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Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide

*Marshall B. Kapp**

The current controversy in the United States over the morality and constitutionality of state statutes that prohibit physicians from assisting patients to commit suicide entails a variety of difficult ethical¹ and legal² issues. In policy terms, the debate has tended to focus on whether legislatures can erect sufficiently stringent yet workable safeguards within state statutes authorizing physician-assisted suicide to protect against serious ethical abuses of this patient/physician prerogative. Proponents of decriminalizing physician-assisted suicide take the affirmative position on this question.³ Skeptics, on the other hand, suggest that opening the door to physician-assisted suicide, however cautiously and conservatively, would inevitably lead (as it apparently has in the current Netherlands experiment with non-prosecution of physicians for participating in physician-assisted

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1. See, e.g., Task Force on Physician-Assisted Suicide of the Society for Health and Human Values, *Physician-Assisted Suicide: Toward a Comprehensive Understanding*, 70 *ACAD. MED.* 583 (1995); Peter B. Terry, *Euthanasia and Assisted Suicide: Ethics and Politics*, 103 *CHEST* 4 (1993).

2. See *Lee v. State of Oregon*, No. 96-6467-HO (D.Or. 1996) (invalidating results of state voter initiative legalizing physician assisted suicide); *Compassion in Dying v. Washington*, 850 F.Supp. 1454 (W.D. Wash 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd*, 79 F.3d 790 (9th Cir. 1996) *en banc*, *reh'g denied*, 85 F.3d 1440 (9th Cir. 1996) *en banc* (invalidating Washington statute prohibiting physician assisted suicide on 14th Amendment due process right to liberty grounds) *cert. granted sub nom*, *Washington v. Glucksburg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110); *Quill v. Koppell*, 870 F.Supp. 78 (S.D.N.Y. 1994), *rev'd in part and aff'd in part, sub nom.*, *Dennis v. Vacco*, 80 F.3d 716 (2nd Cir. 1996), *cert. granted sub nom*, 64 U.S.L.W. 3795 (U.S. Oct. 1, 1996) (No. 95-1858) (invalidating New York statute prohibiting physician-assisted suicide on 14th Amendment equal protection grounds): See generally T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States: Legal and Ethical Observations*, 16 *J. LEGAL MED.* 481 (1995).

3. See, e.g., Charles H. Baron, et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 *HARV J. LEGIS.* 1 (1996); Paul Cotton, *Rational Suicide: No Longer 'Crazy'?* 270 *JAMA* 797 (1993) (noting that "a shift is under way in societal thinking on the issue, the *zeitgeist* is changing. . . . The question is will we shift wisely and with adequate safeguards?")

suicide)⁴ to a movement in principle and practice down a moral slippery slope toward unintended consequences⁵ that almost everyone would condemn.

Most of the arguments on both sides of this discussion have been crafted in generic terms. While a persuasive case against recognition of a constitutional right to physician-assisted suicide generally can be mounted, as analyzed in the particular context of elderly individuals, the anxieties of the slippery slope skeptics appear especially compelling. These are anxieties evidently shared by a substantial portion of the elderly population, since public opinion polls consistently show lower support for legalization of physician-assisted suicide among older citizens than among younger citizens.⁶ The primary reasons for these well-founded worries are briefly outlined below.

I. PARTICULAR RISKS FOR THE ELDERLY

A. *Decision Making Capacity*⁷

In health care decision making generally,⁸ legally and ethically valid choices depend on (besides adequate information and

4. Nancy S. Jecker, *Physician-Assisted Death in the Netherlands and the United States: Ethical and Cultural Aspects of Health Policy Development*, 42 J. AM. GERIATRICS SOC'Y 672 (1994); M.T. Muller et al., *Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?* 42 J. AM. GERIATRICS SOC'Y 624 (1994) (noting that physician-assisted suicide in Dutch nursing homes, which have a primarily elderly patient population, more often than not deviates in practice from the safeguards to which Dutch prosecutors have agreed); CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* (1991). For other international comparisons, see RONALD DWORKIN, *LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 254 n.3 (1993) (discussing laws against assisted suicide in England, France, Germany, Italy, Switzerland, Denmark, Norway and Poland).

5. Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 20 U. RICHMOND L. REV. 1 (1996); Glenn C. Graber & Jennifer Chassman, *Assisted Suicide Is Not Voluntary Active Euthanasia, But It's Awfully Close*, 41 J. AM. GERIATRICS SOC'Y 88 (1993); Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 225 (John Keown, ed., 1995). See Edmund P. Pellegrino, *Compassion Needs Reason Too*, 270 JAMA 874 (1993) (stating that "... euthanasia and assisted suicide are socially disastrous. They are not containable by placing legal limits on their practice. Arguments to the contrary, the 'slippery slope' is an inescapable logical, psychological, historical and empirical reality").

6. Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying? The Public Perspective*, 267 JAMA 2658, 2659 (1992).

7. In this article, the term "decision making capacity," which is a working, clinical concept, is used instead of "competence," which implies a formal legal declaration of the individual's status by a court usually in the context of a guardianship proceeding. See MARSHALL B. KAPF, *KEY WORDS IN ETHICS, LAW, & AGING: A GUIDE TO CONTEMPORARY USAGE* 15-16 (1995).

8. For background on informed consent generally, see, e.g., PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL

voluntariness)⁹ the presence of a cognitively and emotionally capable decision maker. Although defining and evaluating a patient's decision making capacity is an extremely complex and uncertain endeavor,¹⁰ in essence an individual capable of making decisions has the functional ability to make and express authentic choices, give reasons for those choices indicating deliberation, comprehend and manipulate information material to those choices, and understand the potential personal consequences of the choices.¹¹

As even proponents of physician-assisted suicide have acknowledged,¹² a capable decision maker is an especially indispensable prerequisite in a physician-assisted suicide situation, as the costs of error are so great and irremediable. Notably, there are at least a couple of grounds for suspecting that a suicidal individual's capacity may be particularly problematic in cases of purported requests for physician-assisted suicide by older persons.

First, the prevalence of dementia increases dramatically in older patients.¹³ While the presence of dementia (a diagnostic category) by itself, particularly in its early stages, does not necessarily equate with decisional incapacity (a functional concept),¹⁴ in its more severe stages, dementia ordinarily does substantially interfere with an individual's ability to engage in a rational decision making process with respect to important and complicated matters. Physician-assisted suicide certainly qualifies as such a matter.

Much has been made in contemporary ethical and legal discourse of the possibilities for competent patients to guide their

RESEARCH, MAKING HEALTH CARE DECISIONS (1982); PAUL S. APPELBAUM ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE (1987).

9. See discussion *infra* nn. 29-43 and accompanying text.

10. Marshall B. Kapp & Douglas Mossman, *Measuring Decisional Capacity: Cautions on the Construction of a 'Capacimeter'*, 2 PSYCHOL. PUB. POL'Y, & L. 73 (1996).

11. See Marshall B. Kapp, *Assessment of Competence to Make Medical Decisions*, PRACTICAL HANDBOOK OF CLINICAL GERONTOLOGY 174, 179-181 (Laura L. Carstensen et al., eds., 1996); Marshall B. Kapp, *Evaluating Decisionmaking Capacity in the Elderly: A Review of Recent Literature*, 2 J. ELDER ABUSE & NEGLECT 15 (Fall/Winter 1990).

12. See, e.g., Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 NEW ENG. J. MED. 1384, 1386 (1992); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1382 (1992).

13. David S. Geldmacher & Peter J. Whitehouse, *Current Concepts: Evaluation of Dementia*, 335 NEW ENG. J. MED. 330 (1996); William E. Reichman & Jeffrey L. Cummings, *Dementia*, PRACTICE OF GERIATRICS 295-96 (Evan Calkins et al., eds., 2nd ed. 1992); Jeffrey L. Cummings & Lissy F. Jarvik, *Dementia*, in GERIATRIC MEDICINE 428 (Christine K. Cassel et al., eds., 2nd ed. 1990).

