes role morality with what he calls, "the Fourfold Root of Sufficient Reasoning."(46) This offers a scaffold that dissects role morality into four links that consecutively build upon each other. The first link is the "institution," then "roles," followed by "role obligations," and finally "role acts."(46) Using a physician treating a patient with heart failure as an example, the medical profession would be the institution; physician would be the role; providing evidence-based care would be the role obligation; and prescribing an Angiotensin-Converting Enzyme (ACE) inhibitor would be the role act. Luban also explains that each of these links is related to each other in a specific way. He writes,

> …the agent (1) justifies the institution by demonstrating its moral goodness; (2) justifies the role by appealing to the structure of the institution; (3) justifies the role obligations by showing that they are essential to the role; and (4) justifies the role act by showing that the obligations require it.(46)

Thus, the physician in my previous example justifies the medical profession because of its moral goodness (the profession seeks to heal individuals). She justifies her role as a physician because that is a role the medical profession has identified to be useful.

Furthermore, she justifies the role obligation to treat with evidence-based medicine because that is essential to being an effective physician. And finally, she justifies the role act of prescribing an ACE inhibitor because the role obligation requires her to treat with medications that are evidence based, which ACE inhibitors are.

Luban then goes on to explain how this model can be used to justify a role act if it is contrary to common morality. He describes two possible ways of using this model, one he terms the *minimal-threshold test* and the other, the *cumulative-weight test*.(46) In the former, a role act is justified if the former three links are justified, even if only weakly. This is an all or nothing approach and the strength of justifications of each link does not matter. It only matters that they are justified. Luban (rightly, I think) abandons this for the *cumulative-weight test*, which takes into account the strengths of the justifications of each link when assessing if a role act contrary to common morality is permissible.

Thus, with an understanding of the Fourfold Root of Sufficient Reasoning and the *cumulative-weight test* we can apply it to the role act of a physician *not* participating in PAS. In this case, the institution and role are the medical profession and physician, respectively. With respect to the role obligation and role act, the former is the obligation to "do no harm," and the latter is the act of *not* participating in PAS.

The role obligation to "do no harm" has been a principle of medicine since its inception. It is arguably the most crucial element of medicine and enables the sanctity and trust of the physician-patient relationship. By acting against this principle, physicians directly undermine this core relationship and the trust of patients in their doctors, ultimately resulting in a deterioration of the profession. With respect to the case of PAS

then, the role obligation to do no harm should be upheld, and a physician should not participate in the act of PAS.

One possible argument against my claim includes the role of moral acknowledgement. Role of moral acknowledgment refers to the duty of a professional to respond to others, even if it is in violation of professional duties.(46) For example, it is permissible for a psychiatrist to divulge confidential information about a patient if it would result in the prevention of harm to others. The psychiatrist must violate her obligation of confidentiality as a physician in order to prevent harm to another individual. Indeed, this is exactly what the courts ruled in *Tarasoff v. Regents of the University of California.* (47) One might also suggest that a physician must use moral acknowledgment to respect patient autonomy (or beneficence/relief of suffering) over the obligation to "do no harm" when a patient requests PAS.

I am not arguing that the role of moral acknowledgment is unnecessary in medicine. It is absolutely required in certain circumstances. Moreover, I believe that the obligation to respect patient autonomy or beneficence/relief of suffering can override the obligation to "do no harm" (surgery, for example). But, when the questions of respect for autonomy/beneficence and moral acknowledgment drive a physician to respect those principles by guiding and providing the means for patients to kill themselves, the principle of "do no harm" must trump the others. The physician has an ample amount of tools (palliative care, hospice care, religious/spiritual services, social workers, etc.) in the tool kit to be beneficent and relieve suffering. One does not need to resort to prescribing a lethal dose of barbiturates so the patient can committing suicide to achieve those goals. As a final note, although PAS would not be morally justified for physicians to perform

based on the argument I have presented with respect to the physician's role morality, there may be other roles in society where this practice might be acceptable (i.e. thanatologists or others outside the medical profession).

The "Slippery Slope"

The "slippery slope" argument has routinely been used as an argument against the legalization of PAS in the United States. Briefly, the slippery slope argument states that once a certain norm is accepted it will inevitably lead to the acceptance of a morally illicit norm. For the present case, the argument would be that legalization of PAS will inevitably lead to the legalization of euthanasia. For the purposes of this argument, I am assuming that taking of human life, except possibly in self-defense or to defend another, is illicit. It is true that not all slippery slopes are considered equal, and there are important considerations. How many "steps" is the initial norm from the morally illicit one? How steep is the slope (how fast would the acceptance of the morally illicit occur)? And how exactly does one get from one already morally questionable norm (in the case of PAS) to the more morally illicit norm (euthanasia)? What are the factors that influence this transformation?

