



The Unexamined Benefits of the Expansive Legalization of Medical Assistance-in-Dying

Sean Riley · Ben Sarbey

Received: 21 December 2021 / Accepted: 17 May 2022 / Published online: 26 September 2022
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Abstract If you slide far enough down the slippery slope envisioned by opponents of medical assistance-in-dying (MAiD), you eventually land in a ghastly society with industrialized euthanasia, rampant suicide, and devalued life. But what if the slippery slope leads us somewhere better? This paper explores the benefits of eliminating nearly all MAiD prohibitions and regulations. We anticipate three positive effects for public health: 1. Expanded access to those currently not qualified from MAiD by removing ineffective access criteria; 2. Harm reduction by making MAiD safer and by rerouting suicidal patients into alternate care; and 3. Improvements to the health system through lowered healthcare costs and increased patient activation in end-of-life care. Safeguards and prohibitions deny those who wish to die the ability to do so to prevent the *potential* danger of a few being subjected to an undesired early death.

Keywords Medical assistance-in-dying · Suicide · Slippery slope · End-of-life issues · Harm reduction

Introduction

Despite strides in the legalization of medical assistance-in-dying (MAiD) in recent years, laws permitting the administration of lethal medications (by physician in the case of voluntary euthanasia or by self in the case of assisted suicide) are relatively rare across the world. Even within jurisdictions with some form of legal MAiD, safeguards and surveillance restrict who can access the practice and how it can be performed. Research and ethical deliberation on the subject have thus been confined to operate in the space between prohibition and this “restrictive legalization.” Proponents of end-of-life options invest considerable energy in promoting and defending these safeguards. Rarely does anyone question the necessity of the safeguards themselves, but the needle has moved in recent years. Questions have emerged over whether mandates on reporting to health departments, conducting mental health evaluations, and meeting certain prognostic or diagnostic benchmarks might lock out suffering patients (McDougall and Pratt 2020). For this debate to be balanced, we must think about what physician-provided MAiD would look like without restrictions. To do this, we have constructed a thought experiment, detailing what we will call “expansive legalization”:

Medical Aid-in-Dying has been legalized and integrated into existing healthcare systems. Any individual who wishes to end their life, for

S. Riley (✉)
The Ohio State University Wexner Medical Center, 2050
Kenny Rd, Columbus, OH 43215, USA
e-mail: sean.riley@osumc.edu

B. Sarbey
Duke University, 1364 Campus Dr., Durham, NC 27705,
USA
e-mail: ben.sarbey@duke.edu

whatever reason, would be able to do so simply by making a voluntary request for the termination of life to their medical provider. This includes patients with terminal or chronic illness, severe psychological distress, or who are simply tired of living. Physicians alone are entrusted to ensure MAiD is implemented safely, ethically, and efficiently.

Critics argue that rampant euthanasia is the inevitable result of any form of legalization, and with it, undesirable societal and individual consequences—the slippery slope argument. Opponents in the medical community foresee the decay of the physician-patient relationship and the devaluation of other end-of-life options, such as palliative care (Snyder Sulmasy and Mueller 2017). Disability rights groups argue familial and health systems pressure will push vulnerable populations into voluntary and eventually involuntary euthanasia (National Council on Disability 2019). Even religious opponents, who are often concerned more with principle than consequence, predict the emergence of a culture of death (Smith and Doyle 2001). We see something entirely different.

This paper aims to illustrate the many under-explored positive effects that could come from a more expansive regime of MAiD. We will illustrate how expansive legalization adds a missing balance to the current debate and shifts the conversation away from propping up safeguards to guaranteeing equitable access and sound suicide prevention policy. Our paper details three categories of expected benefits of an expansive legal regime: increased access, harm reduction, and improvements to the health system. We conclude that this new model for viewing this debate—that all safeguards have hidden costs—can ensure a wider and more robust conception of the concerns over the expansion of MAiD.

Our paper details three categories of expected benefits of an expansive legal regime: increased access, harm reduction, and improvements to the health system. We then address some of the worst-case scenarios and expected objections to expansive legalization. We conclude that this new model for viewing this debate—one built on accepting trade-offs and compromise—can ensure a wider and more robust conception of the ethical and policy concerns over MAiD.

Expanding Access to the General Public

Since expansive legalization only legally requires a request be voluntary (as is intrinsic to the definition of MAiD), this will in effect open the practice to many groups often locked out: those with difficulty self-administering drugs, those without a certain prognosis of time left to live, those without a terminal diagnosis, those not residing within jurisdiction, or those unable to find a certain number of physicians willing to certify their request. Safeguards, as they are in current legal regimes, exist to protect people from an ostensibly undesirable death, but little consideration is given to whether these laws achieve their intended effects and are not failing those who otherwise might qualify for, and hence deserve, access to the practice. Table 1 shows an overview of these various requirements and restrictions around the world.