14. Panagiota V. Caralis, *Ethical and Legal Issues in the Care of Alzheimer's Patients*, 78 MED. CLINICS N. AM. 877, 878 (1994).

future medical care in the event of subsequent decisional incapacity through the execution of various forms of advance directives.¹⁵ Proposals set forth thus far for physician-assisted suicide would all limit this option to patients with sufficient *present* decisional capacity to request physician-assisted suicide very shortly before its implementation.¹⁶ It is questionable whether such a restriction, if embodied in a statute, could withstand Equal Protection scrutiny, especially if a right to physician-assisted suicide were not only recognized by the courts but held to be fundamental in kind. Perhaps more pertinent from a practical perspective is the fact that most people want to stay alive as long as they remain mentally intact; indeed, it is only at the point of severe mental deterioration, including decisional incapacity, when some persons would anticipate such a gruesome quality of life that they might ever contemplate an assisted (or an unassisted) suicide option. As G. Kevin Donovan stated:

After all, if assisted suicide is a benefit, why should it be denied to those who waited too late to ask, aren't yet sick enough to merit it, or will never be competent enough. . . . If the guidelines are meant to protect the most vulnerable members of society, how do we justify at the same time depriving them of this benefit? The conflict is both inherent and inevitable.¹⁷

At the same time, allowing physician-assisted suicide for patients incapable of making decisions through previously executed advance directives, with all of the ambiguities and uncertainties already attending the rise of advance directives in other contexts,¹⁸ would open the door to precisely the types of abuse that proposals to limit physician-assisted suicide to presently capable patients are intended to prevent. On the other hand, legalizing physician-assisted suicide while restricting its availability to individuals with contemporaneous decisional capacity creates a significant risk that individuals diagnosed with early stage dementias would panic and request physician-assisted suicide preemptively and prematurely out of fear of waiting too long.¹⁹ It is likely, too, that unassisted suicides by early stage dementia patients would become more common in this scenario out of the patients' feeling of necessity to act decisively within an

15. See NANCY M.P. KING, MAKING SENSE OF ADVANCE DIRECTIVES (rev. ed. 1996).

16. See, e.g., TIMOTHY E. QUILL, DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE 161-62 (1993).

17. G. Kevin Donovan, *Letter: Physician-Assisted Suicide*, 274 JAMA 1911 (1995).

18. For a discussion of these ambiguities and uncertainties, see Joan M. Teno et al., eds., *Advance Care Planning: Priorities for Ethical and Empirical Research*, 24 HASTINGS CENTER REPORT S1-S36 (Special Supp. Nov.-Dec. 1994).

19. See Stephen G. Post, *Alzheimer's Disease: Ethics and the Progression of Dementia*, 10 CLINICS GERIATRIC MED. 379, 385-86 (1994).

accelerated time frame.²⁰ The rapid scientific refinement and public availability of genetic testing techniques that may be useful in making more definitive differential diagnoses of early Alzheimer's disease²¹ can only complicate this scenario.

A second and closely related decisional capacity problem is the prevalence of depression among older, and especially seriously ill, patients.²² As with dementia, the simple bestowal of a diagnostic label on older patients should not inevitably lead to an assumption of the global inability of these patients to make medical choices. Nonetheless, an impressive body of evidence indicating a clear connection between severe depression in elderly individuals (not infrequently exacerbated by excessive use of alcohol)²³ and difficulties in complex medical decision making processes,²⁴ as well as a connection between treatable depression and a desire for death in critically ill patients,²⁵ should heighten the discomfort about potential abuses of physician-assisted suicide with the older population.

Further, the notion that physicians are able to distinguish ethically and with any socially acceptable degree of confidence and precision between individuals who are capable of making decisions and older individuals who are not is suspect.²⁶ Even if psychiatric consultation is sought in difficult cases (and most situations of physician-assisted suicide requests ought to be placed

20. Kirsten Rohde et al., *Suicide in Two Patients With Alzheimer's Disease*, 43 J. AM. GERIATRICS SOC'Y 187 (1995).

21. National Institute on Aging/Alzheimer's Association Working Group, *Apolipoprotein E Genotyping in Alzheimer's Disease*, 347 LANCET 1091 (1996).

22. Agency for Health Care Policy and Research, U. S. Dep't of Health and Human Services, AHCPR Pub. No. 93-0550, *Depression in Primary Care*, 1 DETECTION AND DIAGNOSIS 40-41 (1993).