Eugene Volokh and David Newman's description of the slippery slope can adequately address these questions. They break down the slippery slope into four distinct mechanisms: cost-saving, "attitude-altering", changing of political powers, and "desensitization".(48) The cost-saving mechanism is straightforward and it follows that once the initial step is taken the morally illicit step becomes economically easier and more feasible. One example they use to explain this involves gun registration. The

slippery slope is the following: if a law is passed that mandates all gun owners to register their firearms, it will lead to the government confiscating personal firearms, which is the morally illicit norm. The initial step, gun registration, would require the design and implementation of an incredibly expensive and complicated registration system. Once this step is complete, however, the economic barrier has been hurdled. It becomes exceedingly easy and inexpensive for the government to confiscate guns because the costly registration system already exists.(48)

It is just as easy to imagine this playing a large role in the slippery slope from PAS legalization to euthanasia legalization. The act of PAS is much cheaper for insurance companies than expensive, possibly life-saving treatments like chemotherapy. Indeed, this is what happened to Stephanie Packer in California. As her scleroderma progressed, her doctors thought that switching to another chemotherapy drug would provide an extension of life. The insurance company however denied her claim for chemotherapy but did approve the cost of a prescription for life-ending drugs—with a co-payment of $1.20.(49)

The second mechanism is "attitude-altering." This generally relies on what laws *say* rather than what they *do*. If something is law, then individuals will tend to think that it *ought* to be law.(48) The example given by Volokh and Newman refers to the Patriot Act. When lawmakers were considering this legislation, which would allow the government to track email addresses and websites that an individual used or visited, they cited the "pen register" as a precedent. This was a Supreme Court ruling twenty years prior that approved the monitoring of telephone numbers in a similar way. When

lawmakers referred to the pen register, they did not consider the merits of the law itself but accepted it as something that ought to be law because it was law.(48)

This mechanism is certainly applicable to the legalization of PAS. One can imagine that if PAS is legalized, it might follow that many people will think it ought to be legal since it is law. Then, when considering legalizing euthanasia, the merits of the legalization of PAS will not be considered for it is already law. Since, ostensibly, euthanasia is not that different from PAS, it will be easier to legalize euthanasia. This is highlighted in a famous New Yorker article entitled, "The Death Treatment" about a euthanasia case of depressed woman in Belgium named Godelieva. The author writes that, "Until Godelieva's death, Tom [her son] had never given much thought to euthanasia…He assumed that the law was for old people who were already dying. Now it seemed to Tom that there were few people reflecting critically on the law."(50)

Acceptance of the first step could also lead to changes in the power of political groups, the third mechanism by which Volokh and Newman explain slippery slope. The example they use is the legalization of marijuana. The slippery slope here is that if marijuana is legalized, advertising for marijuana will be legalized and consumption will increase. One can imagine that if marijuana were legalized, it would open up a multi-billion dollar industry. The money from this industry could then be used to fund powerful lobbies in Washington that could influence Washington to push for legislation to legalize marijuana advertising. Once this legislation passed congress, the increased exposure of individuals to marijuana through advertising could ultimately increase consumption.(48) Indeed, adult consumption of marijuana has slightly increased in Colorado since

legalization.(51) The unintentional exposure of pediatric patients to marijuana has also steadily increased in Colorado since legalization.(52)

While it is certainly unlikely that the legalization of PAS will unleash a multi-billion dollar industry, one can imagine its legalization changing powers of certain political groups. Consider, for example, the disability community and Compassion and Choices, the oldest and best-funded non-profit organization supporting national legalization, as examples of two opposing political groups. The disability community is, on the whole, one of the largest outspoken opponents of legalization of PAS. One could imagine that if PAS were to be legalized nationally, the political power of Compassion and Choices might increase further. They would become champions of the law (and as mentioned above, if something is law, it must ought to be law). This might afford them more power and a larger voice than that of the disability community. With this newfound power, they could push for broader inclusion criteria for physician-assisted-suicide and ultimately legalization of euthanasia. Though there is no data available at the moment to support this claim, it is still an important consideration especially since the acceptance of PAS is increasing nationally.

Volokh and Newman refer to the final mechanism as “desensitization.” This is the idea that people will focus on big changes but ignore the small ones.(48) The parable of the boiling frog illustrates this well. If a frog is tossed into boiling water, it will immediately jump out. If the frog is placed in a pot of water at room temperature while the heat is gradually increasing, however, the frog will get cooked. When applied to people this means that individuals will not devote much mental energy to small policy changes. They reserve this mental energy for larger decisions.(48)

This mechanism is certainly applicable to the slippery slope of legalization of PAS. One can imagine little changes to the inclusion criteria for eligibility of participating in the practice. Why six months to live and not seven? Why not eight, nine, twelve? It is unlikely that people will pay attention to these little policy changes. What about extending PAS to those individuals with terminal illness who are unable to move? Why should those individuals not have the opportunity to participate in this practice just because they physically are unable to administer the medication themselves? In this case a physician would have to directly administer the medication, which would be euthanasia. This would be a minor (practically, certainly not ethically) policy change to which people may not pay much attention, and it could set the precedent for legalization of euthanasia.

