Lessons from Recent Polls on Physician-Assisted Suicide

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Abstract. Physician-assisted suicide is an active political issue, and recent polls have indicated shifts in public opinion in favor of its permissibility and moral acceptability. However, structural errors and biasing effects exist in these polls, including several subtle logical fallacies as well as cognitive and reporting biases. Analysis of the polls suggests that public support for physician-assisted suicide is more conditional and much softer than the popular news headlines indicate. An understanding of how these factors function beneath the headlines provides important lessons for the discussion of physician-assisted suicide. *National Catholic Bioethics Quarterly* 17.2 (Summer 2017): 247–257.

Physician-assisted suicide will be a prominent legislative issue in the United States in 2017. Lawmakers in twenty-one states rejected physician-assisted suicide measures in 2015, and eleven states blocked similar attempts in 2016.[1] However, after successful legislative enactments in California and the District of Columbia as well as a successful ballot initiative in Colorado in 2016, advocates of physician-assisted suicide are planning legislative introductions in as many as twenty states in 2017, with high priority in New York, New Mexico, and Massachusetts.[2]

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1. "We Are Winning," Patients Rights Action Fund, May 2015, http://patientsrightsaction.org/; and "2016 Doctor-Prescribed Suicide Bills Proposed," Patients Rights Council, accessed April 18, 2017, http://www.patientsrightscouncil.org/.

2. "Different States, Different Strategies for Authorizing Aid in Dying as a Compassionate Option," Compassion and Choices, accessed August 7, 2017, https://www.compassionandchoices.org/.

Some recent polls suggest that public opinion is shifting in favor of physician-assisted suicide. Reported under the headline "In U.S., Support Up for Doctor-Assisted Suicide," a 2015 Gallup poll showed a two-year increase in support, up 17 percent to 68 percent.[3] The report of a 2016 LifeWay Research poll, titled "Most Americans Say Assisted Suicide is Morally Acceptable," showed that "many Americans (69 percent) say physicians should be allowed to assist terminally ill patients in ending their lives."[4] But it is important to understand that structural errors and biasing effects exist in these polls, which incorporate several subtle logical fallacies as well as cognitive and reporting biases.[5] Analysis of the polls suggests that public support for physician-assisted suicide is conditional and much softer than the headlines indicate. An understanding of how these factors function beneath the headlines provides important lessons for the discussion of physician-assisted suicide.

Poll Structure and Results

Both polls presented two propositions to the respondents: one about the permissibility of physician-assisted suicide and the other about its moral acceptability. The Gallup poll was a telephone-interview survey that was structured with closed dichotomous questions, but it also scored respondents who expressed no opinion. Gallup presented the permissibility issue first and structured it as a question about legalization: "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?"[6] Gallup presented two responses, *should* and *should not*, as well as *no opinion*. Next, the poll examined the moral acceptability of several high-profile issues, including doctor-assisted suicide: "Next, I'm going to read you a list of issues. Regardless of whether or not you think it should be legal, for each one, please tell me whether you personally believe that in general it is morally acceptable or morally wrong. How about doctor-assisted suicide?" Gallup presented two responses, *morally acceptable* and *morally wrong*. Although pollsters did not

3. Jeff Jones and Lydia Saad, "Values and Beliefs," Gallup Poll Social Series, May 6–10, 2015, http://www.gallup.com/file/poll/183440/Doctor_Assisted_Suicide_150527.pdf, reported in Andrew Dugan, "In U.S., Support Up for Doctor-Assisted Suicide," *Gallup*, May 27, 2015, http://www.gallup.com/.

4. LifeWay Research, "American Views on Assisted Suicide: Representative Survey of 1,000 Americans," September 21–October 1, 2016, http://lifewayresearch.com/, reported in Bob Smietana, "Most Americans Say Assisted Suicide Is Morally Acceptable," *LifeWay Research*, December 6, 2016, http://lifewayresearch.com/.

