Assisted Suicide - A Few Answers—Many Questions

Robert B. Wallace, MD, Robert S. Olick, JD, PhD
Guest Editorial

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In this issue of The Gerontologist, Roscoe, Malphurs, Dragovic, and Cohen (2001) describe a series of 69 persons who, based on reports from the Oakland County, Michigan, Medical Examiner, underwent physician-assisted suicide (PAS), assisted by Dr. Jack Kevorkian during the years 1990–1998. Contrast groups in this article are 43 persons who underwent PAS according to Oregon statues in 1998–1999 and 1999 U.S. mortality data. The contrasts are of some interest. The Oakland County cases were more likely to be White, female, and divorced or never married compared with the 1999 U.S. average and more likely to be younger than the Oregon PAS cases. In addition, the Oakland Country cases were much less likely to have cancer or be under hospice care at the time of death.

We believe that Roscoe and colleagues’ case series is a useful addition to the literature on PAS, as it was generated by forensic pathology protocols. However, readers should be aware of the limitations of the information provided. The Oakland County situation is related to the activity of only one physician, someone who has received substantial media attention in recent years. Also, some unspecified proportion of the Oakland County cases were autopsied in other jurisdictions; these cases may reflect persons with higher economic means and a lower level of clinical disability, which are requisite for their travel to Oakland County from other geographic locations. For these and other reasons, Roscoe and colleagues report that these investigations were done, but they do not indicate how complete the reviews were. It is important to keep in mind that clinical conditions found at autopsy among those dying of PAS, or any other unnatural cause, are not the same as underlying causes of death under natural circumstances. For example, prevalent atherosclerosis and cancer are common findings at autopsy and are often not clinically apparent, suspected, or relevant.

Any discussion of Jack Kevorkian naturally invites reflection on the ethics of PAS. It is important, however, to maintain focus on the authors’ express intent “to identify and clarify the characteristics of persons for whom assisted death was a desirable option.” They make no attempt to present an argument for or against legalizing PAS or the conditions under which this would be deemed morally justified. References to “Kevorkian euthanasia cases” and comparisons with “legalized physician-assisted suicide” in Oregon may suggest underlying moral positions. But the reader should be careful not to infer a normative prescription from an empirical description; to derive an “ought” from an “is.”

The Oregon Death With Dignity Act (1995), enacted following a state ballot referendum, legalizes a physician’s prescription intended to be self-administered by the patient under certain defined circumstances, including most importantly that the patient

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is an adult whose terminal disease is confirmed by a second physician, and that the patient has decision-making capacity and makes a voluntary, informed choice with both an oral and written request for medication. Oregon also requires that if either the attending or consulting physician believes the patient “may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment,” either physician shall refer the patient for counseling (Oregon Death With Dignity Act, 1995). Roscoe and colleagues’ study appears to offer support for this latter requirement. It also contributes data that should prove useful in identifying persons with chronic illnesses who may be at increased psychosocial risk and more likely to seek out PAS; this information is helpful for the continuing dialogue regarding the options and support services that medicine and society can and should offer patients near the end of life. However, other issues related to the provision of medical care are not addressed. It would have been of value, for example, to determine the objective adequacy and quality of medical care provided in the period prior to PAS. Are important conditions undiagnosed? Is medical therapy, such as pain management, suboptimal?

As noted by Roscoe and colleagues, PAS is illegal (criminalized) in the vast majority of states. But the extant legal status of PAS is neither the first nor last word on what continues to be a lively ethical and policy debate. When the U.S. Supreme Court ruled in 1997 that individuals do not have a constitutionally protected right to PAS, a unanimous Court also made clear that the debate can and should continue in the laboratory of the states (Washington v. Glucksberg, 1997; Vacco v. Quill, 1997). This article by Roscoe and colleagues will further that debate.

References