The most obvious counterargument to the claims I have just made is that there are adequate safeguards in place in the United States, thus we will not slip down the slope to euthanasia legalization. Furthermore, that fact that we are not "like" the European countries that have passed euthanasia laws is also invoked as an argument against a slippery slope. It is true that when opponents of PAS legalization invoke the slippery slope argument they almost exclusively refer to what has happened in the Netherlands, Belgium, and Canada. Certainly, after twenty years of the Death with Dignity Act in Oregon, there are no currently reported data of "slippery slope" examples occurring in Oregon. That being said, it is a bit presumptuous and naïve to think that just because the United States is the United States we will not slide down that slippery slope. Indeed, as mentioned in Part I, there was recently a motion put forth in the legislation in Oregon to allow euthanasia for immobilized, terminally ill patients since they could not themselves administer a lethal dose of medication.(41) This was voted down, but there is now a new

bill in New Mexico that would expand the inclusion criteria of patients who are able to seek PAS, which was mentioned in more detail in Part I.(42) The fact that both of these bills have been introduced to state legislatures is evidence that the slippery slope is relevant in the US and is an important consideration. Moreover, it certainly should not be assumed that medicine will necessarily take the moral high ground. The history of medicine is plagued with discrimination based on race, ethnicity, gender, and sexual orientation. One need only look to the Tuskegee Syphilis Study to understand medicine's susceptibility to flawed moral and ethical judgment and disrespect for human rights.(53)

But, what about the safeguards in place? Surely they will prevent the plunge down the slippery slope. As mentioned above, through "desensitization" these safeguards could be incrementally changed to expand the inclusion criteria for those seeking PAS. Additionally, it is unclear if these safeguards are working as intended. As mentioned in Part I, recent data from Oregon indicate that of those seeking PAS, less than five percent receive a formal psychiatric evaluation from a psychiatrist.(26) We know that most people seeking PAS have terminal cancer, and a large portion of cancer patients have depression. Thus, it is unlikely that only less than five percent of those who seek PAS should be receiving a formal psychiatric evaluation.

Doing vs. Allowing

The next argument commonly invoked with regard to the legalization of PAS is the distinction between "doing" and "allowing". Judith Jarvis Thomson's take on Philippa Foot's famous Trolley Problem classically exemplifies this distinction. The scenario is as follows: There is a trolley with broken brakes hurtling down a track, and it

will inevitably run over and kill five people if nothing is done. Someone who is watching this happen notices a switch next to the track. If she flips this switch, the train will be diverted onto another track. This track however has one person on it who will be killed if the trolley is diverted (Figure 1). Is it morally permissible for the woman to flip the switch? In the second scenario, the conditions are the same, except a man atop a bridge is watching this train hurtling down the track on course to kill five people. He is standing next to a man of such significant proportions that if he is pushed in front of the train, he will stop the train but die in the process (Figure 2). Is it morally permissible for the bystander to push the man in front of the train? The intuitive answer to this question is always that the first is permissible but the second is impermissible. But why is this the case? Ostensibly, it seems that both scenarios are equivalent.

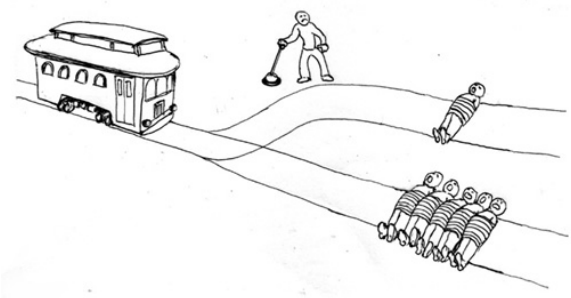

Figure 1. Trolley Problem First Scenario.(54)

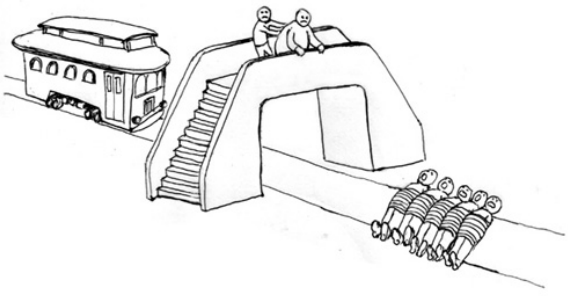

Figure 2. Trolley Problem Second Scenario.(55)