Most countries have established strict criteria that must be met for the practice to be considered legal. Although prosecutions have thus far been rare in all jurisdictions, the watching eye of the government still leads physicians to be reluctant to participate, leaving patients to look for other physicians. For instance, approximately a quarter of Dutch physicians who refused requests for MAiD cite waiting for review committee assessment and the administrative burden of reporting as considerations for their reason for denying MAiD (Onwuteaka-Philipsen et al. 2017).

The two principles most often invoked in favor of MAiD—enhancing autonomy and preventing suffering—can be equally relevant in cases of patients who legally qualify for MAiD as in cases with patients who do not qualify. Current legal regimes include requirements that do nothing better than lock out decisionally competent, suffering patients persistent in their desires for MAiD: First, the terminality requirements use health status to lock out and discriminate against patients without a terminal prognosis (Coleman 2010). Second, rules that prevent physicians from initiating the conversation about MAiD, such as those in the Australian state of Victoria, unnecessarily limit a physician's duty to care for their patient and present all of the options (Victoria State Government: Health and Human Services 2021). Patients may otherwise be too afraid to broach the subject or may be unaware that they qualify. Third, laws that draw a distinction between physical and psychological suffering

Table 1 MAiD Requirements and Permissions by Country

	The Oregon Model (Oregon Legislative Assembly 2019)	The Australian Model (Gentle Australia 2021)	The Dutch Model (Regional Euthanasia Review Committees 2019)	The Canadian Model (Health Canada 2019)	The Swiss Model ^a (Swiss Academy of Medical Science 2018)
What are the age restrictions?	Patient must be at least 18 years old	Patient must be at least 18 years old	Patient must be at least 12 years old (Parental consent if under 17 years old)	Patient must be at least 18 years old	N/A
Is citizenship or residency required?	Yes, patient must be resident of the state	Yes, patient must be resident of the state	No, but there have been no reported cases of use by non-citizens	Yes, patient must be Canadian citizen	No, medical tourism is permitted
Does the patient have to be terminally ill ?	Yes, patient must have prognosis of six months or less	Yes, patient must have prognosis of six months, twelve months for neurodegenerative ^b	No, patient must only be suffering intolerably and have no reasonable alternatives	No, patient must be suffering intolerable from an irremediable condition where a natural death is foreseeable	No, but this may be a requirement of the non-profit organizations that administer MAiD
Are there mandatory waiting periods ?	Yes, 15-day waiting period between two oral requests ^c	Yes, but exemptions for those likely to die or lose capacity	No waiting period	Yes, 10-day waiting period between written request and administration	No waiting period
Are multiple medical opinions required?	Yes, two independent physicians must confirm diagnosis and decisional capacity; if either physician is doubtful, a psychiatric evaluation is necessary	Yes, two independent trained medical practitioners must see the patient and give written approval	Yes, two independent physicians must see the patient and give written approval	Yes, two independent physicians must give written approval on eligibility	No medical opinions are necessary
Who can administer the lethal medications ?	Only the patient can administer the medications	Only the patient can administer the medications unless the patient is incapable or self-administration is otherwise inappropriate.	Physicians or the patient can administer the medications	Physicians, nurse practitioners, or the patient can administer the medications	Only the patient can administer the medications
Is physician attendance required during the procedure?	No, physicians and other healthcare workers are not required to attend	Yes, the attending physician and a witness must be present during administration	Yes, the attending physician must be present during administration	Varies by province; healthcare workers typically are present	No, physicians and other healthcare workers are not required to attend

^a Since the practice is legal via omission, Switzerland only forbids assisted suicide for “selfish reasons.” Many of these safeguards are not explicitly banned by law, but they are de facto banned via guidance by the Swiss Academy of Medical Science

^b Queensland requires twelve months prognosis for all cases

^c Oregon has recently amended their law to allow waivers of the waiting period if the patient will not live that long

discriminate against individuals with mental health conditions. Psychiatric conditions need not necessitate a patient lacks decisional capacity (Hatherley 2019; Parker 2013). Fourth, waiting periods often prevent patients from accessing MAiD because they die before the period is over (Seller et al. 2019). Lastly, proscription against clinician-administration often prevents disabled patients who otherwise qualify from accessing MAiD, or otherwise leads them to hasten their death earlier than desired (Silvers 2018). For example, patients with esophageal cancer may be unable to swallow life ending medications on their own.

Some jurisdictions have tried to strike a balance between access and safeguards such as the waiting period or the self-administration mandate. Victoria allows practitioners to apply for a permit to allow clinician-administration in cases where the patient would be unable to apply themselves (Victoria State Government: Health and Human Services 2021). While laudable, this slows down the process and adds to the regulatory burden. Likewise, Oregon and several Australian states allow exemptions to their waiting periods in cases where physicians believe death is imminent within the time period (Oregon Legislative Assembly 2019; Victoria State Government: Health and Human Services 2021). These jurisdictions require physicians to submit paperwork detailing the prognosis before expediting the procedure. Another positive trend is expanding the eligibility of participating healthcare workers to include nurse practitioners and physician assistants, as is the case in New Mexico, Canada, and several Australian states (Health Canada 2019; New Mexico Legislature 2019; Victoria State Government: Health and Human Services 2021). While these problems are not present in all regimes, and each could be repealed or reformed on their own, an expanded regime suffers from none of these drawbacks and requires less oversight to ensure individual requirements are met.