23. See Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 ISSUES L. & MED. 415, 427-28 (1995).

24. Linda Ganzini et al., *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Treatment*, 151 AM. J. PSYCHIATRY 1631 (1994); Melinda A. Lee & Linda Ganzini, *The Effect of Recovery From Depression on Preferences for Life-Sustaining Therapy in Older Patients*, 49 J. GERONT.: MED. SCI. M15 (1994) (noting that depressed patients exhibit less consistency in their preferences over time than nondepressed persons); Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143 (1993); Melinda A. Lee & Linda Ganzini, *Depression in the Elderly: Effect on Patient Attitudes Toward Life-Sustaining Therapy*, 40 J. AM. GERIATRICS SOC'Y 983 (1992). But see Erich H. Loewy, *Of Depression, Anecdote, and Prejudice: A Confession*, 40 J. AM. GERIATRICS SOC'Y 1068 (1992) (interpreting certain research as casting doubt on the connection between depression and impaired decision-making ability).

25. Harvey Max Chochinov et al., *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCHIATRY 1185 (1995).

26. See Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 NEW ENG. J. MED. 1100 (1991).

in this category), as suggested by Timothy Quill and colleagues,²⁷ there is no assurance either that the psychiatrist would have any special training and expertise in evaluating the decisional capacity of older persons for physician-assisted suicide purposes,²⁸ or that insurers would routinely pay for such consultations.

B. *Voluntariness*

In health care decision making generally, and certainly in the context of physician-assisted suicide, only voluntary patient requests made without duress, undue influence or coercion have any plausible claim to legal and ethical legitimacy.²⁹ Several factors may significantly and perhaps inherently impinge on the voluntariness of purported requests for physician-assisted suicide made by elderly patients.

First, the United States is currently a fundamentally ageist society in which older individuals are often made to feel that they are of little or vastly reduced worth.³⁰ Despite the tremendous (arguably even disproportionate)³¹ public financial resources devoted to the health care and income support of the elderly mainly for political reasons,³² the continual social message to which the elderly are exposed is a theme that glorifies youth and vitality while devaluing the present contributions of the aged. The upshot of this psychological atmosphere is a potential endangerment of older individuals' freedom of choice. As Nancy Osgood noted:

Older people, living in a suicide-permissive society characterized by ageism, may come to see themselves as a burden on their families or on society and feel it is incumbent on them to take their own lives The right to die then becomes not a right at all but rather an obligation In a society that devalues old age and old people, in which older adults are seen as 'expendable' and as an economic burden on younger members, older people may come to feel it is their social duty to kill themselves.³³

Put somewhat differently:

27. Quill et al., *supra* note 12, at 1382.

28. Cf. Marshall B. Kapp, *Implications of the Patient Self-Determination Act for Psychiatric Practice*, 45 HOSP. & COMM. PSYCHIATRY 355 (1994).

29. ALAN MEISEL, *THE RIGHT TO DIE* 98-99 (2nd ed. 1995).

30. See, e.g., ROBERT N. BUTLER, *WHY SURVIVE? GROWING OLD IN AMERICA* (1968).

31. See, e.g., PHILLIP LONGMAN, *THE RETURN OF THRIFT: HOW THE COLLAPSE OF THE MIDDLE CLASS WELFARE STATE WILL REAWAKEN VALUES IN AMERICA* 73-86 (discussing Social Security), 93-4 (Medicare), 127-39 (veterans' benefits), 140-56 (military retirement benefits), 157-68 (government retiree benefits) (1996).

32. See, e.g., ROBERT J. SAMUELSON, *THE GOOD LIFE AND ITS DISCONTENTS: THE AMERICAN DREAM IN THE AGE OF ENTITLEMENT* 143 (1995).

33. Osgood, *supra* note 23, at 418.

The problem . . . involves the voluntariness of the decision. If choosing death becomes a socially accepted alternative, then patients needing much care may begin to consider themselves selfish merely for choosing to live. The pressure on the elderly . . . would be particularly great if death came to be seen as a 'solution' to . . . old age.³⁴

Notably, the impact of an ageist society is evidenced already in the disproportionately high rate of suicide attempts and completions among the elderly in the United States.³⁵ By contrast, the suicide rate of the elderly in societies which hold and communicate more respect for the aged is a much rarer event.³⁶

