

Title: Results from a Survey of American Geriatrics Society Members' Views on Physician-Assisted Suicide

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: [10.1111/jgs.16245](https://doi.org/10.1111/jgs.16245)

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Abstract word count: 251

Main text word count: 4,584

Number of tables: 2

Number of figures: 0

Abstract

Background: Physician-assisted suicide (PAS) is a controversial practice, currently legal in nine states and the District of Columbia. No prior study explores the views of the American Geriatrics Society (AGS) membership on PAS.

Design: We surveyed 1488 randomly selected AGS members via email.

Participants: 369 AGS members (24.8% response rate).

Analysis: We conducted bivariate correlation analyses of beliefs related to support for PAS. We also conducted qualitative analysis of open-ended responses.

Results: There was no consensus regarding the acceptability of PAS, with 47% supporting and 52% opposing this practice. PAS being legal in the respondent's state, belief that respect for autonomy alone is sufficient to justify PAS, and intent to prescribe or support requests for PAS if legal in state of practice all correlated with support for PAS. There was no consensus on whether the AGS should oppose, support, or adopt a neutral stance on PAS. Most respondents believed that PAS is more complex among patients with low health literacy, low English proficiency, disability, dependency, or frailty. Most respondents supported mandatory palliative care consultation and independent assessments from two physicians. Themes identified from qualitative analysis include: role of the medical profession, uncertainty of the role of professional organizations, potential unintended consequences, autonomy, and ethical and moral considerations.

Conclusion: There was no consensus among respondents regarding the acceptability of PAS. Respondents expressed concern about vulnerable older populations and the need for safeguards when responding to requests for PAS. Ethical, legal and policy discussions regarding PAS should include consideration of this population.

Keywords: physician assisted suicide, physician aid in dying, physician assisted death, palliative care end-of-life care

Background

End-of-life care is an important issue for patients, families, and caregivers. In its 2014 report, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,” the Institute of Medicine (IOM) indicates that despite considerable progress, important challenges remain in providing end-of-life care for Americans that is high-quality, compassionate, and reflective of individuals’ care preferences.¹ The IOM report explicitly recommends that end-of-life care be person-centered, family-oriented, available, and covered by insurance. The report further states that patients who receive palliative care and hospice may live longer than similarly ill people who do not receive such care, and that these services alleviate much of the suffering and symptom burden often associated with dying. The IOM report does not address the issue of physician-assisted suicide, but the shift in the patient-physician relationship away from paternalism and toward shared decision-making in which patients’ preferences and autonomy are more explicitly recognized, the legalization of physician-assisted suicide in several states, and medicine’s ability to extend life often without parallel extension of function, make physician-assisted suicide a salient – and controversial – topic.

Physician-assisted suicide (PAS) is defined as the physician providing medication or a prescription to a terminally ill patient at the patient’s explicit request with the understanding that the patient intends to use the medication(s) to end their life.² With advances in medicine and technology, individuals with chronic and terminal diseases are living longer but often face prolonged periods of disability and potential suffering related to their conditions. This trend has led to increased attention to PAS as a potential option for patients at the end of life.

Physician-Assisted Suicide (PAS) in the United States

In recent years, US public opinion shifted toward greater acceptance of PAS as an option for terminally ill patients. A 2017 survey indicated that 67% of American adults supported legalizing PAS.³ In 2017, 27 states reviewed and rejected legalization of PAS.⁴ At least 23 states considered such legislation in 2018, and so far in 2019, 18 states are considering it.⁵ By the end of 2018, PAS was legal in seven states (Oregon, Washington, Montana, Vermont, California, Colorado and Hawaii) and the District of Columbia⁴, and legalized formally in all but Montana and the District of Columbia, where the option of PAS is given to individuals by court decision. In 2019, New Jersey⁶ and Maine⁷ legalized PAS. PAS remains controversial among health professionals and among lay individuals.