5. Here and throughout this essay, I use the term *bias* to refer to "the fact that the results of research or an experiment are not accurate because a particular factor has not been considered when collecting the information," and not to refer to "a strong feeling in favor of or against one group of people, or on one side in an argument, in a way that influences your decisions in an unfair way" (*Oxford Learner's Dictionary of Academic English*, s.v. "bias").

6. Gallup found a similar response distribution when pollsters asked a separate sample of respondents a similar question, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it?"

supply the option of *no opinion*, they did record and score voluntary responses of *depends on situation*, *not a moral issue*, and *no opinion*.[7]

The LifeWay Research poll was an online survey that structured the propositions as two statements and inverted the order in which the issues were introduced, presenting moral acceptability first, followed by permissibility. LifeWay phrased both statements as affirmative for physician-assisted suicide and underlined the determinative phrases in the presented statements: "When a person is facing a painful terminal disease, it is morally acceptable to ask for a physician's aid in taking his or her life," followed by "Physicians should be allowed to assist terminally ill patients in ending their life."[8] LifeWay requested and scored responses on a closed four-choice Likert scale: *strongly agree*, *somewhat agree*, *somewhat disagree*, and *strongly disagree*. There was not an option for *no opinion*.[9] The results of both polls are shown in Table 1.

Table 1. Results of Gallup and LifeWay Polls on Physician-Assisted Suicide

Permissibility		Moral Acceptability	
Gallup			
Question 1. "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?"		*Question 2*. "Regardless of whether or not you think it should be legal, for each one, please tell me whether you personally believe that in general it is morally acceptable or morally wrong. How about doctor-assisted suicide?"	
Should	68%	Morally acceptable	56%
Should not	28%	Morally wrong	37%
No opinion	4%	Depends on situation	4%
		Not a moral issue	*
		No opinion	2%
LifeWay			
Question 2. "Physicians should be allowed to assist terminally ill patients in ending their life."		*Question 1*. "When a person is facing a painful terminal disease, it is morally acceptable to ask for a physician's aid in taking his or her life."	
Strongly agree	32%	Strongly agree	31%
Somewhat agree	37%	Somewhat agree	36%
Somewhat disagree	17%	Somewhat disagree	17%
Strongly disagree	14%	Strongly disagree	16%

Sources: Gallup data from Andrew Dugan, "In U.S., Support Up for Doctor-Assisted Suicide," *Gallup*, May 27, 2015; LifeWay data from Bob Smietana, "Most Americans Say Assisted Suicide Is Morally Acceptable," *LifeWay Research*, December 6, 2016.

7. Jeff Jones and Lydia Saad, "Gallup Poll Social Series: Values and Beliefs," referenced in Dugan, "Support Up for Doctor-Assisted Suicide."

8. LifeWay Research, "American Views on Assisted Suicide: Representative Survey of 1,000 Americans," December 6, 2016, http://lifewayresearch.com/.

9. Ibid., referenced in Smietana, "Assisted Suicide Is Morally Acceptable."

The Hierarchical Rule of the Debate

Despite confounding concepts of morality, permissibility, and legality in the polls, both sides in the physician-assisted suicide debate seem to have adopted the same hierarchical rule for the contest: what is legal must be permissible, and what is permissible must be moral (Figure 1). The issue is determining what lies within the domain of those concepts.

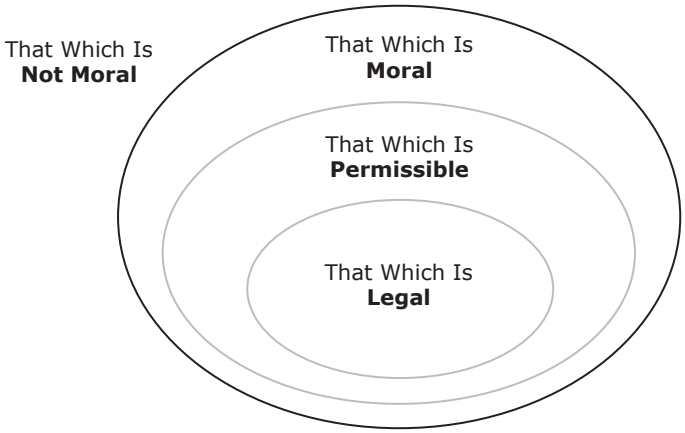

Figure 1. The Hierarchical Rule of the Debate

Notice that the hierarchy moves from the general to the specific. The first question is whether physician-assisted suicide can be moral. The second is whether, or more precisely under what conditions, it is permissible. The third is whether, or under what constraints, it will be legalized.