Foot explains this moral intuition with *positive* and *negative duties*.(56) On the one hand, *negative duties* are those in which it is required to refrain from doing harm. On the other hand, *positive duties* are those that require one to assist with those in distress. In the trolley example, the *negative duty* is to refrain from killing the one, while the *positive duty* is to save the lives of the five. Foot indicates that *negative duties* carry more moral stringency than do *positive duties*.(56) But why is this the case? Thomson addresses this by invoking the distinction between diverting and introducing a threat. In the first scenario, the threat of the trolley is simply being diverted from five people to one. There is no introduction of an additional threat in this case—the threat is merely diverted to fewer people. In the second scenario, the threat of the trolley killing five can only be stopped by pushing the man onto the tracks. In this case, a threat that had not been there previously—the man being pushed onto the tracks and dying—is introduced. Thus, she believes it is morally acceptable to divert a threat that is already present to save the lives of the five, but it is morally unacceptable to introduce a new threat to one to save the lives of the five.(56) Thus, it seems that it requires considerably more moral justification to override *negative duties* than it does for *positive* ones.

In the first scenario, the woman pulling the lever must decide between two *negative duties*. She must refrain from killing five or refrain from killing one, which is an easy moral choice, so she may flip the switch. In the second scenario, the man must decide between a *negative duty* to refrain from killing the man and a *positive duty* to save the five. Because there is more moral stringency on *negative duties*, the man must refrain from killing the man rather than save the five.(56)

I can now apply this to the distinction between withdrawing life-support and PAS. In the case of withdrawing life-support, the physician has a *positive duty* to respect her patient's autonomy to refuse treatment and a *positive duty* to relieve suffering. There is really no choice in this case because each are *positive duties* that are certainly morally permissible; thus, the act of withdrawing life-support is permissible. With respect to PAS, the *positive duties* of respecting patient autonomy and relief of suffering are pitted against a *negative duty* to refrain from killing. As *negative duties* carry more stringency, it is morally impermissible for the physician to override the *negative duty* of refraining from killing and offer PAS to satisfy the *positive duties* of respect for patient autonomy and relief of suffering. One might claim that the physician who withdraws life-support precipitates the patient's death, which would override the *negative duty* of refraining from killing. But, the physician is not introducing a new threat in this case—the underlying disease actively killing the patient is already present and removal of life-support allows the natural disease process to take its course. In the case of PAS, the physician *is* introducing a new threat by prescribing a lethal dose of medication to patient so they can commit suicide—a threat that was not there prior to involvement by the physician.

I would now like to address some additional arguments that James Rachels puts forth with regard to the distinction between withdrawing life support and euthanasia. His position is that there is no important distinction between the two.(57) Although he explicitly writes about euthanasia, his arguments can easily be applied to PAS. His first argument involves an example of a man with incurable throat cancer who wishes to remove all life-sustaining treatments. In doing so, Rachels argues, the physician actually

increases suffering because it may take longer for the patient to die than if euthanasia/PAS were used. He indicates that this is in direct contradiction to the premise that drives removal of life-sustaining treatment in the first place, namely relief of suffering. While it is true that removing life-sustaining measures compared to that of euthanasia/PAS may prolong the dying process, adequate pain control is still available and feasible. Although it is unlikely that physicians can completely control pain during the dying process, they can almost always adequately address it. Thus, while the dying process may be longer, it is not necessarily a "suffering" process due to physical pain—although there may still be a large component of "existential" suffering, and there are certainly other ways to ameliorate this suffering rather than suicide.

More importantly, however, the goal of removal of life-sustaining treatment is not primarily the relief of suffering—it is driven by the recognition that there is little to no benefit from continued aggressive intervention. Although it is routinely the case that there *is* relief of suffering by withdrawing care, it is not the primary intention. Rather, the intention is to remove burdensome care that is no longer efficacious—the benefit of the treatment no longer outweighs the negatives of receiving the treatment. This is unlike PAS in which the primary intention is to relieve suffering by killing the patient. The idea of intention with respect to PAS will be explored more thoroughly in the following section.

His next argument, which I think is more robust, is his claim that killing is no morally worse than letting die.(57) He uses two cases to support his claim. In the first, Smith will get a large inheritance if his six-year-old cousin dies. One night, while his cousin is taking a bath, Smith enters the bathroom, drowns his cousin, and arranges

things to make it look like an accident. In the second case, Jones stands to gain the same inheritance and plans to kill his cousin in the same way Smith did. When Jones walks in to the bathroom, however, his cousin is already drowning and Jones lets his cousin "accidently" drown. The two cases are identical except Smith kills his cousin, while Jones "lets" his cousin die. Rachels argues that this distinction is not important since they both had the same intention and motive. The simple fact that one killed and the other "let die" is not enough to make any real moral difference.(57)

With further examination of the two cases, however, we can see that there is a subtle difference. What was the actual cause of the cousin's death in each case? In the first, it is clear that Smith is the cause. If he had not been in the bathroom, the cousin would not have drowned. But, this is not the case in the second. In fact, if Jones had not been in the bathroom, his cousin would still have drowned. Put concisely, Smith was the means of his cousin's death, while Jones was *not* the means of his cousin's death.

Although I do agree with Rachels that this distinction is not strong enough to make Jones' action morally defensible, when it comes to withdrawing life-support and PAS the distinction is important. Examining these two cases, there is the same distinction. On the one hand, when a physician withdraws life-sustaining treatment, he is not the direct means of the patient's death; the underlying, terminal disease is. On the other hand, when a physician prescribes a lethal dose of medication for a patient to consume, she is the means of the patient's death. The American College of Physicians' description of the distinction is nicely worded:

> Withdrawal of treatment based on patient's wishes respects patient's bodily integrity and right to be free of unwanted treatment. PAS/euthanasia are interventions done with the intent to end the patient's life.(58)

But, isn't the act of removing life-support by the physician the cause of the patient's death? If the physician were not there, the patient would still be alive (although still actively dying unlike the child in the tub) on the life-sustaining measures. The common understanding is that withdrawing life-sustaining treatment and not starting life-sustaining treatment are ethically equivalent. There is no distinction between the two. A patient can initially refuse life-sustaining treatment whether a physician is present or not. It is not the presence of the physician that is the cause of the patient's death; it is the underlying disease. This same reasoning can then be applied to withdrawing life-sustaining treatment as it is ethically equivalent.

Foreseeing vs. Intending and the Doctrine of Double Effect

The final argument considers the distinction between foreseeing and intending. What is the difference between giving pain-relieving medication while foreseeing that the needed medication may hasten death and giving a lethal dose of medication with the intention of killing the patient to relieve suffering? The doctrine of double effect is routinely invoked to address this distinction. This doctrine states that the permissibility of an action with a foreseeable evil side effect depends on the intention of the action. The formal formulation is as follows:

1. The action in itself from its object be good or at least indifferent.
2. The good effect and not the evil effect be intended.
3. The good effect be not produced by means of an evil effect.
4. There be a proportionally grave reason for permitting the evil effect.(59)

I will examine and address each of these steps in turn following analyses already discussed by Stephen Latham using classical Catholic moral theories, then use them to show the distinction between PAS and the use of pain medication to relieve suffering.

First, I will examine step one, "The action in itself from its object be good or at least indifferent." Catholic moral theory begins examination of this step with a discussion of interior and external acts. Interior acts are those that one considers only internally. There is no acting upon the outside world. Exterior acts are those that are considered internally and then acted upon the outside world.(60) For example, one might consider eating an apple. This would be an interior act. If that individual then acted upon the outside world to grab and eat an apple, it would be an exterior act. These acts can then be determined good or evil depending on the *object* to which the act aims.(60) An "object of an action is that which the agent sets out to do or effect."(60) Or, simply, an object is the good at which an agent aims.

When considering interior and external acts, it is important to consider the ends of these acts. On the one hand, the object and the end are not the same in external acts. For example, a soccer player's object may be to score a goal, while the end—via the action of scoring—would be to win the game and move onto the semifinals. On the other hand, the object and end are the same in interior acts. Simply thinking about eating an apple has no other end outside the thought itself.

External acts must then be judged as good or evil based on their objects and not the ends.(60) Suppose I wish to help a fellow medical student out by giving her a study guide I made. If my action is to help a fellow medical student (object) by giving her my study guide (end), then the action may be considered good. If, however, my action is to

help bolster my image and reputation as a kind, generous, and cooperative medical student (object) by giving a study guide to her (end), then the action would be evil (or at least less good). Thus, applying this to the original case between PAS and administration of pain medication, the object of the former is killing the patient while that of the latter is administration of morphine. Although they each have the same end to relieve suffering, only the latter is good "in itself from its object."(60)

Step two of the formulation addresses what the actor intends. But how does one determine what someone intends? Catholic moral theory uses a description of the interrelated relationship between Intellect and Will to discuss this. Every human action begins with Intellect, which is the ability to understand the facts of the world and make judgments about them. The Intellect can then decide what it wishes to attain from this understanding and judgment—an end. Will, is then, the setting in motion of actions that will lead to the attainment of this end. Thus, "intention" can then be thought of as the leaning of the Will to attain some end that the Intellect finds desirable. This does not mean that intention is a means to an end, however. For example, if I wish to learn how to play guitar (Intellect's end), my Will can intend to do so, but I still have to find the means to do this—hire a teacher or learn through a video game, etc.(60)