Although there has been increasing interest in surveying the US public regarding their views about PAS, to the best of our knowledge, there have been no surveys of geriatrics health care professionals’ views about PAS. In particular, little is known about views regarding PAS among members of the American Geriatrics Society, an organization comprised of geriatrics health care professionals that develops guidance to support clinicians who care for older people, many of whom are frail or have multiple chronic conditions, with the goal of improving care in advancing age and at the end of life. AGS

members' views about PAS are important to elicit given their central roles in both caring for and advocating for older adults. This paper reports on the results of a survey of AGS members conducted to better understand their views on PAS.

Terminology

The Hastings Center uses the term “physician-assisted death” (PAD) when referring to the practice described above.⁸ Other terms describing PAD include physician aid-in-dying, patient-directed aid-in-dying, and patient-administered hastened death. We used the term PAS in this paper for convenience, and our survey included one question to determine whether a consensus might be reached about a favored term. Although the medical literature commonly uses the term PAS, it is far from a uniformly accepted term, and the term PAD appears to have since gained greater acceptance. Since we used the term “physician-assisted suicide” (PAS) in the survey that is the focus of this paper, we will use the term PAS throughout to avoid confusion.

PAS, in which the patient self-administers the lethal intervention, is distinct from voluntary active euthanasia, in which a third party administers, at a patient's request, a medication or other interventions intended to cause death.⁹ This distinction was included in the introduction to the survey.

METHODS

Survey Development

In 2015, at the request of AGS leadership, two AGS Ethics Committee members (LR and TF) presented an update on PAS to participants of the Donald W. Reynolds Foundation (DWRf) Annual Grantee Meeting. This meeting assembled faculty from 44 DWRf grantee institutions charged with advancing geriatrics education. The update included a summary of the 2002 AGS position statement on PAS and of current international policies on this issue. The presentation was followed by open discussion and a small group exercise that later informed the development of the survey presented here regarding PAS.

Co-authors LR and TF developed the survey, with iterative input from a third co-author (VJP) and the AGS Ethics Committee. In addition to demographic and practice information, the survey included questions about the relationship of PAS to the availability of palliative care, respondents' experiences with PAS (e.g. requests for PAS and responses to these requests), and concerns for special populations with regard to PAS. One survey question explored interest in safeguards to protect against inappropriate use and abuse of PAS where it is legal. Other survey questions asked if PAS should be available for physicians to provide to their terminally ill patients and, distinct from personal opinion, the appropriate position for AGS to take on the issue. Respondents were also invited to provide an open-ended response to explain their answer choices. The full survey is available in online Appendix A.

AGS staff distributed the survey on March 24, 2016 using the online platform SurveyMonkey¹⁰ to 1,488 randomly selected AGS members, a sample representing approximately 20% of the AGS membership at the time. Reminder e-mails were sent after two weeks, with additional reminder e-mails sent three days prior and one day prior to closing the survey. We closed the survey on April 22, 2016.

Data Analysis

Quantitative analysis

We generated descriptive statistics to identify baseline characteristics of the sample, including gender, discipline, board certification or practice pattern, and length of time in practice. We conducted bivariate correlation analyses of beliefs related to support among respondents for PAS as an option for physicians to provide their terminally ill patients. Bivariate correlation analyses demonstrated the unadjusted relationship between variables of interest for further analysis. We used a statistical significance level of $p < .05$. Logistic regressions are not presented due to small sample size. All quantitative data analyses were conducted using the statistical software package SPSS version 22.0.¹¹

Qualitative analysis

We conducted a qualitative analysis of the open-ended responses. Six members of the study team—4 geriatricians (LR, TF, RR, UB), a health psychologist (JB), and a gerontologist (JT)—used an approach drawn from grounded theory to code the data.¹² Responses were loaded into ATLAS qualitative analysis software,¹³ reviewed, and coded based on a preliminary coding scheme that was updated twice as new ideas were encountered. Using an iterative process, the team grouped quotes with similar codes into themes. De-identified data including the coded quotes assigned to each theme is available upon request to the authors.