The Dutch have made the judgment that physician-assisted suicide can be moral, it is permissible in conditions of intolerable suffering, and it is legal under constraints of terminal or psychiatric illness. The government is debating whether the domain of permissibility should be expanded to include "a completed life."[10] In the United States, we are locked in a conflict over the morality of physician-assisted suicide, although debating questions of permissibility and legalization has become

10. The Dutch government notes that under the Dutch Termination of Life on Request and Assisted Suicide (Review Procedures) Act, requests for physician-assisted suicide or euthanasia "often come from patients experiencing unbearable suffering with no prospect of improvement." Government of the Netherlands, "Euthanasia, Assisted Suicide and Non-Resuscitation on Request," accessed April 18, 2017, https://www.government.nl/. The Minister of Health, Welfare and Sport and the Minister of Security and Justice wrote to the Dutch House of Representatives regarding the government position on "completed life" and its plans to expand the current euthanasia–assisted suicide law to accommodate "people who are *generally of an advanced age*, who in their own opinion no longer have any *life prospects* and have as a result developed a *persistent, active desire to die.*" Edith Schippers and Gerard Adriaan van der Steur, "Letter of the Government Position on 'Completed Life,'" Government of the Netherlands, October 12, 2016, original emphasis, https://www.government.nl/.

the method of presenting it. As we shall see, things often seem muddled because this approach is not purely logical.

The parties' agreement on the hierarchical rule also seems to apply only prospectively to the policy dispute but not ultimately to the enforceability of its conclusion. If physician-assisted suicide is legalized, its opponents will refuse to concede that it is moral, in the same manner that its proponents currently assert that laws criminalizing suicide assistance are immoral.

Biasing Conditionals

A conditional statement in and of itself does not constitute a logical argument.[11] However, when the content of the antecedent is taken as a true premise and the inferential link between the antecedent and the consequent is taken in support of the consequent as a conclusion or judgment, an argument has been presented as a hypothetical syllogism.

As a matter of first impression, both polls present essentially the same conditional statement to the respondent: given these particular conditions, physician-assisted suicide is acceptable.[12] If the respondent chooses the affirmative, the conclusion is drawn that physician-assisted suicide is generally acceptable to him.

It is important to note that neither poll expressly confronts the true central premise or the fundamental question of the physician-assisted suicide debate: is it ever morally acceptable for a doctor to intentionally take the life of or hasten the death of a patient as a primary end?[13]

Instead, both polls provide the respondent with this prompt: begin your thinking by considering the plight of a patient who has a terminal illness and is in pain. This establishes an anchoring heuristic and creates a sympathetic framework within which the underlying fundamental moral judgment is cast. To see this more clearly,

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11. Patrick J. Hurley, *A Concise Introduction to Logic*, 11th ed. (Boston: Wadsworth, 2012), 22–24.

12. Here I am using *acceptable* as a bin that includes that which is moral, permissible, or legal.

13. Notice that this question itself is a derivative of even more fundamental questions about the morality of suicide, the morality of assistance to suicide, and the fundamental role of the physician in society. The World Medical Association founds its opposition to physician-assisted suicide on a synthesis of these more fundamental concerns: "Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically" ("WMA Statement on Physician-Assisted Suicide," in *Handbook of WMA Policies*, World Medical Association, accessed April 18, 2017, https://www.wma.net/). The American Medical Association more directly states that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer." AMA, *Code of Medical Ethics*, opinion 5.7, "Physician-Assisted Suicide," updated 2016. The British Medical Association policy is even more direct and "opposes all forms of assisted dying." Among several reasons in support of this policy, the BMA cites that "such a change would be contrary to the ethics of clinical practice, as the principal purpose of medicine is to improve patients' quality of life, not to foreshorten it." BMA, "Physician-Assisted Dying," last updated June 30, 2016, https://www.bma.org.uk/.