We take expanded access to those who would otherwise qualify for MAiD to be a benefit of expansive legalization. This benefit may be counterbalanced by other consequences, but it remains an important part of any adequate consideration of risks and benefits of further legalization of MAiD.

Reducing Harm

Rerouting Private Suicides Into Alternative Care

An expansive legal regime around MAiD would alter the landscape for suicides conducted without any medical assistance, which we will refer to as “private suicides.” Let’s start with some basic facts. First, there is a low completion rate. Between 2007 and 2014, in the United States, only 8.5 per cent of suicide attempts resulted in death (Conner et al. 2019). Second, of suicides that do not complete, complications are common. Two-thirds of survived suicide attempts result in hospitalization, and extreme cases can result in permanent mental or physical disability (Conner et al. 2019). These are bad effects. But we also know that MAiD has far higher efficacy rates and much lower complication rates than private suicide (Groenewoud et al. 2000). Expansive legalization may have the effect of increasing suicide efficacy rates and decreasing suicide complication rates.

Taken together, these points illustrate a conundrum: decreasing complications related to any procedure is ostensibly a positive effect, but what about when the very mechanism reducing the complications is death? What if a higher suicide completion rate was comprised of suicides deemed to be more ethically permissible? What if the suicides themselves were much more peaceful and painless? Expansive legalization offers those contemplating private suicide a safer medical option that could not only reduce complications but also filter out cases of easily treatable suicidal ideation. MAiD can then be thought of as a carrot-and-stick approach directing suicidal patients toward medical care.

We know that suicide implementation is difficult to pull off both psychologically and physically. Overcoming the fear of lethal injury can be daunting. Even without physical impediments and logistical hurdles, private suicides require an acquired ability to enact self-injury (Joiner et al. 2009). Many who wish for suicide are functionally unable to enact it without medical assistance. This alone can cause considerable fear and suffering. Pulling people away from their suicidal states, for even a brief time, can reduce the likelihood a suicidal act will occur (Deisenhammer et al. 2009). A considerable number of suicidal patients demonstrate some readiness for interpersonal contact. If patients can

be encouraged to reach out for help and distance themselves from their first suicidal thought, total suicides may reduce.

Additionally, physicians willing to perform MAiD may be viewed as more understanding or more open to sympathizing with an individual's desire to die, which would be reduced with expansive legalization. If patients reach out for medical help in the form of MAiD, some suicides may be avoided because of entry into the medical system and access to alternative treatment. In cases where alternate therapy fails and a patient still desires to die, it may be preferable for patients to participate in MAiD rather than be left to suffer on their own or attempt a less-safe less-reliable private suicide. Individuals who never consult a physician, who are denied MAiD, or who are resistant to alternate treatment might still pursue private suicide on their own, but this is no better or worse than our current situation.

Putting a greater number of suicidal persons in clinical settings surrounded by medical professionals is a positive effect and that providing a safer means of doing *anything*, even if it is dying, is preferable to the alternative. While removing restrictions might lead to a surge in MAiD requests, it does not necessarily follow that this will lead to a corresponding surge in completed MAiD procedures. There is no reason to believe physicians will suddenly disavow their personal or professional morals and perform MAiD on obviously unethical cases. A harm reduction approach may reduce the prevalence of self-harm and private suicide by encouraging medical involvement in the process. Patients whose MAiD requests are granted would be pursuing an option that a healthcare provider has deemed reasonable and ethical. Operating on the assumption that MAiD is ethically permissible, we should want patients who desire MAiD and are choosing so voluntarily and with decisional capacity to have access. Patients whose requests are denied are better off: they now have medical professional assistance, and if they choose to reject that, they are no worse off. Putting a greater number of suicidal persons in clinical settings surrounded by medical professionals is a positive effect and that providing a safer means of doing *anything*, even if it is dying, is preferable to the alternative. To date, no evidence suggests restrictive legalization has led to an increase in private suicides, but no negative association between the two exists either (Nanner 2017).

Providing General Comfort Through an “Easy Exit”

Knowing MAiD programs *could* be available if requested can itself relieve pain and anxiety. For instance, some patients who seek MAiD have been comforted by the mere knowledge that MAiD exists (Buchbinder 2021). Counsellors assisting suicidal individuals have observed that patients take solace in the possibility of dying by suicide if their situation further deteriorates (Heckler 1994). Only about two-thirds of MAiD prescriptions in the United States are ever consumed, sometimes because patients die before they can consume them, other times because patients opt not to take the medications—they merely wanted to have the option (Death with Dignity National Center 2020). The diminishment of suffering in such cases would be an additional benefit of the widespread availability of MAiD.