IRB Approval

The Roseman University of Health Sciences Institutional Review Board approved this survey on March 22, 2016 (protocol number 16-SM-MD-0201).

RESULTS

Quantitative Results

Response Rate and Descriptive Characteristics

Results are provided in Table 1. 369 AGS members responded to the survey (24.8% response rate). Respondent characteristics are depicted in Table 1. 60% of respondents were female, and 81% of respondents were physicians, the same percentage of physicians as in the overall AGS membership at the time of the survey (e-mail communication with Mary Jordan Samuel, 7/31/18). Two-thirds of respondents had been in practice for 16 years or more.

Attitudes Regarding PAS and Experience with PAS

Results are provided in Table 2. Survey respondents were nearly equally divided regarding the acceptability of PAS, with 52% opposed to PAS and 47% believing that physicians should have PAS as an option for their patients with terminal illness.

We present a summary of the survey results in Table 2. 25% of respondents believed that respecting a patient's autonomy alone was sufficient to justify PAS. Respondents' attitudes about PAS relative to the availability of high-quality palliative care and their willingness to provide or otherwise support PAS were divided, with 54% of respondents reporting that PAS would not be necessary if high-quality palliative care is provided, while another 40% believed that PAS may be necessary even if high-quality palliative care is available. 37% of respondents would provide PAS to a patient if PAS were legal in their state of practice, while 46% would support a patient's request for PAS. As the responses to this question total more than 100%, and because some respondents might include in "supporting an individual's choice for PAS" the more active instance of providing it, it is not clear to what extent respondents distinguished the two options.

The survey asked respondents to choose one option from among 5 choices and 'other' for the most appropriate term for PAS. No option was preferred by a majority of respondents, but a plurality, 29%, preferred "patient-directed aid in dying." The terms "death with dignity" and "physician-assisted suicide" both received support from greater than 20% of respondents. No clear preference emerged among survey respondents for the best term to describe this practice.

Overall, 38% of survey respondents believed the AGS should take a neutral stance on the issue of PAS and 27% endorsed the notion of the AGS supporting PAS with appropriate safeguards and education, while 31% suggested that the AGS discourage or prohibit the practice of PAS. Approximately 70% of respondents believed that PAS is more complex when the individual who might desire PAS belongs to a special population, e.g. patients with low health literacy, limited English proficiency, or disability, dependency, or frailty.

One survey question presented respondents with multiple options for safeguards against abuse of PAS and allowed for multiple selections. Mandatory palliative care consultation and the requirement that two physician assessments result in concurrence that PAS is appropriate were each supported by just over three quarters of respondents. A required waiting period between the request for PAS and

provision of a prescription, and assessment of decisional capacity and/or depression by the patient's physician or a new consultant, each garnered support from slightly more than half of respondents.

Notably, a small fraction of respondents had any experience with PAS; only 2% of respondents had ever prescribed medication for the purpose of PAS, with 14% having verbally or otherwise supported a patient's decision to pursue PAS.

No survey item had a non-response rate (missing data) of greater than 5%. Therefore, no statistical adjustment was required to account for the missing responses.¹⁴ To ease interpretation and presentation of results, we re-coded some variables to minimize double negative wording in the text.

Bivariate Correlations

We conducted bivariate correlation analyses of variables related to support for PAS as an option for terminally ill patients. PAS being legal in the respondent's state ($r = 0.20$, $p < 0.05$), belief that respect for autonomy alone is sufficient to justify PAS ($r = 0.53$, $p < 0.05$), and intention to prescribe ($r = 0.78$, $p < 0.05$) or support requests ($r = 0.81$, $p < 0.05$) for PAS if legal in state of practice all correlated with support for PAS as an option for physicians to provide for their terminally ill patients. Respondent male gender negatively correlated with support for PAS ($r = -0.11$, $p < 0.05$). Respondents' length of time in current position and concerns about vulnerabilities, such as low health literacy or mental capacity, were not related to support for the PAS as an option for physicians to provide for their terminally ill patients.