Latham then addresses the distinction between intentions of proximate and distant ends. Without this analysis, one might think that the intention in both cases, PAS and administration of pain medication, is the same, to relieve suffering. It is just the means that are different in each case. But if one considers proximate and distant intentions, this is not true. In both cases, there is a distant intention aimed at the end of being good physicians. In each case, there is a more proximate intention aimed at the end to relieve

suffering that in turn would lead to the distant end of being a good physician. But, in the case of PAS, there is an even more proximate intention aimed at the end of killing the patient to attain the more distant end of the relief of suffering. Thus, one can say that the proximate end of administrating pain medication is relief of suffering, while the proximate end of PAS is killing the patient in order to satisfy the more distant end of relief of suffering.(60)

The third step of the formulation is relatively straightforward and does not need extensive analysis. The good effect must not be produced by an evil act. It would be permissible for me to make my colleague famous by writing an article touting her accomplishments, but it would be impermissible if I made her famous by writing an article filled with slander.

The last step of the formulation, "There be a proportionally grave reason for permitting the evil effect," has to do with the circumstances surrounding the act. In order for an act to be considered good, it must have a good object, good end, and good circumstances.(60) For example, if a child with ruptured appendicitis is in a considerable amount of pain, it would not be justified to give an adequate amount of pain medication to completely relieve his suffering if there was a chance that that amount would lead to his death. Although this is a surgical emergency, the child is highly likely to survive following surgery. If, however, a child is in a considerable amount of pain during a sickle-cell crisis with fulminant multiple organ failure, then a potentially lethal dose of pain medication would be justified. In the latter case there is a proportionally grave reason to give a dose of pain medication that may kill the patient. He is likely to die, thus controlling his pain at the risk of hastening death is permissible.

All that is left now is too apply each of the four steps of the doctrine of double effect to PAS and the administration of pain medication. With regards to PAS: There are two effects of the act, one good (relief of suffering) and one bad (killing the patient). Is the act in itself from its object good? No, the object is to kill the patient. Is the good effect and the not the evil effect intended? No, the proximate end of killing the patient is intended. Is the good effect not produced by means of the evil effect? No, the relief of suffering is produced by means of killing. Is there a proportionally grave reason for permitting the evil effect? As there are doubtless other ways to relieve suffering, this is likely "no." In any case, PAS fails to meet the criteria of the doctrine of double effect and is therefore impermissible.(60)

With respect to administration of pain medication: There are two effects of the act, one good (relief of suffering) and one bad (risk of killing the patient). Is the act in itself from its object good? Yes, the object is to give the patient pain medication. Is the good effect and not the evil effect intended? Yes, the proximate end of relief of suffering is intended. Is the good effect not produced by means of an evil effect? Yes, relief of suffering is produced my means of administration of pain medication. Is there a proportionally grave reason for permitting the evil effect? This depends on the circumstances. If there are ways to relieve suffering that do not put the patient's life at risk, then this is a "no". If there are no alternative approaches, then this is a "yes". In the latter case, administration of pain medication is therefore morally permissible when considering the criteria set forth by the doctrine of double effect.(60)

I foresee two potential arguments against the doctrine of double effect. First, some argue that intention does not and should not matter.(61) It is the outcome that matters, not

the intention (consequentialism). Even if the intention of the physician was not to kill the patient when giving a potentially lethal dose of medication (the intention was to relieve suffering), the act is still morally impermissible if the patient dies because the patient dies. This claim that intention does not matter seems counterintuitive, however. There are numerous acts that have good and bad effects but are still routinely considered permissible. Consider surgery; although a surgeon causes controlled trauma to a human being, it is considered permissible because the intention is to repair an injury or to heal the patient. If intention did not matter, it would be virtually impossible for an individual or society to attain desirable ends.

The second argument states that while intention matters, one is still morally responsible for the ultimate outcome—the death of the patient due to a lethal dose of pain medication. I agree with this statement, but I do not think its veracity is mutually exclusive with the doctrine of double effect. Being held morally responsible for an action does not necessarily have bearing on the determination of the moral permissibility of that action. A physician who inadvertently causes the death of a patient by administering a necessary dose of medication to control pain *is* responsible for the patient's death. The act, however, is still morally permissible as indicated by intention and the doctrine of double effect.

Conclusion

By examining the bioethical arguments of role morality, the "slippery slope," doing vs. allowing, and intending vs. foreseeing, I have shown that PAS is morally impermissible. Included in the physician's role morality is the concept of "do no harm",

which is integral to the safe and ethical practice of medicine. While this doctrine is often breeched when the good benefits outweigh the harms (i.e. surgery), it should never be breeched when the harm is directly and intentionally causing the patients death. Although there is no current data from Oregon to supporting the veracity of the "slippery slope" argument, PAS legalization is still susceptible to it, which could ultimately lead to the more prevalent and expanded use of the practice and the legalization of euthanasia. Next, by examining the ideas of *positive* vs. *negative duties* and introducing vs. diverting threats, it is clear that withdrawing life-support and PAS are morally distinct practices—the former is "allowing" and the latter is "doing". Finally, a close examination of the proximate intentions of PAS and relieving pain with administration of a possibly lethal dose of medication reveal that they are morally distinct, and the criteria of the doctrine of double effect is met for administering pain medication but not for PAS.