suppose the initial Gallup question had been, "When a person with an anxiety disorder says they are suffering unbearably, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?" And suppose the initial LifeWay statement had instead been cast in this way: "When a person of advanced age in their own opinion no longer has any life prospects and has, as a result, developed a persistent, active desire to die, it is morally acceptable to ask for a physician's aid in taking his or her life."[14] It is quite possible that under these conditionals, the headlines would have reported entirely different conclusions regarding the social support for physician-assisted suicide.

Begging the Question

In presenting a logical argument to respondents, both polls commit the logical fallacy of begging the question, which assumes or suppresses a controversial and possibly false first premise and may also include the use of the conclusion to support that premise.[15] In structuring the argument as a hypothetical syllogism with a conditional proposition, both polls suppress the fundamental premise of the physician-assisted suicide debate and then establish a logical construct, which begins with a declared first premise that under certain necessary conditions physician-assisted suicide is acceptable.

The premise that physician-assisted suicide may be acceptable under certain necessary conditions is dependent on and incorporates a suppressed primary premise that physician-assisted suicide can ever be morally acceptable. Indeed, if physician-assisted suicide cannot be morally acceptable, then the conditional proposition is invalid. However, using the conditional as an initial premise, the arguments conclude that physician-assisted suicide is permissible or morally acceptable under the conditions specified.

Here is a logical deconstruction of the argument presented in the first Gallup question, which structures the issue of the permissibility of physician-assisted suicide in terms of its legalization as a professional act. The suppressed primary premises in the argument must be explicated:

> Premise 1 (suppressed): Physician-assisted suicide can be morally acceptable.
>
> Premise 2 (suppressed): If an act can be morally acceptable, it can also be legally permissible.
>
> Premise 3: If necessary conditions are met, physician-assisted suicide is legally permissible.

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14. These conditionals are not matters of hyperbole. Physician-assisted suicide and euthanasia are currently practiced on the psychiatrically ill in the Netherlands. A recent review found that of sixty-six patients who received physician-assisted suicide or euthanasia for a psychiatric illness in the Netherlands between 2011 and 2014, 42 percent had post-traumatic stress and other anxiety disorders. Scott Y. H. Kim, Raymond G. De Vries, and John R. Peteet, "Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014," *JAMA Psychiatry* 73.4 (April 2016): 362–368, doi: 10.1001/jamapsychiatry.2015.2887. As noted here in an earlier footnote, the Dutch government is planning to extend the practice to those with "a completed life."

15. Hurley, *Concise Introduction to Logic*, 157–159.

Premise 4: An incurable disease with severe pain is a necessary condition for physician-assisted suicide to be legally permissible.

Premise 5: A patient request is a necessary condition for physician-assisted suicide to be legally permissible.

Premise 6: Some patients have an incurable disease with severe pain and request physician-assisted suicide.

Conclusion: For those patients with an incurable disease and severe pain who request it, doctors should be allowed by law to perform physician-assisted suicide.

The second LifeWay statement comes closer to the fundamental question. It centers on the permissibility of physician-assisted suicide but again specifies the conditional of a terminal illness. Here is a logical deconstruction of the second LifeWay statement:

Premise 1 (suppressed): Physician-assisted suicide can be morally acceptable.

Premise 2 (suppressed): If an act can be morally acceptable, it can also be permissible.

Premise 3: If necessary conditions are met, physician-assisted suicide is permissible.

Premise 4: A terminal illness is a necessary condition for physician-assisted suicide to be permissible.

Premise 5: Some patients have a terminal illness.

Conclusion: For those patients with a terminal illness, physicians should be permitted to perform physician-assisted suicide.