Improving the Clinical Policies and Procedures Governing MAiD

MAiD may become safer with expansive legalization by promoting the physician presence during the procedure, instead of taking the medications at home with no medically trained persons in attendance, as is often the case in the United States. Since data monitoring began in Oregon in 1997 and in Washington in 2009, sixty-three out of 1557 patients (4 per cent) who ingested lethal medications experienced complications, including vomiting, seizures, nausea, waking up after losing consciousness, or lingering for hours before dying (Al Rabadi et al. 2019). Data from the Netherlands before legalization in 2001 found 3 per cent of euthanasia cases and 7 per cent of assisted suicide cases resulted in complications (Groenewoud et al. 2000). Complications are a reality with MAiD, but so is medical liability. In Oregon, physicians are confirmed present in only 39 per cent of cases since 2001 (Oregon Health Authority Center for Health Statistics 2019). Physicians frequently fear legal repercussion or have time constraints (Buchbinder 2021). Removing legal barriers could encourage physicians, especially in the United States, to be present in more MAiD cases.

While more recent data on complications are not publicly available in jurisdictions with both physician-administered and self-administered MAiD, institutionalization of the practice has established best

practices and safety protocols (Regional Euthanasia Review Committees 2019). This is especially true of self-administration, as physicians have devised more effective drug combinations to make administration safer and more peaceful (Dear 2019). Clinical guidance and quality improvement efforts have emerged separate from government regulation. One example is the American Clinicians Academy on Medical Aid in Dying (ACAMAID), which provides physicians in the United States with formal education on MAiD (in the form of CME credits), a referral system and a forum to discuss developments in the field (American Clinicians Academy on Medical Aid in Dying 2022). There is no reason to believe that these organizations would discontinue work in an expansive regime. If anything, the removal of restrictions could improve implementation research and quality improvement efforts.

Expansive legalization would also encourage the shift away from the more complication-prone self-administration and toward the more medically reliable physician-administration. Countries with both options show a strong preference for physician-administration. For instance, patients opt for self-administration in less than 0.2 per cent in Canada (Health Canada 2019).

Improving the Health System

Much attention has been paid recently to the exorbitant costs associated with end-of-life care, as more and more patients die in hospitals or with highly medicalized hospice services. One estimate finds nearly a quarter of Medicare payments are for patients in their dying year (Riley and Lubitz 2010). Although other studies have found the last year of life only contributes to 13 per cent of personal healthcare costs in the United States, this is still a reasonable target for reducing healthcare spending and redistributing healthcare resources (Aldridge and Kelley 2015). Naturally, MAiD could reduce some spending through allowing patients to hasten their deaths before high-cost treatment if that is what they desire.

Several studies have attempted to project what the costs savings of MAiD might look like. Using Dutch data available from 1998, Ezekiel Emanuel and Margaret Battin created a framework projecting a cost savings in the United States of roughly \$1 billion

USD each year (adjusted for inflation, \$627 million USD each year in 1995) (Emanuel and Battin 1998). This estimate assumed 2.7 per cent of deaths attributable to MAiD, yet Dutch data suggest the number has exceeded 5 per cent recently. It also doesn't consider that an ageing population will heighten healthcare costs and increase the pool of people eligible for MAiD. A more recent estimate, also using Dutch and Belgian data, projected annual healthcare savings between \$34 million and \$138.8 million in the Canadian health system (Trachtenberg and Manns 2017). These sums are small when compared to total health expenditures in both countries, but these amounts could still reduce suffering in other areas. Extra resources that would otherwise be spent on a patient denied MAiD are now free to redistribute elsewhere in the healthcare system (Shaw and Morton 2020). This includes organs or hospital beds. Patients undergoing MAiD could know they are helping save the lives of others.

An additional benefit of integrating MAiD into the healthcare system is the impact it might have on the culture surrounding dying. The institutionalization of MAiD could assist the practice's acceptance as standard medical practice, which could reduce the stigma on suicide—putting the suffering of individuals and the ability to remedy it in the limelight (Le Glaz et al. 2019). Renewed interest in and acceptance of MAiD could encourage others to engage in end-of-life discussions with their providers (Buchbinder 2021). This could lead to an increase in advance care planning as more persons want to express this wish before losing decisional capacity. This fits with a growing movement around death positivity across the western world, which aims to break down taboos surrounding death and dying.

Access for Non-Persistent or Decisionally Incapacitated Cases

One objection to expansive legalization concerns permitting MAiD for cases where the wish to die is not persistent or where the patient does not have decisional capacity. This debate would be exacerbated by the removal of strict barriers to entry for patients with psychiatric requests. Let us consider a hypothetical example of such an individual, the Rhodes Scholar:

A physically healthy 22-year-old college graduate has been awarded a Rhodes Scholarship to pursue postgraduate studies in Oxford, but this otherwise amazing opportunity has spawned overwhelming anxiety and depressive symptoms. These symptoms are strong, but the doctors have good reason to believe they are temporary and could be adequately managed with existing treatments. The Rhodes Scholar decides they want to terminate their life through the now-legal MAiD mechanisms, despite their bright future, familial support, and strong social network. Their request is granted.