Concluding Remarks

In this thesis, I first showed that there are several important aspects of physicians' beliefs about PAS that should be considered when discussing the appropriateness of legalizing PAS nationally. I then presented through discussions of several, well-established bioethical considerations—role morality, the "slippery slope", doing vs. allowing, and foreseeing vs. intending—that the practice of PAS is morally impermissible. It is clear that this issue is heavily nuanced and is more complex than just an argument to relieve suffering and respect the autonomy of dying patients.

Perhaps medicine should push for a treatment of death and dying different from endorsing a practice that intentionally kills patients. Death in the US and most of the western world has been "medicalized."(36) Rather than being surrounded by community and family, death and dying has moved to the domain of medicine, as a large portion of patients at the end of life die in the hospital. One of the most important reasons for this is how the medical profession and society more broadly handle death. Death is something to be shunned, ignored, and saved for a later day. Especially in medicine, the topic of death is routinely averted in cases where it should necessarily be discussed. Moreover, death is treated like something that can be conquered or cured rather than an inevitable part of life. As a result, patients and physicians address death and face difficult end-of-life decisions for the first time when it is already too late—when patients are already dying in the hospital. These circumstances obviously lead to inferior end-of-life decision-making and care.

I am under no illusion that death is an easy topic to talk or think about. It certainly is not. As mentioned before, we, as humans, have an inherent, existential uneasiness or

"ambivalence" toward death.(25) But, I think we can, and need, to do better to initiate conversations about death and dying early and often. In her book, Lydia Dugdale uses the *Ars Moriendi* as an example of what this might look like.(62) The Catholic Church in Europe released this handbook in the decades following Europe's worst outbreak of the Bubonic Plague. It was essentially a checklist of items that people could use to prepare for the death of themselves and their loved ones and offered a framework that spiritually, emotional, and practically prepared individuals to confront and accept the inevitability of death.

A system like this would certainly look different in 2019, but if there were a profession-wide, and society-wide, push to create a system that strove for the similar preparation for death, it could transform the quality of end-of-life care. Most patients who ask for physician-assisted suicide do so because of loss of autonomy and being less able to engage in activities that make life enjoyable.(26) These are existential concerns, not concerns about physical pain. I have to wonder that if we had a system alike to the *Ars Moriendi* in place that prepared individuals for death, existential concerns at the end of life would be minimized and a practice like physician-assisted suicide would be superfluous and obsolete.

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Appendices

Appendix 1

Please indicate for each of the questions how important each item is for you when thinking about the legalization and practice of physician-assisted suicide.

1) Patients will perceive the medical profession more positively.
a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree
2) Patients will perceive the medical profession more negatively.
a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree
3) Patients will trust their doctors less.
a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree
4) Patients will trust their doctors more.
a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree
5) Legalization of PAS would negatively affect marginalized or underserved communities, including but not limited to racial and ethic minorities, the disabled, the elderly, and those of lower socioeconomic status.
a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree
6) The legalization of PAS with save health care system money.
a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree
7) Medical professionals should never intentionally induce death ("do no harm" argument).

a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree

8) The legalization of PAS will lead to the legalization of euthanasia ("slippery slope" argument)

a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree

9) The legalization of PAS will improve the clinical care of patients at the end-of-life.

a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree

10) The legalization of PAS will worsen the clinical care of patients at the end-of-life.

a) Strongly agree
b) Agree
c) Neutral
d) Disagree
e) Strongly disagree

Are there any factors that affect how you think about PAS that are not listed above? If so, please list them here (free response):

Appendix 2

Introduction

In this study, we would like to know your views on physician-assisted suicide (PAS), also known as aid-in-dying (AID), in the United States.

PAS/AID occurs when physicians provide patients with prescriptions for lethal medications that patients may self-administer with the intention of ending their lives. PAS/AID is currently legal in six US states, decriminalized in one state, and illegal in forty-three.

This practice is distinct from euthanasia, in which a physician directly administers a drug or drugs with the intention of ending the patient's life.