Qualitative Results

Respondents were given the opportunity to share the rationale for their answer selections in an open-ended survey question, including their choice of an appropriate stance for AGS to take on PAS. 204 respondents shared their views. The comments included are intended only to provide examples and do not reflect the actual distribution of positive versus negative responses.

We outline themes emerging from the qualitative analysis below, along with quotes reflecting each theme:

THEME 1: Role of the medical profession with respect to PAS

Some respondents expressed uncertainty about whether PAS should fall within the medical profession's scope of practice:

Even if society deems it legal...for dying patients to commit suicide, the medical profession believes, as do I, that intentionally ending a person's life is beyond the scope of medicine.

Obviously a very controversial issue. Personally, I could not participate or refer a patient for physician assisted suicide because ...it feels so much against what doctoring is all about. ...I believe palliative care should be able to support these patients in need. I could not see supporting the practice...

Living is a terminal condition. In some cases, we may think we know how close a patient is to that last breath, and we are often wrong. We should aim “to cure sometimes, to relieve often, to comfort always...”

Like abortion, this is an emotional topic. As a geriatric[ian], I have seen situations that could justify suicide. I would rather see this as an acceptable decision/action, as opposed to a lonely ride into the next level beyond life.

THEME 2: Uncertainty of the role of professional organizations in the PAS debate

Respondents expressed both support for and opposition to the AGS weighing in on the issue of PAS:

This issue must be addressed since it is legal in some states, however the Society should not advocate or encourage its practice.

We (AGS) should advocate for robust safeguards in those States where it is legal, to ensure that it is not abused.

If the AGS supports in any form physician assisted suicide I will no longer be a member of AGS... Taking a stand will show support, let's let that decision be solely that of the patient and the caregivers involved.

THEME 3: Potential unintended consequences of PAS

Some respondents addressed potential consequences of PAS, such as creating a ‘slippery slope,’ or other potential consequences of PAS including incremental extension,¹⁵ progression toward abuse of this option, and potential impacts on society:

I feel that the number of cases in which physician assisted suicide might possibly be applicable is very small and the chance of a slippery slope is too great.

[It is a] poor example for youth who want to end their misery by taking their life. The fact that suicide is legal at all presents an example of autonomy to end one's life, which can easily be misunderstood by children.

THEME 4: Autonomy and PAS

Some respondents focused on the issue of autonomy as a reason to support the availability of PAS for terminally ill patients with decisional capacity:

I believe that patients with advanced end-stage conditions that have no chance of improvement with existing appropriate support in terms of palliative care/psychiatry should have a chance to decide about the way and time they will die.

This is an example, albeit extreme, of patient-centered care where we need to support the patient's choice when not coerced by lack of resources, comprehension, or education.

...Further, given that our capacity for autonomy is so valuable, how can it be right deliberately to extinguish it by deliberately extinguishing its bearer?

THEME 5: Ethical and moral considerations regarding PAS

Some respondents raised ethical and/or moral concerns about PAS, stemming sometimes from religious faith, and distinct from any identification with the medical profession. Others cited human dignity as counter to the practice:

This is a temporary stage a human being is on and has to go back to the creator with complete humility and dignity. Accept the natural way of death the creator has prescribed for you.

Physician-assisted suicide is wrong. We should not be pressured into thinking it's a good thing because it's fashionable. It is wrong to take a life, (even your own) ...

This is a moral issue, not a medical issue.