A second ground for suspicion about the voluntariness of an older individual's purported request for physician-assisted suicide arises from the role of an individual's family in this decision. While normally, families of older patients are an integral, positive force in supporting and assisting the effectuation of the patient's autonomous decision making, this is not always the case.³⁷ The psychological, physical and financial burdens on family members of very sick and frail individuals, especially those with chronic conditions requiring extensive, ongoing provision of care in the home, are great and can affect the patient's exercise of autonomy in many different ways.³⁸ With respect to the present analysis, even the most sincere and well-intentioned families³⁹ in such circumstances may end up, consciously or not, subtly or more directly pressuring the older patient to relieve the family's burden by selecting the physician-assisted suicide option.⁴⁰ The stress on the family, regardless of its palpability and magnitude, can never be a morally or legally acceptable justification for unduly influencing a vulnerable older person to agree to premature active death hastening.⁴¹ Nevertheless, when combined with an older person's own sense of guilt about imposing a burden on the family because of continuing life and thus continuing

34. JOHN F. KILNER, *LIFE ON THE LINE: ETHICS, AGING, ENDING PATIENTS' LIVES, AND ALLOCATING VITAL RESOURCES* 114 (1992).

35. Robert L. Frierson, *Suicide Attempts by the Old and the Very Old*, 151 *ARCH. INTERN. MED.* 141 (1991); Yeates Conwell et al., *Completed Suicide at Age 50 and Over*, 38 *J. AM. GERIATRICS SOC'Y* 640 (1990).

36. Jennifer A. Zima, Student Note, *Assisted Suicide: Society's Response to a Plea for Relief or a Simple Solution to the Cries of the Needy?*, 23 *RUTGERS L. REV.* 387, 398 (1992).

37. Carin E. Reust and Susan Mattingly, *Family Involvement in Medical Decision Making*, 28 *FAM. MED.* 39 (1996); Marshall B. Kapp, *Health Care Decision Making by the Elderly: I Get By With a Little Help From My Family*, 31 *GERONTOLOGIST* 619 (1991).

38. Cf. Marshall B. Kapp, *Who's the Parent Here? The Family's Impact on the Autonomy of Older Persons*, 41 *EMORY L. J.* 773 (1992).

39. Not all families meet this ideal. See, e.g., Osgood, *supra* note 24, at 431-32.

40. See Hendin & Klerman, *supra* note 24, at 144.

41. James S. Goodwin, *Mercy Killing: Mercy for Whom?*, 265 *JAMA* 326 (1991).

the individual's provision of care,⁴² any pressure brought by the family can exert a powerful psychological force on the dependent patient's choices and actions.⁴³

C. Ageism in the Health Care System

As noted above, the voluntary nature of an older person's purported request for physician-assisted suicide is threatened both by general ageism in American society and by caregiver burden and other forces acting on the patient's family. Voluntariness, as well as the "informed" component of an older patient's physician-assisted suicide decision, may also be jeopardized by ageist attitudes and practices that directly pervade the present health care delivery system.

From the earliest part of their training, physicians and other health professionals are taught to devalue the lives of older patients.⁴⁴ One important way in which this attitude becomes manifested in practice is demonstrated by the overwhelming evidence that chronological age, *by itself* (that is, not used as a proxy for or indicator of some other, more clinically and ethically defensible consideration such as likely prognosis), frequently is a large risk factor for specific older patients being offered less aggressive medical treatment than normally would be offered to a younger, otherwise identical patient.⁴⁵ Thus, as verified most recently in the major national Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUP-PORT),⁴⁶ old age *per se* is used consciously or subconsciously by

42. Concerns about being a burden on one's family are a major reason that Americans cite for considering alternatives to end their lives. Blendon et al., *supra* note 6, at 2660.