The Rhodes Scholar is presumably one of the worst-case scenarios envisioned by MAiD opponents, but there is little reason to believe the request for MAiD would be granted in such a case. Physicians are unlikely to participate because they are guided by more than just legal obligation. They must adhere to hospital policy and their own consciences. They will be pressured from other physicians, outside groups, and the media to properly employ bioethical principles when assessing MAiD cases. Clearly, the Rhodes Scholar case falls into an ethical grey area between balancing safety and autonomy. Their request is not persistent and other treatment options exist. Expansive legalization, in no way, shape, or form, compels physicians to participate in ethically dubious cases such as this one. Removing laws governing MAiD cannot imply any obligation to perform MAiD. Guaranteeing voluntariness, persistence, and decisional capacity would likely be top priorities of medical professionals, as they are in medical circles today.

Many objectors to MAiD might respond that such patients could simply bounce from physician to physician until they found a willing participant (Preston 2017). It is difficult to imagine that a patient would be able to find a doctor with such a flagrant disregard of the ethics of their profession. Not only are corrupt physicians rare, any who exercise such fast and loose judgment over cases will be the target of consumer boycott, public relations problems, and the watchful eye of medical boards. Further, the point undermines itself: any patient willing to invest the time and energy into doctor shopping is demonstrating the very persistence in their wish that critics claim is missing.

Nonetheless, access for those with psychiatric conditions, such as treatment-resistant depression

or dementia, is still hotly debated (Nicolini et al. 2020). Opponents claim that psychiatric conditions interfere with an individual's capacity to make decisions regarding their health or that psychiatric conditions can always be treated. Hatherley argues that the empirical and moral evidence for both these claims is weak (Hatherley 2019). First, decisional capacity can be measured and tested on psychiatric patients—the psychiatric condition need not necessitate an inability to understand, appreciate, or express healthcare decisions. Second, prognostic uncertainty over relief from psychiatric symptoms, implying a sliver of hope for recovery, does not always outweigh the suffering a patient is likely to feel if MAiD is denied. Regardless, evidence from regimes which do permit psychiatric qualification for MAiD suggests that these cases are exceptionally rare.

Coercion From Family, Finances, or the Health System

A common charge against MAiD is concern over abuse of vulnerable patients. This will be relevant to a system with no legal barriers. Charges of abuse and coercion range from depictions of family members pressuring loved ones into an early death for their own financial gain to images of negligent physicians flouting the rules and ignoring professional guidelines in killing their patients (National Council on Disability 2019).

First, little evidence of abuse exists in current regimes. Oregon and Washington have seen no devolution of the practice into non-voluntary or involuntary euthanasia (Blanke et al. 2017). Patients, families, or physicians have not reported experiencing undue influence in their decision-making around MAiD. In the Netherlands and Belgium, since legalization, only two cases have ever been prosecuted, and both were acquitted (Hughes 2021). The United States has prosecuted one (Rich 2002). Dutch review committees have found due care criteria were not met in merely 101 instances of MAiD (0.18 per cent) (Riley et al. 2020). Though abuse might be unreported, this is reason to believe it is rare, if it exists at all.

Second, physicians have demonstrated they can be trusted to handle MAiD with due care. Rather than engaging in harmful behaviour, Dutch physicians have stated they not only strive to meet due

care criteria, but they think these rules are in line with their personal ethics (Riley et al. 2020). Incidence of physician maleficence in medicine at large is extremely rare. We already entrust doctors with powers over life and death through prescribing risky medicines and performing invasive procedures. Legal prohibitions on battery and murder would still be in effect, along with the array of support structures for reporting and prosecuting such crimes.

Let us consider what potential abuse by physicians might look like. If physicians intend to harm or kill patients, there are more efficient ways to do so. The lethal medications prescribed for MAiD are effective at hastening death *in a peaceful and painless manner*, but are not necessarily the best drugs at causing death (Riley 2017). Presuming it is already reasonable to entrust doctors with expansive powers over our physical and mental well-being, there needs to be good reason to believe we should not continue to place our trust in physicians. Thus, the critic of MAiD must shoulder the burden of demonstrating good reasons to distrust physicians with such powers.

Third, those who have historically accessed MAiD are disproportionately the least vulnerable members of society, allaying concerns that marginalized populations will pursue the law. Early studies have shown that the majority of MAiD participants are wealthy, white, secular, well-educated, and over the age of sixty-five (Battin et al. 2007). Most patients have terminal illness, even in jurisdictions where it is not a requirement for MAiD. Some argue this imbalance exists because safeguards work, but this must reckon with the fact that having vulnerabilities does not ethically necessitate that one cannot reliably qualify for MAiD.

