Medical ethics can be thorny even with a relatively benign topic being considered. But physician-assisted suicide (PAS) is anything but benign. It contains elements of personal beliefs, religion, human rights, end-of-life-care, the law, and euthanasia - a very provocative issue in its own right, one which has been brought to international prominence by the recent suicide of David Goodall, a 104-year-old scientist from Australia. Goodall decided that he had enough. But euthanasia is illegal in Australia at this time, so Goodall elected to fly to Switzerland, where he died with the aid of a Swiss assisted dying agency.

Goodall's thoughts on the matter were clear.

"I'm not happy. I want to die. It's not sad particularly. What is sad is if one is prevented.

"My feeling is that an old person like myself should have full citizenship rights including the right of assisted suicide."

At the heart of the matter is an individual's right to choose how and how long to live. It should not be surprising that opinions are all over the map. And these opinions raise some intriguing issues.

As of mid-2017 physician-assisted suicide was legal in five states in the US - Oregon, Vermont, Washington, California, and Montana (1) and the District of Columbia. But there are a number of
limits. These include:

- A terminal illness
- Six months (or less) to live.
- Who is permitted to write the prescription for the drugs.
- Mandatory waiting periods and as many as three different consents by the patient.
- **Mental Competence.** It is here where the beliefs are the strongest and the opinions the loudest.

Alzheimer's Disease (AD) is arguably the worst of all possible afflictions. Its progression and outlook are predictable and gruesome, there are no effective drugs to prevent or treat it (2), and it takes an enormous physical, emotional, and financial toll on both the patient and his or her (3) family. And it kills slowly, (4) forcing victims and their families to go through different stages, each marked by a decrease in cognitive function. By the end, the victim barely resembles the person he or she once was.

Anyone who has spent time in a nursing home has seen what this disease does to people, so it is not surprising that some people who have just been diagnosed with AD will wish to end their lives. But when? This is where legal and ethical matters become very murky.

There are two diametrically opposed opinions about assisted suicide for victims of AD. Neither is right or wrong, but there is an interesting bit of logic that bears examining: Under current state laws, it is impossible for someone with AD, regardless of the stage, to have the option of physician-assisted suicide. This is because of a Catch-22 situation that is built into our laws; one that leaves AD patients who wish to end their lives in a uniquely bad situation.

1. **The six-month rule.**

   All five states specify that a candidate for PAS must have six or fewer months to live. While this requirement at least makes sense for terminal cancer patients, it falls flat when applied to AD. When patients are in early stages of AD they have far more than six months to live. Six years would be far more common. So, under current state laws, AD patients cannot choose PAS since they are not (yet) terminally ill.

2. **Mental capacity: A sound mind.**

   Unlike other diseases, the nature of AD guarantees that a person cannot possibly be of sound mind when he or she is near death; they lack the capacity to make any choice. This is where things get complicated, which can be seen in a few questions:

   1. At the time when an early-onset AD patient is lucid enough to make a rational decision about how or when to end his or her end of life, current laws automatically disqualified them from doing so because they are too healthy. Does it make any sense for sufferers of this particular affliction to be deprived of the right to determine their own fate simply because they are too "healthy" at the time?

   2. If the goal of PAS is to prevent unnecessary suffering then why are AD patients and their families forced to suffer for years with no recourse while others who just happen to be afflicted with a different terminal disease have the right to choose their own fates? Is this
logical, humane, or medically sensible?

3. Critics have cited potential abuses, for example, a financial benefit to the patient’s family, as a reason to forbid the act. Is the possibility of abuse sufficient cause to bar a practice that some view as merciful?

4. What if someone with early Alzheimer's makes his preferences known while still competent but seems content, maybe even happy, five years later when he or she is no longer competent?

This is a topic with no right answers but also no wrong questions. Five million people in the US are currently living with AD and 16 million [1] are projected to have the disease by 2050. This very contentious issue is worth a discussion.

NOTES:

(1) Montana’s law resulted from a ruling by Montana’s Supreme Court, not a vote.

(2) Some neurologists maintain that drugs like Aricept are useful in delaying progression of the disease. If they do it’s not by much, and, since all three approved drugs work by inhibiting the enzyme acetylcholine esterase, they have plenty of side effects. This is to be expected since this is the same mechanism by which VX gas kills people.

(3) "Her" is often accurate. Woman have one chance in six of developing AD; the risk in men is one in 11.

(4) The average survival time from diagnosis to death is 4-8 years, but some people live 20 years with AD.

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