43. Rohde, *supra* note 20, at 188; Jecker, *supra* note 4, at 676.

44. See, e.g., Jecker, *supra* note 4, at 676.

45. Terri R. Fried et al., *The Association Between Age of Hospitalized Patients and the Delivery of Advanced Cardiac Life Support*, 11 J. GEN. INTERN. MED. 257 (1996); Teri A. Manolio & Curt D. Furberg, *Age As a Predictor of Outcome: What Role Does It Play?*, 92 AM. J. MED. 1 (1992); Charles L. Bennett et al., *Patterns of Care Related to Age of Men With Prostate Cancer*, 67 CANCER 2633 (1991); Robert J. Mayer & W. Bradford Patterson, *How Is Cancer Treatment Chosen?*, 318 NEW ENG. J. MED. 636 (1988) (criticizing this practice and arguing for more individualization of the way physicians shape treatment decisions among elderly patients); Terrie Wetle, *Age As a Risk Factor for Inadequate Treatment*, 258 JAMA 516 (1987); Steven Neu & Carl M. Kjellstrand, *Stopping Long-Term Dialysis: An Empirical Study of Withdrawal of Life-Supporting Treatment*, 314 NEW ENG. J. MED. 14 (1986); Norman K. Brown & Donovan J. Thompson, *Nontreatment of Fever in Extended-Care Facilities*, 300 NEW ENG. J. MED. 1246 (1979). See also, *Editorial: Do Doctors Short-Change Old People?*, 342 LANCET 1 (1993) (stating that age bias affecting medical care is not a strictly American phenomenon). See also Jeremiah A. Baroness et al., *Clinical Decision-Making in Catastrophic Situations: The Relevance of Age*, 36 J. AM. GERIATRICS SOC'Y 919 (1988).

46. Rosemarie B. Hakim et al., *Factors Associated With Do-Not-Resuscitate Orders: Patients' Preferences, Prognoses, and Physicians' Judgments*, 125 ANNALS INTERN. MED.

many physicians as the basis for: (a) slanting the information and options provided to the patient (or surrogate decision maker, in the case of patients incapable of making decisions), thus diminishing the "informed" part of informed consent; and for (b) applying gentle or more firm pressure on the patient to accept less aggressive care than might otherwise be advised, thus jeopardizing the voluntariness of the patient's decision. This specter of age discrimination in medical practice bodes poorly for any reasonable expectation of just, fair administration of a legalized physician-assisted suicide option for older patients.

The elderly as a group based solely on chronological age are also targeted for proposed discrimination on the macro, or social policy, level as well as at the individual bedside. As American society continues to struggle with the challenge of health care cost containment,⁴⁷ a number of serious proposals have been put forward which would, through various strategies, categorically ration health care according to the age of the patient.⁴⁸ Although vigorous ethical, legal, economic and social objections to these proposals have been mounted,⁴⁹ the enthusiasm with which age-

284, 288, 291 (1996) (Do-Not-Resuscitate orders were written earlier for patients older than seventy-five years of age, regardless of prognosis for survival).

47. For a discussion of the impediments posed by managed care and cost control to the operation of the sorts of effective, collaborative, and committed physician/patient relationships that physician-assisted suicide proponents recognize as essential to assuring that patient choices are voluntarily, knowingly, and capably made, see Eric D. Caine & Yeates C. Conwell, *Self-Determined Death, the Physician, and Medical Priorities: Is There Time to Talk?*, 270 JAMA 875, 876 (1993).

48. The seminal and best statement of the argument in favor of categorical, age-based health care rationing is found in DANIEL CALLAHAN, *SETTING LIMITS* (1987). See also Daniel Callahan, *Old Age and New Policy*, 261 JAMA 905 (1989); NORMAN DANIELS, *JUST HEALTH CARE* (1985); NORMAN DANIELS, *AM I MY PARENTS' KEEPER?: AN ESSAY ON JUSTICE BETWEEN THE YOUNG AND THE OLD* (1988); Margaret P. Battin, *Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?*, 97 ETHICS 317 (1987). In Great Britain, physicians have made rationing decisions based on the patient's age for years under the charade of "clinical indications." See J.E.C. Dickerson & M.J. Brown, *Influence of Age on General Practitioners' Definition and Treatment of Hypertension*, 310 BRIT. MED. J. 574 (1995); Tony Hope et al., *'Not Clinically Indicated': Patients' Interests or Resource Allocation?*, 306 BRIT. MED. J. 379 (1993).