Both arguments beg the question, "How do you know that physician-assisted suicide can be morally acceptable?" They also use a conclusion that physician-assisted suicide is permissible or allowable by law for terminally ill patients as evidence to reinforce the premise that physician-assisted suicide can be morally acceptable. Nonetheless, the superficial structure of both arguments appears legitimate. This is because both are deductively valid, although unsound. In both arguments, the suppressed first premise is questionable, but the conclusion necessarily obtains.

Confusing the Necessary with the Sufficient

Both polls commit the logical fallacy of confusing the necessary with the sufficient.[16] For those respondents whose support for physician-assisted suicide is conditional, the first Gallup poll question defines terminal illness, severe pain, and a

16. Here I adopt the definitions of Brian Skyrms. Necessary condition: "A property *H* is a *necessary condition* for a property *I* if and only if *whenever I is present, H is present*." Sufficient condition: "A property *F* is a *sufficient condition* for a property *G* if and only if *whenever F is present, G is present*." Brian Skyrms, *Choice and Chance: An Introduction to Inductive Logic*, 4th ed. (Belmont, CA: Wadsworth, 2000), 69, original emphasis. By these rules, for terminal illness to be a necessary condition for the permissibility of physician-assisted suicide, whenever physician-assisted suicide is permissible, a terminal illness must be present. For terminal illness to be a sufficient condition for the permissibility of physician-assisted suicide, whenever a terminal illness is present, then physician-assisted suicide must be permissible.

patient request as necessary conditions for the proposition supporting the legalization of physician-assisted suicide. The second LifeWay statement defines terminal illness as a necessary condition for the permissibility of physician-assisted suicide. In both polls, the conditional—given these particular conditions, physician-assisted suicide is acceptable—becomes this *modus ponens* argument:

If these conditions are met, then physician-assisted suicide is acceptable.

These conditions are met.

Thus, physician-assisted suicide is acceptable.

In a conditional statement, the antecedent is a sufficient condition and the consequent is a necessary condition.[17] Thus, both polls structurally assert that their specified necessary conditions are actually sufficient conditions. However, while terminal illness or pain and patient request are defined as necessary conditions for support of physician-assisted suicide, they may not be sufficient conditions in the minds of those in the public who are not categorically opposed.

Neither poll addresses the sufficiency question fully. Neither asks whether other conditions should or should not be met: What if the patient is mentally ill or incompetent? What if the patient is a child? What if the patient is poor and cannot afford treatment? What about the character of the pain? Should others be allowed to ask for assisted suicide when the patient cannot request it?

For the act of physician-assisted suicide to be permitted in a strictly causal sense, the only necessary conditions are a willing and able physician, a suicidal patient, and a lethal instrument, which in combination become sufficient. From consequential moral and permissive legal standpoints, the nature, safeguards, and limits of the process come from the unambiguous definition of the set of conditions that are necessary and sufficient, that is, the complete set of conditions that permit and constrain the act. For some people, no conditions can be sufficient for physician-assisted suicide. Ominously, others need only the necessary conditions of minimal causal sufficiency. It is probable that most of the poll respondents had not given this aspect of the issue much thought, but an open-ended question could have begun that process.

Straw Man Fallacy

Neither poll explores the effect of palliative or hospice care on terminally ill patients. This subjects both polls to a straw man fallacy by disregarding relevant information that can weigh against physician-assisted suicide and thus creates another anchoring cognitive bias in favor of its desirability. A recent meta-analysis in *JAMA* found that palliative care significantly improves quality of life and reduces symptom burdens.[18] However, a recent review in the *New England Journal of Medicine* notes

17. Hurley, *Concise Introduction to Logic*, 22–24.

18. Dio Kavalieratos et al., "Association between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-Analysis," *JAMA* 316.20 (November 2016): 2104–2114, doi: 10.1001/jama.2016.16840.

that nine of ten adults in the United States are unaware of the nature of palliative care, and when informed of it would want it for themselves or their families.[19]

Neither poll examines whether the respondents would conditionally alter their opinions about physician-assisted suicide if they knew that palliative or hospice care were options for symptom relief. