Assisted suicide legislation in the United States

Student's Name

Institution of Affiliation

Assisted suicide legislation in the United States

Physician-assisted suicide (PAS) happens when a physician facilitates the death of a patient by offering the necessary means and information to enable the patient to engage in the act o ending his or her life. In a literal sense, suicide refers to self-killing, the taking of one's own life. However, in the case where some else other than the patient performs the act of life-ending, such as administering the lethal drug dose; it is known as euthanasia, regardless of whether it is voluntary or non-voluntary (against the patient's will). For instance, the physician can provide sleeping pills and information concerning the lethal dosage, while aware that the patient may commit suicide. In the American history of assisted suicide, the common law treated suicide as an offense against the society, and, at some point of the English law-the source of American common suicide law, treated failed suicide as a crime and successful suicide as an offense against the state, resulting in penalties being imposed on the body, the estate, or both of the deceased. Similarly, at some point and in some areas, assisted suicide has been categorized as a form of homicide. Notably, in a discussion of the meaning of assisted suicide or death, it is, therefore, essential to explore the various meanings of suicide. In doing so, this paper will explore the history of physician-assisted suicide legislation in the US, its development, and its financial implications.

Currently, eight states (California, Colorado, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington) legalized physician suicide through legislation. One state (Montana) legalized physician-assisted suicide through a court ruling. Forty-one states consider physician-assisted suicide illegal. Thirty-four states have laws that prohibit physician-assisted suicide. Three states (Alabama, Massachusetts, and West Virginia) prohibit physician-assisted suicide by common law. Four states (Nevada, North Carolina, Utah, and Wyoming) do not have particular

laws concerning physician-assisted suicide, and as a result, may not recognize common law or otherwise, unclear on the legality of physician-assisted suicide. However, the federal government and all 50 states prohibit euthanasia under general homicide laws. The federal government does not have physician-assisted suicide laws. The laws are mainly handled at the state level.

History of the law of Physician-Assisted Suicide

For over seven centuries, the Anglo American common law tradition punished or otherwise disapproved assessed suicide. As a result, most of the American colonies adopted the common law approach. In its earliest beginning, the common law did not treat assisted suicide the same way it treated attempted suicide, suicide, and homicide (Meisel, 2020). Some jurisdictions treated assisted suicide as a type of criminal homicide, and the perpetrator could even be tried as if he or she had actually killed the victim, regardless of whether it was voluntarily or non-voluntarily. Other jurisdictions viewed the individual assisting in the suicide as an accessory to the crime of homicide with the likelihood of lesser penalty being imposed on him or her than if he or she was viewed as a murderer. Similarly, others created a separate crime for assisted suicide. Besides, others such as Michigan refused to criminally convict those who help others commit suicide, which is the reason that Dr. Jack Kevorkian was not successfully prosecuted for his assisted suicides in Michigan in the 1990s.

The journey to adopt the physician-assisted suicide was reinforced in 1977 when the eight states mentioned earlier signed the right-to-die bills into law. In 1987, California became the first state to approve physician-aid-in-dying. In the 1990s, opinion surveys indicated that more than half of Americans supported physician-assisted death, and Jack Kevorkian participated in his first assisted suicide. On June 25, 1990, the Supreme Court Ruled in Cruzan Case that a person has the right to refuse life-saving medical service (Meisel, 2020). In 1990,

Oregon becomes the first state in history of America to pass the Death with Dignity Act, which permitted physician-assisted suicide. However, in 1997, President Clinton prohibited the use of federal funds for assisted suicide, in the Assisted Suicide Funding Restriction Act of 1997. In 2008, Washington became the second state to pass Death with Dignity Act, which legalized physician-assisted suicide. Washington was followed by the state of Montana, which legalized physician-assisted suicide. The fourth state to pass the law was Vermont in 2014 followed by New Mexico in 2014. In 2015, California became the fifth state to legalize physician-assisted suicide legislation (Meisel, 2020). Colorado followed suit in 2016, then DC in 2017. Hawaii is the eighth state to legalize the legislation in 2018, while New Jersey passed the legislation in 2019. Similarly, Main passed the legislation on June 12, 2019.

Currently, the law of assisted suicide is exclusively a matter of the law of the individual states as opposed to federal law. Similarly, the laws fluctuate from state to state. However, there are some elements common to the majority aspects of the assisted suicide law. Except for the mentioned few states that have legalized aided suicide, helping another person to end his or her life- including a terminally-ill individual, as well as a terminally-ill individual who is close to death; remains a criminal offense in all the other states (Meisel, 2020). Besides, even in the states that physician-assisted suicide has been legalized, helping another person to end his or her life outside of the stringent requirements of the aid-in-dying law is still considered as a criminal offense. The implication is that an individual who is not a physician but otherwise conforms to the aid-in-in dying law is subjected to prosecution, as is for a physician who fails to comply with the legal requirements for physician-assisted death.

Importance of Physician-assisted Suicide Legislation

Physician-assisted suicide is an essential issue in the US health policy because it provides an opportunity to enhance all forms of patient-centered care at the end of life. Even though the legislation is under special scrutiny, comprehending how and when the practices involved in the PAS take place can assist in strengthening the US health care policy stakeholders refine decision-making approaches (Cavallo & Von Roenn, 2017). Besides, the US health care policy development can significantly benefit from the legalization of PAS because the legislation is associated with improved hospice and palliative care services. After all, more patients may bring up concerns regarding end-of-life matters, and their providers will have an opportunity to a range of alternatives. Research indicates that patients who have requested PAS also receive a hospice referral, and they are less likely to take medicines, showing that eliminating all barriers to all end-of-life alternatives enhances patient-centered care (Cavallo & Von Roenn, 2017).

Past Voter Initiatives Concerning PAS

The PAS has a long history of voter initiatives. In 1991, Washington voters defeated the PAS initiative. In 1992, the California voters defeated Proposition 161, the California Death with Dignity Act, which would have allowed physicians to hastened death by actively administering o prescribing medicines for self-administration by suffering, terminally-ill patients. In 1997, Oregon voters kept the Death with Dignity Act that allowed PAS. Similarly, in 1998, Michigan voters defeated the PAS proposal. Besides, in 2008, Washington voters passed the Death with Dignity Act that allowed PAS. In 2012, the Massachusetts voters defeated the Death with Dignity Ballot Measure that would legalize PAS by permitting doctors to administer a lethal dosage of medicines to individuals with less those six months to live (Meisel, 2020).

Identification of key stakeholders/interest groups

Several stakeholders play a crucial role in the implementation of physician-assisted suicide. Besides, they have significant power and persuasive abilities in the legality or dismissal of the idea of PAS. The stakeholders include physicians, patients, pharmaceutical companies, and insurance companies (Sawanni, 2020). Through PAS, pharmaceutical companies can gain and benefit from their participation in the implementation of the legislation. Even though this act might seem unethical, the law of business dictates that when there is demand, someone needs to establish a supply for the commodity. However, some critical problems can occur by making these pills readily accessible. As stakeholders, patients are defined as terminally ill persons with less than six months to live. Patients care about this legislation because it offers them a choice to end the sufferings and die in peace.

Besides, physicians are key stakeholders because they have to prescribe the drugs necessary for the patients to commit PAS. However, this legislation is against their Hippocratic Oath they take and, as such, puts them in a moral dilemma they have to live with even after the patient has long been gone (Sulmasy & Mueller, 2017). Their decisions to speak to the patients concerning PAS options make them significant stakeholders (Sawanni, 2020). On the other hand, insurance companies are a primary stakeholder because more life insurance policies have a contestable clause, which states that within a two year grace period, the insurance company will not compensate if the policyholder commits suicide, which includes PAS. It is a common practice for people to update their insurance and get betters and more costly plans making it extremely likely that they will die in the next two year grace period. Therefore, through PAS, insurance companies can reap a lot of financial rewards, making the key stakeholders (ProCon.org, 2018). Patients are forced to pay for this kind of treatment out of their pocket

because insurance companies do not cover it. The insurance companies do not also have to pay anything when the patient dies.

Analysis of health policies or legislation to address physician-assisted suicide

The Death with Dignity Act legislation was proposed to address the issue of physician-assisted suicide. The legislation addressed the issue of physician-assisted suicide by allowing a qualified terminally-ill adult to voluntarily ask and receive a prescription medicine to quicken their death. The principal justification cited for this policy change has been the implementation of principles of autonomy and dignity (Simmons, 2018). Most patients have mentioned that losing autonomy is the most common reason for the Death with Dignity Act patients to choose PAS. As of September 2019, the legislation allowed the aid in dying status to become in effect in several states, which included California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, Oregon, Vermont, and Washington. As noted earlier, in Montana, physician-assisted was made legal by a court ruling which passed the Death with Dignity Act. The death with dignity laws outlines the process by which qualified persons may obtain life-ending medications. As a result, it is up to patients eligible and their caregivers to implement the laws on an individual basis because there are no governmental programs that offer assistance (Simmons, 2018). However, the department of health in each state monitors the law. This legislation change has significantly help terminally-ill patients who suffered a lot during end-of-life to permit the physician to hasten their deaths to relieve them from the suffering and die with the dignity they deserve.

Financial implications

Many scholars have linked the efforts to decrease the high cost of death with the legalization of physician-assisted suicide. Besides, there has been a widespread perception in the

US that the country spends a considerably excessive amount of money on high technology healthcare for terminally-ill and dying paints. There, there have been arguments that managed care and managed death-through physician-assisted suicide are less expensive than fee-for-service care and extended survival (ProCon.org, 2018). As such, most people agree that less expensive is better (Fotolia, 2015). However, as noted earlier, no government programs or insurance companies are swilling to foot the cost of physician-assisted suicide. As a result, the patient must pay for the act from his or her pocket (ProCon.org, 2018). Besides, in case one had a life assurance cover that is active within two years grace period, implementing the policy change will mean that the insurance company will not pay the damages death with suicide will have voided the cover; hence the family o the deceased may end up losing a lot of money at the expense of insurance companies.

Overall, the physician-assisted debate has raised a lot of questions on its legality. Besides, the policy change has had a long journey since its proposal in the early 1980s. Previously, the common law prohibited all American citizens from participating in physician-assisted suicide, and severe penalties could e imposed on the deceased property as well as the physician who performed the act. However, due to public pressure and justification of the principles of autonomy and dignity, the matter of physician-assisted suicide has become a matter of the law of the individual states exclusively. As pressure mounted, Oregon became the first state to pass the Death with Dignity Act. Physician-assisted suicide is an essential issue in the US health policy because it provides an opportunity to enhance all forms of patient-centered care at the end of life. Besides, various stakeholders influence the implementation of PAS. Further, the implementation of PAS has been aided by the proposal of the Death with Dignity Act in multiple states. Most

importantly, even though PAS has several benefits to the healthcare system and patients, there is the severe financial implication of the policy on the patient's side.

References

Cavallo, J., & Von Roenn, J. H. (2017). Examining the Impact of 'Death With Dignity'Legislation.

Fotolia. (2015). Why you shouldn't overlook the financial implications of doctor-assisted suicide. Retrieved 26 March 2020, from https://business.financialpost.com/personal-finance/why-you-shouldnt-overlook-the-financial-implications-of-physician-assisted-suicide

Meisel, A. (2020). A History of the Law of Assisted Dying in the United States. *SMU Law Review, Forthcoming*, 2019-25. Retrieved from> file:///C:/Users/USSER/Downloads/SSRN-id3491401.pdf

ProCon.org. (2018). Would Financial Motivations Encourage Insurance Companies and Health Care Providers to Promote Euthanasia and Physician-Assisted Suicide? – Euthanasia. Retrieved 26 March 2020, from https://euthanasia.procon.org/questions/would-financial-motivations-encourage-insurance-companies-and-health-care-providers-to-promote-euthanasia-and-physician-assisted-suicide/

Sawanni, J. (2020). The Stakeholders in Physician Assisted Suicide. Retrieved 25 March 2020, from https://medium.com/@Dying_With_Dignity/the-stakeholders-in-physician-assisted-suicide-6726604f8b7b

Simmons K. M. (2018). Suicide and Death with Dignity. *Journal of law and the biosciences*, *5*(2), 436–439. https://doi.org/10.1093/jlb/lsy008

Sulmasy, L. S., & Mueller, P. S. (2017). Ethics and the legalization of physician-assisted suicide: an American College of Physicians position paper. *Annals of internal medicine*, *167*(8), 576-578.