DISCUSSION

To our knowledge, this is the first survey of geriatric health care professionals in the United States regarding PAS. Survey respondents - 5% of the AGS membership - were nearly evenly divided (52% opposed, 47% in favor) regarding PAS. While just over one-third of respondents (37%) stated they would fulfill a patient's request for PAS, a larger percentage (46%) indicated they would support this request. This distinction between willingness to actively versus more passively participate in PAS is consistent with findings from previous surveys of palliative care professionals.¹⁶

The majority of respondents to our survey were seasoned geriatrics health care professionals, with two-thirds in practice for more than 15 years. Most respondents (83%) were board-certified in geriatric medicine, and nearly one in five (19%) were board-certified in hospice and palliative medicine. Nearly half (46%) self-identified as practicing palliative care, highlighting an important overlap between geriatrics and palliative care. 54% of respondents believed that PAS was not necessary if high-quality palliative care is provided, while 40% of respondents believed that PAS may be necessary or appropriate even if high-quality palliative care is available.

Provided a selection of proposed safeguards, three quarters of respondents supported the safeguards of mandatory palliative care consultation and of two physicians making independent assessments and concurring that PAS is appropriate. More than half of respondents supported waiting periods and

capacity and/or depression assessments as safeguards against misuse of PAS. Interest in these particular safeguards, out of the options provided, points to the need for every effort to be made to address reversible symptoms and identify other reasons an individual might pursue PAS. Palliative care consultation is one type of safeguard presented to survey respondents, and reflects the value of an interprofessional team-based approach to patients requesting PAS. For instance, the tasks of symptom management and meaningful goals of care conversations are within the scope of practice of geriatrics as well as palliative care clinicians. Furthermore, engaging disciplines such as nursing, psychology, social work, and chaplaincy should be considered when addressing end-of-life concerns that lead a patient to request PAS. Hence, rather than consider that a particular specialty is necessary or sufficient to do this work, it is the inclusion of individuals most skilled in eliciting the concerns of a particular patient that is paramount.

We found no clear consensus about the preferred term for a physician providing medication or a prescription to a terminally ill patient at the patient's request with the understanding that the patient intends to use the medications to end their life. "Physician-assisted suicide," the term preferred by 22% of respondents, has been used frequently in the American press and was the term included in the AGS member survey. A plurality of respondents, nearly one-third, preferred "patient-directed aid in dying" for the practice. This wording is centered on patient autonomy, but only one in four respondents believed that respecting a patient's autonomy alone is sufficient to justify PAS. Notably, "patient-directed aid in dying" semantically removes the physician from this process. The relative preference for this wording may reflect the ambivalence expressed by some respondents regarding the role of the medical profession in this practice.

Similarly, we found no clear consensus regarding respondents' opinions as to whether the AGS should oppose, support, or remain neutral regarding PAS. Slightly more than one-third (38%) of respondents thought the AGS should adopt a neutral stance on PAS but advocate for robust safeguards in states where it is legal, slightly less than one-third of respondents (27%) thought the AGS should support PAS with appropriate safeguards and education, and slightly less than one-third (31%) of respondents thought the AGS should actively discourage or oppose PAS.

Approximately 70% of respondents believed that the issue of PAS was more complex among special populations of patients with low health literacy, low English proficiency, disability, dependency, or frailty. Some respondents elaborated on this theme, expressing concerns both that vulnerable individuals might be coerced into requesting PAS and that vulnerable individuals might face greater difficulty in accessing PAS.

Five themes arose from the qualitative responses submitted by survey respondents. The first theme involves the role of the medical profession, if any, with regard to PAS, with respondents both supporting

and opposing the role of the medical profession in the practice of PAS. This points to ethical questions raised by modern medicine's ability to extend the lives of individuals with terminal illness, often without commensurate preservation of functional status and quality of life. A related but broader theme that arose from qualitative responses is the role of professional organizations in navigating this issue, with comments espousing support, opposition, neutrality and taking no stance. Neutrality toward PAS by professional organizations has been both championed¹⁷ and criticized.¹⁵

Respondents' concerns regarding PAS included the potential for its use beyond that defined in the survey and the risk of individuals being pressured to make such a request. Both qualitative and quantitative responses showed concern especially for frail, disabled or dependent individuals and those with limited health literacy or limited English proficiency. The assessment of decisional capacity may be more difficult in all of these cases, emphasizing the importance of considering appropriate safeguards for those considering acting on or supporting a terminally ill patient's request for PAS.

