One Pager

Physician-Assisted Suicide

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Physician-Assisted Suicide

What Is the Issue?

American society is at a critical inflection point on issues related to the end of life. Advocates for physician-assisted suicide tout the practice as one which fosters personal autonomy, values compassion, and delivers "death with dignity." In some ways their efforts have unfortunately borne fruit, albeit rotten fruit—the trend toward the normalization and legalization of physician-assisted suicide has recently quickened. It took 20 years for the first four states to legalize physician-assisted suicide, but over the last five years, six additional jurisdictions have joined them. Currently, physician-assisted suicide is legal in California, Colorado, the District of Columbia, Hawaii, Maine, Montana, New Jersey, Oregon, Vermont, and Washington, and efforts to legalize it elsewhere continue apace.

Despite this development, however, Americans have traditionally rejected physician-assisted suicide when they are presented with all the facts. Indeed, since Oregon passed the Death with Dignity Act in 1994 by ballot measure by the narrow margin of 51% to 49%, some 30 states have rejected physician-assisted suicide, even though roughly 175 different proposals have been put forth over the years nationwide to legalize it in various jurisdictions. And 33 states currently maintain statutes criminalizing assisted suicide. In addition, the United States Supreme Court and numerous state courts have refused to find that there is a fundamental constitutional right to physician-assisted suicide, thereby leaving the issue to be resolved by the political process at the state level.

What Are the Stakes?

The stakes could not be higher. The lives of the terminally ill, the sick, the disabled, the poor, and the depressed are put directly at risk by physician-assisted suicide. This practice is sold by pro-death organizations as a way to ensure "death with dignity," but it delivers nothing of the kind. Experiences drawn from Europe and the U.S. states which now permit physician-assisted suicide show that wherever it is normalized, it harms those who need competent medical care and community services the most, perversely offering death at the very time they need life-preserving care. Physician-assisted suicide also turns doctors from healers into killers, rendering the Hippocratic Oath a dead letter. Finally, physician-assisted suicide guarantees a slippery slope in which a "right to die" inevitably morphs into a "duty to die," as those who are terminally ill or disabled are made to feel guilty for their condition and

encouraged to resort to suicide to ease the supposed "burden" on others and society posed by their continued existence.

Put as simply as possible, physician-assisted suicide radically transforms the way we view and treat the sick, disabled, and dying, and introduces a cold, utilitarian calculus totally alien to our traditions. It views people as dispensable if they cost too much to treat or heal, and it offers an untimely death as a solution to what it views as a burdensome cohort of our fellow citizens. And if the movement toward accepting physician-assisted suicide is not stopped, its application will only broaden. Those who confidently predicted in their own jurisdictions that the practice would be limited and would be properly policed by procedural safeguards have now—under the hard counsel of experience—had to admit that physician-assisted suicide inevitably justifies more and more killing for more and more citizens for more and more reasons. Once we accept its logic, physician-assisted suicide becomes a runaway train leading to a culture of death, endangering not just the vulnerable but also people deemed otherwise expendable by those in power.

What Should Be Done?

While of course not perfect, we already have good answers as to how to help the terminally ill, the sick, the disabled, the poor, and the depressed. Palliative care has greatly improved in the last decade to treat those with terminal diagnoses and keep them comfortable and integrated with family in their remaining time. Meanwhile, medical treatments, modalities, and community initiatives to assist the chronically sick, the disabled, and the poor have grown more sophisticated and responsive. And treatments for mental illness and depression have also improved greatly, to include widespread suicide prevention efforts. This is no time to give in to the siren song of physician-assisted suicide. The vulnerable among us deserve better than what is being sold by the advocates of death, and we are more than capable of providing it. The alternative to physician-assisted suicide is to continue practicing medicine as we have since the time of Hippocrates, and to harness what we have come to know about treating terminal illnesses, disabilities, and depression to provide integrated care to those who need it so they can live fulfilled lives. Physician-assisted suicide promises compassion and dignity but delivers only premature death, and neither our doctors nor we as a society have any business promoting or facilitating it.