49. Michael M. Rivlin, *Protecting Elderly People: Flaws in Ageist Arguments*, 310 BRIT. MED. J. 1179 (1995); TOO OLD FOR HEALTH CARE?: CONTROVERSIES IN MEDICINE, LAW, ECONOMICS, AND ETHICS (Robert H. Binstock & Stephen Post, eds., 1991); Nancy S. Jecker, *Age-Based Rationing and Women*, 266 J. AM. GERIATRICS SOC'Y 3012 (1991); Nancy S. Jecker & Robert A. Pearlman, *Ethical Constraints on Rationing Medical Care by Age*, 37 J. AM. GERIATRICS SOC'Y 1067 (1989); Marshall B. Kapp, *Rationing Health Care: Will It Be Necessary? Can It Be Done Without Age or Disability Discrimination?*, 5 ISSUES L. & MED. 337 (1989); Edward L. Schneider, *Options to Control the Rising Health Care Costs of Older Americans*, 261 JAMA 907 (1989); David C. Thomasma, *Moving the Aged into the House of the Dead: A Critique of Ageist Social Policy*, 37 J. AM. GERIATRICS SOC'Y 169 (1989); Larry R. Churchill, *Should We Ration Health Care by Age?*, 36 J. AM. GERIATRICS SOC'Y 614 (1988); Nancy S. Jecker, *Disenfranchising the Elderly From Life-Extending Medical Care*, 2 PUB. AFF. Q. 51 (1988).

based rationing proposals have been received if not embraced by key decision makers ought to shake confidence in our ability, and indeed even our desire, to effectively implement legalized physician-assisted suicide in a non-age discriminatory fashion.

II. ALTERNATIVES TO PHYSICIAN-ASSISTED SUICIDE

The emotional and intellectual appeal of physician-assisted suicide appears to derive from fears patients harbor about suffering unremitting physical pain,⁵⁰ psychological indignity, loss of control and independence,⁵¹ and abandonment during a time of critical illness that for most individuals is likely to occur near the end of life. While end of life concerns may be relevant to persons of all ages, the elderly correctly feel that they are particularly vulnerable to the risks of poor and insensitive care in this context.

The track record of health care professionals in humanely and respectfully caring for patients near the end of their lives surely leaves much to be desired.⁵² Trying to avoid dealing with deficiencies in current end of life care, however, by allowing and thereby encouraging older persons and others to opt out of the health care delivery system near what elderly persons perceive is the end of their life, and to preempt objectionable care by allowing physician-assisted suicide is not the answer.

Instead, a more ethically and legally viable alternative is to confront current deficiencies directly and improve the ethical as well as clinical quality and process of end of life medical care.⁵³ The Ethics Committee of the American Geriatrics Society has endorsed enhanced pain control through active palliation

50. Blendon, *supra* note 6, at 2660; Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. PAIN & SYMPTOM MGMT. 290 (1991); Zima, *supra* note 36, at 399. *But see* Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1805 (1996) (finding that oncology patients experiencing pain are unlikely to seek physician-assisted suicide unless they are also suffering from clinical depression).

51. See Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996).

52. The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995).

53. See Dame Cicely Saunders, *In Britain, Fewer Conflicts of Conscience*, 25 HASTINGS CENTER REP. 44 (1995) (stating that good hospice care practically eliminates patients' requests for death hastening); MARGARET P. BATTIN, *THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE* (1994). The Institute of Medicine of the National Academy of Sciences (Washington, DC) is conducting a project entitled *Care at the End of Life*, which is scheduled to produce a report in early 1997.

efforts.⁵⁴ Improved professional and public support of nonprofessional caregivers would help assure older patients that they will not be left to die alone and impersonally, thereby reducing a primary incentive for individuals to seek physician-assisted suicide as a preemptive measure.⁵⁵

Unlike actively intervening for the purpose, intention and expectation of hastening older patients' deaths by complying with questionably valid physician-assisted suicide requests, physicians who work at improving the quality and process of end-of-life care to make it more responsive to and respectful of the authentic values and preferences of older patients are performing a noble and life-affirming service. To accomplish this objective, initiative is demanded at three distinct but interrelated levels: clinical practice, institutional change and political action.⁵⁶ Legalizing physician-assisted suicide, particularly through judicial fiat, would probably destroy health care professionals' incentive to take these needed initiatives and expose vulnerable, fearful elders to the serious and unnecessary risk of being prematurely deprived of the fullness of their days.

54. American Geriatrics Society Ethics Committee, *Physician-Assisted Suicide and Voluntary Active Euthanasia*, 43 J. AM. GERIATRICS SOC'Y 579 (1995).

55. Council on Scientific Affairs, American Medical Association, *Good Care of the Dying Patient*, 275 JAMA 474, 476 (1996).

56. Greg A. Sachs et al., *Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia*, 43 J. AM. GERIATRICS SOC'Y 553 (1995).