In providing open-ended responses to the request for additional thoughts or factors contributing to their support for or rejection of PAS, respondents most commonly cited moral or ethical reasons. While many respondents opposed to PAS cited ethical conflict, a preponderance of those supporting PAS cited autonomy, itself a pillar of ethical reasoning (along with beneficence, nonmaleficence, and justice).¹⁸ Hence, support for or opposition to PAS appears to depend on which ethical principle one believes carries the greatest weight in this context.

LIMITATIONS

The most important limitation of our study is that our survey reflects the views of a small fraction of the AGS membership. The AGS Ethics Committee surveyed a random sample of AGS members representing approximately 20% of the membership at the time the survey was conducted. The response rate of 24.8% is lower than that recommended to avoid non-response bias¹⁹ but falls within the range of known response rates for internet-based surveys from some studies²⁰ but not others²¹; regardless, our results reflect the views of only 5% of AGS members. This small response rate and final sample size prevent us from asserting generalizability even among AGS members, and also prevent us from presenting logistic regression with any certainty about its import.

It is possible that those who chose to respond to the survey had stronger opinions about PAS than non-responders, and that non-responders had more mild or neutral thoughts on the issue. Hence, the views expressed by survey respondents may be stronger and more polarized than those of the AGS membership as a whole. While we believe that a strength of our study is that the percent of survey respondents and of AGS membership who were physicians when the survey was conducted is the same, we do not know if other potentially important demographic characteristics were similar between these two groups.

Additionally, it is possible that the study results would have been different if a term other than PAS had been used in the survey questions. The term suicide can be emotionally charged and carries stigma for many; use of another term in the survey might have produced different results. Also, in spite of the use of the term “suicide,” and the distinction we made in the survey between PAS and voluntary active euthanasia, some respondents may still have conflated these terms.

It is unclear whether respondents who are board-certified in geriatrics versus those who are board-certified in hospice and palliative medicine (some respondents may have board certifications in both specialties) were more likely to receive requests for PAS, or were more supportive of PAS. Our survey did not establish these categories as mutually exclusive. Furthermore, the same question allowed respondents to report practicing palliative care with or without formal board certification. Our survey is therefore not able to address these two issues. These distinctions, however, may not be critical. As noted above, we believe that the ability to address end-of-life concerns that might reverse a patient’s interest in PAS, by any discipline or specialty, is more important than the specific discipline or specialty per se.

AGS membership includes a variety of professionals who care for older adults. 81% of survey respondents were physicians, the same percentage of AGS members who are physicians. A small number of other health care professionals responded, and it is not possible based on our survey, designed primarily to elicit physicians’ attitudes and experiences with PAS, to determine if they provided answers through the lens of health professionals generally, or from their viewpoint on the role of physicians specifically.

Finally, respondents were asked to identify the most appropriate position for the AGS to take on the issue of PAS, but a response that ‘the AGS should take no position on PAS’ was not provided in the survey. The omission of a ‘take no position’ option in the survey may have swayed some results. A very small number of respondents who selected the multiple-choice option of the AGS taking a neutral position implied in their freehand responses that they would prefer that the AGS not take any position. We speculate that some respondents who might have chosen a ‘take no position’ option, had it been an option in the survey, may have selected “choose a neutral stance,” as the latter appeared most similar to the respondent’s view. Also, some respondents may have conflated neutrality and no position. Either instance would lead to overestimation of support for a neutral position. Lastly, the response choices of support for or neutrality toward PAS explicitly included safeguards to accompany the practice, which may have swayed some responses toward neutrality or support.

CONCLUSION

We report the findings of the first survey of AGS members' views on physician-assisted suicide. Despite the low response rate to this survey (representing 5% of AGS members at the time of the survey), the results provide important insights into how some AGS members view PAS. It is notable that 42% of respondents had never faced a request for PAS at the time they completed the survey, and as such had not had to decide whether to provide medication for or otherwise support an individual's request for PAS.

Survey data reveal mixed views and experiences among AGS members with regard to PAS, including paradigms leading both to support for and opposition to the practice. Respondents acknowledged the challenge of determining decisional capacity, especially among those who are disabled, dependent, or frail, those with limited health literacy, and those with limited English proficiency, in both quantitative and qualitative responses. These issues, in particular, deserve further study as legalization of PAS in several states may make this practice more available to, and more commonly requested by, terminally ill older adults in the future.

That vulnerable groups might be more prone to coercion into accessing PAS or, conversely, have greater difficulty accessing PAS than those without such vulnerabilities, underscores the disproportionate difficulty these groups face in receiving health care consistent with their values and goals, and points to the need for better ways to serve these individuals. Given the recent increase in the number of states permitting PAS and the likely increase in providers receiving requests for PAS, ethical, legal and policy discussions regarding this practice should ensure that especially careful consideration is given to terminally ill older adults who possess one or more of the aforementioned vulnerabilities.

ACKNOWLEDGEMENTS

The authors gratefully acknowledge the American Geriatrics Society for the opportunity to survey the AGS membership. We thank Nancy Lundebjerg, Chief Executive Officer of the AGS, and the AGS Board for their thoughtful guidance in this work, Mary Jordan Samuel and Aimee Cegelka from the AGS staff for their logistical support, and Dr. Debra Saliba for her critical review of the manuscript. We also thank Drs. Joseph Shega, Alexia Torke and Nirranjan Thotala for their thoughtful contributions. Finally, we thank those AGS members who completed the survey and provided invaluable qualitative comments.

Conflict of Interest and Disclosures

Authors LJR, JMB, AJC, RLR, UKB, CAV, JT, VSP, and TWF have no conflicts of interest to disclose.

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Analysis and interpretation of data: LJR, TWF, JMB, JT, UKB, and RLR

Manuscript preparation: LJR, TWF, JMB, CAV, AJC, and RLR

Sponsors Role: None

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Table 1

Respondent Characteristics

| CHARACTERISTICS | N 369 (%)* |
|--|------------|
| Gender** | |
| Male | 140 (40%) |
| Female | 211 (60%) |
| Rather not say | 3 (1%) |
| Discipline | |
| Physician | 297 (81%) |
| Nurse/Nurse practitioner | 31 (8%) |
| Pharmacist | 10 (3%) |
| Physician assistant/social worker/physical or occupational therapist/other healthcare professional | 15 (4%) |
| Board certification or practice pattern*** | |
| Geriatric medicine board certification | 275 (75%) |
| Hospice and palliative medicine board certification | 69 (19%) |
| Practice hospice and palliative care | 153 (42%) |
| Commonly refer patients to palliative care | 140 (43%) |
| Length of time in practice | |
| < 1 year | 3 (1%) |
| 1-5 years | 44 (12%) |
| 6-10 years | 38 (10%) |
| 11-15 years | 41 (11%) |
| ≥16 years | 227 (67%) |

*Totals may not equal 369 and 100% due to participant non-response on individual survey questions and opportunities for multiple answer selections for other questions.