Legality of PAS/AID

1. In your opinion, should PAS/AID be legal in your state?

☐Yes ☐No

2. In your opinion, should PAS/AID be decriminalized in your state?

☐Yes ☐No

3. If legal or decriminalized, would you participate in the practice of PAS/AID?

☐Yes ☐Possibly ☐Unlikely ☐Never

Current Practices of PAS/AID

Please indicate to what extent you agree or disagree with the following statements for the practice of PAS/AID in states where it is currently legal:

4. Most patients who seek PAS/AID do so because of physical pain.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

5. Current PAS/AID laws provide safeguards (patient must be competent, ≥ 18 yo, prognosis ≤ 6 mo, capable of self-administration of medication, request observed by 2 witnesses).

These safeguards are adequate to protect patients seeking PAS/AID.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

6. Current PAS/AID laws require physicians who suspect depression or other mental illness in a patient seeking PAS/AID to consult a psychiatrist.

Physicians who are not psychiatrists are sufficiently trained to screen for depression in patients who are seeking PAS/AID.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

7. Most physicians can predict with certainty whether a patient seeking PAS/AID has 6 months or less to live.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Implications of PAS/AID

To what extent do you agree or disagree with the following statements.

If PAS/AID were legalized throughout the United States:

8. PAS/AID would improve the clinical care of patients at the end-of-life.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

9. Patients would view the medical profession more negatively.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

10. Patients would trust their physicians more.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

11. Racial and ethnic minorities would feel pressure to end their lives.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

12. Patients with lower socioeconomic status would feel pressure to end their lives.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

13. Patients with mental or physical disabilities would feel pressure to end their lives.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

14. PAS/AID would save money for the health care system.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

15. Health insurance companies would cover PAS/AID over more expensive, possibly life-saving treatments, like chemotherapy.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

16. PAS/AID would lead to an increased number of medical malpractice suits.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

17. PAS/AID would lead to an increase in suicides in the community.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

18. PAS/AID would lead to the legalization of euthanasia.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

Other Considerations Regarding PAS/AID

Please indicate to what extent you agree or disagree with the following statements:

19. Sometimes providing PAS/AID is necessary in order to relieve suffering.

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

20. Sometimes providing PAS/AID is necessary in order to respect patient autonomy.

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

21. There are important ethical distinctions between PAS/AID and withdrawing life-support.

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

22. PAS/AID would be unnecessary if all patients had access to excellent palliative care.

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

23. The medical profession should endorse PAS/AID as a morally valid medical option**.**

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

24. Physicians who participate in PAS/AID thereby abandon their patients.

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

25. A patient's request for PAS/AID should override the physician's moral objections to performing it.

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐

Physician Perspectives on Death

Please indicate to what extent you agree or disagree with the following statements about death:

26. I am comfortable talking with patients about death.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

27. My ability to think about my own mortality is relevant to providing good care for patients at the end of life.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

28. Medical professionals should never intentionally hasten a patient's death at the end of life.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
☐	☐	☐	☐	☐

29. How often are you faced with end-of-life issues in your daily practice?

- ☐ Several times a week
- ☐ Every week
- ☐ Nearly every week
- ☐ Two to three times a month
- ☐ About once a month
- ☐ Several times a year
- ☐ About once or twice a year
- ☐ Less than once a year
- ☐ Never

30. If you think PAS/AID should be legal or decriminalized but would unwilling or unlikely to perform it yourself, please explain why.

If you would be willing to participate in a 10-20 minute confidential phone interview about physician-assisted suicide/aid-in-dying and the practice of medicine, please check this box ☐ and indicate below the preferred way to reach you. A portion of respondents who volunteer will be contacted.

Phone number: (_____) _____

E-mail: _____

Demographics

In the following questions, please tell us more about you and your practice.

31. Do you practice in a Veterans Affairs facility?

☐Yes ☐No

32. If not, approximately what percent of the patients that you serve are on Medicaid or underinsured?

☐0-14%
☐15-29 %
☐30-44 %
☐45-59 %
☐60-74 %
☐75-89 %
☐90-100 %

33. How old are you?

☐25-34 yrs
☐35-44 yrs
☐45-54 yrs
☐55-64 yrs
☐65-75 yrs
☐75+ yrs

34. What is your preferred gender identity?

_____ (leave blank if you do not wish to specify)

35. Do you consider yourself Hispanic or Latino?

☐Yes
☐No

36. How would you classify your race? [CHECK ONLY ONE]

☐Asian
If Asian, do you think of yourself as…
☐East Asian or Pacific Islander
☐South Asian
☐Other Asian
☐Black or African American
☐American Indian or Alaskan Native
☐White or Caucasian
☐Other (please specify): _____
☐Do not wish to specify

37. What is your medical specialty?

☐Internal Medicine
Subspecialty: _____
☐Surgery
Subspecialty: _____
☐Psychiatry
☐Obstetrics/Gynecology
☐Neurology
☐Emergency Medicine
☐Anesthesia
☐Other
Please specify:_____

THANK YOU FOR YOUR PARTICIPATION!