Received: 13 May 2024 | Revised: 12 July 2024 | Accepted: 23 July 2024

DOI: 10.1111/jgs.19195

LETTER TO THE EDITOR

Journal of the American Geriatrics Society

Should doctors prescribe death? Resisting the expansion of assisted suicide

In a recent article in this Journal, Pope and Brodoff advocate using voluntarily stopping eating and drinking (VSED) in patients with mild cognitive impairment (MCI) or early dementia as a "bridge to MAID" (medical aid in dying).[1] VSED allows the physician to declare a patient terminal due to dehydration, thus eligible to receive a lethal prescription. According to Pope and Brodoff, the lack of access to MAID for patients with MCI or early dementia "vexes a growing population who zealously want to avoid living with late-stage dementia." They cite the track record in Canada of using VSED as a bridge to MAID. They call upon MAID clinicians in the United States to "develop guidelines to identify which patients may combine VSED and MAID."[1]

As clinicians who care for people with dementia, we oppose the proposal of Pope and Brodoff. We believe this is another among many other strategies to expand medicalized suicide. Pope has previously published his own list of needed expansions of MAID laws in the United States. Included in his list are removal of the terminal condition requirement, shortening of waiting times for obtaining lethal prescriptions, inclusion of mid-level practitioners as authorized prescribers of lethal agents, and allowing death by intravenous administration of the lethal agent.[2]

Expansions of existing laws are already occurring, often at the expense of what were originally considered necessary safeguards. In New Mexico and Washington, nurse practitioners and physician assistants may now write lethal prescriptions. State residency requirements have been rescinded in Oregon and Vermont. In 2023, both Oregon and Washington rescinded the waiting period for those whose death is deemed "imminent" (WA) or within 15 days (OR), so lethal prescriptions can be written the same day as the initial evaluation for these patients.[3]

In Canada, MAID is already "expanded" since its inception in 2016 by including active euthanasia—death by provider injection or infusion rather than oral prescription. Initially natural death had to be "reasonably foreseeable." In 2021 that safeguard was removed.[4] Deaths by MAID rose from 7595 in 2021 to 10,064 in 2022.[5] MAID deaths now include an increasing number of patients with a variety of chronic nonterminal conditions.[4] Some describe MAID for those simply tired of living.[6]

Regarding this expansion of MAID in Canada, David Brooks writes, "The lines between assisted suicide for medical reasons, as defined by the original MAID criteria, and straight-up suicide are blurring.. .. Suddenly debates arise over which lives are worth living.. .. Suddenly people who are ill or infirm are implicitly encouraged to feel guilty for wanting to live."[4] With ethical lines being blurred, many who live with disabilities fear we are creating a culture in which their lives will be devalued by physicians as well as society. Assisted death may come to be seen as a duty rather than merely a right. Those living with disabilities may believe the subtly coercive message that they are a burden on society.[7]

A final concern about expanding assisted suicide comes from emerging data in Europe that suggest a positive correlation between legalization of assisted suicide or euthanasia and subsequent increase in all forms of intentional self-initiated death.[8] These findings seem to disproportionately affect older women. What happens when adolescents or young adults who are contemplating suicide see older adults approving of it by medical means? We believe the best prevention of harmful expansions of assisted suicide laws is to not legalize this practice in the first place.

There are alternatives to assisted suicide. Patients need physicians willing to walk alongside them in their suffering. They need compassionate, team-based, person-centered palliative and hospice care. Physicians need to bring the virtues of medical practice to the bedside—presence, empathy, fidelity, wisdom, courage, temperance, and grace. Palliate as aggressively as needed, yes—but never with motive or manner to kill.

In the words of Dame Cecily Saunders, we declare to the patient, "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die."[9] As many states grapple with the issue of assisted suicide and its potential expansion this year,

See related editorial by Pope and Brodoff.

we affirm that legalization does not make assisted death right or ethical. We call upon our profession to honor its commitments both to individual persons in our care and to the society we are together helping to shape. We reaffirm our longstanding ethic: doctors must not prescribe death.[10]

AUTHOR CONTRIBUTIONS

Each author contributed substantially to this manuscript.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

SPONSOR'S ROLE

There was no sponsor for the creation of this manuscript.

FINANCIAL DISCLOSURE

The authors received no funding in the creation of this manuscript and have not published it in any format elsewhere.

Peter Jaggard MD[1,2]
Richard Sams MD[3,4]

[1]*Presbyterian Homes, Evanston, Illinois, USA*
[2]*Endeavor Health System, Evanston, Illinois, USA*
[3]*Department of Family and Community Medicine, The Medical College of Georgia at Augusta University, Augusta, Georgia, USA*
[4]*Georgia War Veterans Nursing Home, Augusta, Georgia, USA*

Correspondence
Peter Jaggard, Presbyterian Homes, 137 Glenwood Avenue, Winnetka, IL 60093, USA.
Email: petros1954@comcast.net

REFERENCES

1. Pope TM, Brodoff L. Medical aid in dying to avoid late-stage dementia. *J Am Geriatr Soc*. 2024;72:1-7. doi:10.1111/jgs.18785
2. Pope TM. Top ten new and needed expansions of U.S. medical aid in dying Laws. *Am J Bioeth*. 2023;23(11):89-91. doi:10.1080/15265161.2023.2256244
3. Komrad MS, Hanson A, Geppert CMA, Pies RW. Beyond terminal illness: the widening scope of physician-assisted suicide in the US. *Psychiatr Times*. 2024;41(6):12-13. https://www.psychiatrictimes.com/view/beyond-terminal-illness-the-widening-scope-of-physician-assisted-suicide-in-the-us
4. Brooks D. The Canadian way of death. *The Atlantic*. 2023;331(5):84-95. Available online as The Outer Limits of Liberalism. Accessed April 29, 2024.
5. Pullman D. Slowing the Slide Down the Slippery Slope of Medical Assistance in Dying: Mutual Learnings for Canada and the US. *Am J Bioeth*. 2023;23(11):64-72. doi:10.1080/15265161.2023.2201190
6. Mathison E. Taking the long view on slippery slope objections. *J Med Ethics*. 2021;47(10):674-675. doi:10.1136/medethics-2021-107837
7. Janz H. Plagued to death by ableism: what the COVID-19 pandemic and the expansion of eligibility for MAID reveal about the lethal dangers of medical and systemic ableism in Canada. *Can J Bioeth*. 2023;6(3–4):137-141.
8. Jones D. Euthanasia, assisted suicide, and suicide rates in Europe. *J Ethics Mental Health*. 2022;11:1-35.
9. Saunders C. Care of the dying–1. The problem of euthanasia. *Nurs Times*. 1976;72(26):1003-1005.
10. Pellegrino ED. Doctors must not kill. *J Clin Ethics Summer*. 1992;3(2):95-102.