**The survey included options for “transgender” and “other”; no respondents selected those choices.

***Respondents were asked to select all that apply.

Table 2

Respondents' Attitudes Regarding PAS and Experiences with PAS

| Respondents' Attitudes | N (%)* |
|--|---------------|
| Should physicians have as an option for patients with terminal illness the ability to prescribe a lethal medication that the patient can take to end her life by her own hand? | |
| Yes | 172 (47%) |
| No | 192 (52%) |
| Respect for autonomy <i>alone</i> justifies PAS for patients who request it. | |
| Yes | 95 (26%) |
| No | 268 (73%) |
| Which statement best describes your sentiment on high quality palliative care and assisted suicide/death (all statements refer to terminally ill patients)? | |
| PAS not necessary/appropriate if high quality palliative care is provided | 199 (54%) |
| PAS may be necessary/appropriate if high quality palliative care is unavailable | 19 (5%) |
| PAS may be necessary/appropriate even if high quality palliative care is available | 147 (40%) |
| If legal in your state and your terminally ill patient requested – would you fulfill the patient's request by providing lethal medication? | |
| Yes | 135 (37%) |
| Would like to but prohibited by entity (e.g., government or faith-based) that I work for | 33 (9%) |
| No | 187 (51%) |
| If legal in your state and your terminally ill patient requested – would you support the patient's request for lethal medication? | |
| Yes | 170 (46%) |
| Would like to but prohibited entity that I work for | 26 (7%) |
| No | 159 (43%) |
| Terminology AGS should adopt to describe PAS | |
| Death with dignity | 85 (23%) |
| Patient-directed aid in dying | 106 (29%) |

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| | |
|--|---------------------------------|
| Physician aid-in-dying Physician assisted death Physician assisted suicide | 29 (8%) 35 (10%) 82 (22%) |
| Appropriate position AGS should adopt on PAS* | |
| Support practice with appropriate safeguards and education | 99 (27%) |
| Choose a neutral stance but advocate for robust safeguards in states where it is legal | 140 (38%) |
| Discourage its practice | 65 (18%) |
| Prohibit its practice in any circumstance | 46 (13%) |
| Proportion of respondents who acknowledge unique challenges for the groups listed below to choose or access assistance in taking their lives, with a substance prescribed/provided by a physician, when faced with a terminal condition: | |
| Have low health literacy | |
| Yes | 271 (73%) |
| No | 70 (19%) |
| Have limited English proficiency | |
| Yes | 262 (71%) |
| No | 107 (29%) |
| Are disabled, dependent, or frail | |
| Yes | 253 (69%) |
| No | 90 (24%) |
| In States where providing, at the request of patients with terminal illness, a lethal medication that the patient can take by their own hand to end their life is legal, what safeguards would be most effective? (Select all that apply.) | |
| a. At least two physicians make separate assessments resulting in concurrent recommendations | 254 (75%) |
| b. Capacity and/or depression assessments must be completed by patient's physician | 191 (57%) |
| c. Capacity and/or depression assessments must be completed by a physician who does not previously know the patient | 174 (52%) |
| d. Maintenance of a database to track demographics such as race, socioeconomic status | 157 (47%) |
| e. Mandatory palliative care consultation | 251 (75%) |
| f. Third party or blinded review process | 88 (26%) |
| g. Waiting period between request and provision of prescription | 215 (64%) |
| h. Other _____ | 38 (10%) |

| Respondents' Clinical Experiences | |
|---|------------|
| Have you provided, prescribed or supported for a patient with a terminal illness, at the patient's request, a medication that the patient can take by their own hand to end her or his life?* | |
| I have prescribed or provided the means for a patient with a terminal illness to end her or his life | 8 (2.2%) |
| I have supported such a patient by verbally making it clear that I support their decision | 38 (10.3%) |
| I have supported such a patient by referring them to a provider who may be better able to assist them | 12 (3.3%) |
| I have not provided, prescribed or supported a patient with a terminal illness in pursuing this course | 192 (52%) |
| I have never been in a situation that required me to make this decision | 154 (42%) |

*Totals may not equal 369 and 100% due to participant non-response on individual survey questions and opportunities for multiple answer selections for other questions.

**Respondents were provided with a list of terms from which to choose.