Many argue the health system will push those who cannot afford continuing treatment into MAiD, but the evidence does not support this. Financial incentives are more likely to influence a decision to pursue futile treatment than they are to influence MAiD (Freeman et al. 2018). In Oregon, between 1998 and 2016, only 3.4 per cent of MAiD patients listed financial concerns as a reason for their request (Oregon Health Authority Center for Health Statistics 2019). The charge that financial pressure will push patients into an otherwise unwanted MAiD, like many of the concerns over abuse of the vulnerable, is unsupported by existing evidence. While absence of evidence is not evidence of absence, it does make any of

these claims of coercion merely speculative. Despite this, there do remain legitimate concerns over insurance incentives to cover MAiD while denying curative treatment. These can be solved with quick policy fixes, as California did in their 2015 law prohibiting insurance companies from communicating about denial of coverage and the availability of MAiD in tandem and from communicating about MAiD before a patient has made a request (California State Legislature 2015).

Decay of the Physician-Patient Relationship

Another prominent concern raised by opponents is the impact MAiD will have on the physician-patient relationship. While restrictive legalization has not led to the decay of trust in doctors or the medical system, concerns persist that the erosion may be gradual, and hence yet to come in current regimes. Current polling suggests otherwise. In the Netherlands, public support for their MAiD law is 76 per cent (Onwuteaka-Philipsen et al. 2017). Seventy-four per cent of Americans believe euthanasia should be legal (Brenan 2020). A 2005 study found only 20 per cent of U.S. patients said they would trust their physicians less if MAiD were legalized (Hall et al. 2005). Surely those who are uncomfortable receiving care from a participating physician will be able to locate a physician more in line with their care preferences.

Why would this lead to a distrust in physicians? Both sides can reject the other's vision of what happens, but it really boils down to patients simply having a different bioethical view than their physician. But let us now ask: how many patients have a clear-cut bioethical stance on MAiD to begin with? For how many patients would this be a deciding factor? How many patients know whether their physician supports or has participated in other controversial practices, like abortion? How many patients can even access that information? Health privacy laws will make this information difficult to ascertain, and hence renders these clashes unlikely. Given the low frequency of MAiD as is, it is likely the relationship would remain intact, just as has been in every country with legalization of some type (Emanuel et al. 2016).

Expansive legalization might instead strengthen the bond between patients and their healthcare providers by empowering their choices and activating

them to plan for end-of-life care. A United Kingdom study in 2015 found 87 per cent of those polled would either increase or maintain the same level of trust in their trust in their physicians if MAiD were legalized (Campaign for Dying in Dignity 2015). Patients would be able to talk about death and dying openly with physicians no longer encumbered by legal obligation to avoid certain subjects (Nelson 2019).

A related argument to the concerns over the decay in medical relationships is the decline in investment in other end-of-life options. Many critics argue that patients will be presented with a false choice when presented with MAiD, as other palliation-oriented options are not affordable or available or are low quality. This theory is undermined by the fact that most MAiD patients are currently enrolled in hospice—as much as 90 per cent in Oregon (Oregon Health Authority Center for Health Statistics 2019). Critics further charge patients may choose to hasten their deaths only because they fear not being provided adequate palliative care. Again, evidence is lacking (Cholbi 2018). According to a Center to Advance Palliative Care report, the relationship between access to high-quality palliative care and the legalization of MAiD is the opposite: states permitting MAiD tend to have better palliative care measures (Morrison et al. 2011). The slippery slope argument foreseeing the inevitable implosion of the healthcare sector is speculative at best and deceptive at worst.

Conclusion

The debate over MAiD remains incomplete without a better picture of what a system without current restrictions might look like. We have made the case that an expansive legal regime of MAiD would include considerable positive effects. We believe an expansive MAiD regime could improve access to patients locked out, reduce harms associated with private and medicalized suicide, and improve healthcare by redistributing resources and activating patient interest in their health, along with many other unseen positive effects.

This thought experiment brings into serious question the validity and reliability of safeguards currently governing MAiD. We recognize that the political plausibility of expansive legalization faces many practical hurdles, in part due to the fact that

safeguards exist, in some part, as political compromise to ensure any form of legalization passes. However, expansive legalization could persist as a counterweight to those advancing more restrictive MAiD policy. Safeguards and prohibitions deny many who wish to die the ability to do so simply to prevent a mere *potential* danger of the few being subjected to an undesired early death. We question now whether we should continue to put the *real* suffering of the many over the *hypothetical* suffering of the few. Safeguards and prohibitions deny many who wish to die the ability to do so simply to prevent a mere *potential* danger of the few being subjected to an undesired early death. This, in turn, raises the question whether we, as a society, have gone far enough in allowing end-of-life options such as MAiD, instead of whether we have gone too far.

Declarations

Disclosure statement No potential conflict of interest was reported by the authors.

References

- Al Rabadi, L., M. LeBlanc, T. Bucy, et al. 2019. Trends in medical aid in dying in Oregon and Washington. *JAMA Network Open* 2(8): e198648-e198648.
- Aldridge, M.D., and A.S. Kelley. 2015. The myth regarding the high cost of end-of-life care. *American Journal of Public Health* 105(12): 2411–2415.
- American Clinicians Academy on Medical Aid in Dying. American Clinicians Academy on Medical Aid in Dying. <https://www.acamaid.org/>. Accessed April 27, 2022
- Battin, M.P., A. van der Heide, L. Ganzini, G. van der Wal, and B.D. Onwuteaka-Philipsen. 2007. Legal physician-assisted dying in Oregon and the Netherlands: Evidence concerning the impact on patients in “vulnerable” groups. *Journal of Medical Ethics* 33(10): 591.
- Blanke, C., M. LeBlanc, D. Hershman, L. Ellis, and F. Meyskens. 2017. Characterizing 18 years of the Death With Dignity Act in Oregon. *JAMA Oncology* 3(10): 1403–1406.
- Brenan, M. 2020. American’s strong support for euthanasia persists. *Gallup*, May 18. <https://news.gallup.com/poll/235145/americansstrong-support-euthanasia-persists.aspx>. Accessed 20 Sept 2020
- Buchbinder, M. 2021. *Scripting death: Stories of assisted dying in America*. Berkeley University of California Press.
- California State Legislature. 2015. Assembly Bill No. 15: End of Life Options Act. Accessed September 21, 2020.

- Campaign for Dying in Dignity. 2015. Press Release: Patients would trust doctors more if assisted dying was legal. Accessed August 18, 2020.
- Cholbi, M. 2018. Palliation and medically assisted dying: A case study in the use of slippery slope arguments in public policy. In *The Palgrave handbook of philosophy and public policy*, edited by D. Boonin, 691–702. Cham: Springer International Publishing.
- Coleman, D. 2010. Assisted suicide laws create discriminatory double standard for who gets suicide prevention and who gets suicide assistance: Not Dead Yet responds to Autonomy, Inc. *Disability Health Journal* 3(1): 39–50.
- Conner, A., D. Azrael, and M. Miller. 2019. Suicide case-fatality rates in the United States, 2007 to 2014. *Annals of Internal Medicine* 171(12): 885–895.
- Dear, J. 2019. The doctors who invented a new way to help people die. *The Atlantic*, January 23. <https://www.theatlantic.com/health/archive/2019/01/medical-aid-in-dying-medications/580591/>. Accessed July 22, 2020.
- Death with Dignity National Center. Frequently asked questions about death with dignity. <https://deathwithdignity.org/resources/faqs/>. Accessed September 2, 2020.
- Deisenhammer, E.A., C.M. Ing, R. Strauss, G. Kemmler, H. Hinterhuber, and E.M. Weiss. 2009. The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt? *Journal of Clinical Psychiatry* 70(1): 19–24.
- Emanuel, E.J., and M.P. Battin. 1998. What are the potential cost savings from legalizing physician-assisted suicide? *New England Journal of Medicine* 339(3): 167–172.
- Emanuel, E.J., B.D. Onwuteaka-Philipsen, J.W. Urwin, and J. Cohen. 2016. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA* 316(1): 79–90.
- Freeman, L.M., S.L. Rose, and S.J. Youngner. 2018. Poverty: Not a justification for banning physician-assisted death. *Hastings Centre Report* 48(6): 38–46.
- Go Gentle Australia. 2021. Comparative table of VAD legislation in Australia. Last modified April 27, 2022. <https://www.dwdv.org.au/comparative-table-of-vad-legislation-in-australia/>. Accessed September 5, 2022.
- Groenewoud, J.H., A. van der Heide, B.D. Onwuteaka-Philipsen, D.L. Willems, P.J. van der Maas, and G. van der Wal. 2000. Clinical problems with the performance of euthanasia and physician-assisted suicide in the Netherlands. *New England Journal of Medicine* 342(8): 551–556.
- Hall, M., F. Trachtenberg, and E. Dugan. 2005. The impact on patient trust of legalising physician aid in dying. *Journal of Medical Ethics* 31(12): 693.
- Hatherley, J.J. 2019. Is the exclusion of psychiatric patients from access to physician-assisted suicide discriminatory? *Journal of Medical Ethics* 45(12): 817–820.
- Health Canada. 2019. Fourth interim report on medical assistance in dying in Canada. Accessed October 1, 2020.
- Heckler, R. 1994. *Waking up alive: The descent, the suicide attempt, and the return to life*. NY: Putnam.
- Hughes, J.A. 2021. Advance euthanasia directives and the Dutch prosecution. *Journal of Medical Ethics* 47(4): 253.
- Joiner, T.E., K.A. Van Orden, T.K. Witte, et al. 2009. Main predictions of the interpersonal-psychological theory of suicidal behavior: Empirical tests in two samples of young adults. *Journal of Abnormal Psychology* 118(3): 634–646.
- Le Glaz, A., S. Berrouguet, D.-H. Kim-Dufor, M. Walter, and C. Lemey. 2019. Euthanasia for mental suffering reduces stigmatization but may lead to an extension of this practice without safeguards. *The American Journal of Bioethics* 19(10): 57–59.
- McDougall, R., and B. Pratt. 2020. Too much safety? Safeguards and equal access in the context of voluntary assisted dying legislation. *BMC Medical Ethics* 21(1): 38.
- Morrison, R.S., R. Augustin, P. Souvanna, and D.E. Meier. 2011. America's care of serious illness: A state-by-state report card on access to palliative care in our nation's hospitals. *Journal of Palliative Medicine* 14(10): 1094–1096.
- Nanner, H. 2017. How did the Netherlands's euthanasia policy affect suicide numbers? Critiquing an analysis on trends in the jurisdiction. *Journal of Ethics in Mental Health* 10 (Open).
- National Council on Disability. 2019. The danger of assisted suicide laws: Part of the Bioethics and Disability series. https://ncd.gov/sites/default/files/NCD_Assisted_Suicide_Report_508.pdf. Accessed September 3, 2020.
- Nelson, A. 2019. Can the case for legalised physician assisted dying withstand objections based on sanctity of life and the doctor-patient relationship? *Manchester Review of Law, Crime and Ethics* 8: 83–101.
- New Mexico Legislature. 2019. Elizabeth Whitefield End of Life Options Act. In *HB0090*, edited by 54th Legislature—State of New Mexico.
- Nicolini, M.E., S.Y.H. Kim, M.E. Churchill, and C. Gastmans. 2020. Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons. *Psychological Medicine* 50(8): 1241–1256.
- Onwuteaka-Philipsen, B., J. Legemaate, A. van der Heide, et al. 2017. Third Evaluation of the Termination of Life on Request and Assisted Suicide Act. https://publicaties.zonmw.nl/fileadmin/zonmw/documenten/Kwaliteit_van_zorg/Evaluatie_Regelgeving/Derde_evaluatie_Wtl.pdf. Accessed September 5, 2022.
- Oregon Health Authority Center for Health Statistics. 2019. Oregon Death with Dignity Act: 2018 data summary. https://www.oregon.gov/oha/PH/PROVIDERPARTNER_RESOURCES/EVALUATIONRESEARCH/DEATH_WITHDIGNITYACT/Documents/year21.pdf. Accessed September 22, 2020.
- Oregon Legislative Assembly. 2019. Senate Bill 579. Accessed September 14, 2020.
- Parker, M. 2013. Defending the indefensible? Psychiatry, assisted suicide and human freedom. *International Journal of Law and Psychiatry* 36(5-6): 485–497.
- Preston, R. 2017. Physician-assisted suicide—a clean bill of health? *British Medical Bulletin* 123(1): 69–77.
- Regional Euthanasia Review Committees. 2019. Euthanasia Code 2018: Review Procedures in Practice. Accessed September 22, 2020.

- Rich, B.A. 2002. Oregon versus Ashcroft: Pain relief, physician-assisted suicide, and the Controlled Substances Act. *Pain Medicine* 3(4): 353–360.
- Riley, G.F., and J.D. Lubitz. 2010. Long-term trends in Medicare payments in the last year of life. *Health Services Research* 45(2): 565–576.
- Riley, S.R. 2017. Navigating the new era of assisted suicide and execution drugs. *Journal of Law and the Biosciences* 4(2): 424–434.
- Riley, S. R., A. Overbeek, and A. van der Heide. 2020. Physician adherence to clinical guidelines in euthanasia and assisted suicide in the Netherlands: A qualitative study. *Family Practice* 37(2): 269–275.
- Seller, L., M.-È. Bouthillier, and V. Fraser. 2019. Situating requests for medical aid in dying within the broader context of end-of-life care: Ethical considerations. *Journal of Medical Ethics* 45(2): 106–111.
- Shaw, D., and A. Morton. 2020. Counting the cost of denying assisted dying. *Clinical Ethics* 15(2): 65–70.
- Silvers, A. 2018. Disability and physician-assisted death. In *Physician-assisted death: Scanning the landscape: Proceedings of a workshop*, edited by R.A. English, C.T. Liverman, C.M. Cilio and J. Alper, 30–33. Washington, DC: National Academies of Sciences, Engineering, and Medicine.
- Smith, W.J., and D.J. Doyle. 2001. Culture of death: The assault on medical ethics in America. *Canadian Medical Association Journal* 165(6): 801.
- Snyder Sulmasy, L., and P.S. Mueller. 2017. Ethics and the legalization of physician-assisted suicide: An American College of Physicians position paper. *Annals of Internal Medicine* 167(8): 576–578.
- Swiss Academy of Medical Science. 2018. Management of dying and death. SAMS House of Academies. <https://www.samw.ch/en/Ethics/Topics-A-to-Z/Dying-and-death.html>. Accessed October 3, 2020.
- Trachtenberg, A. J., and B. Manns. 2017. Cost analysis of medical assistance in dying in Canada. *Canadian Medical Association Journal* 189(3): E101.
- Victoria State Government: Health and Human Services. 2021. Voluntary assisted dying: Guidance for health professionals. <https://www.health.vic.gov.au/patient-care/health-practitioner-information>. Accessed April 27, 2022.

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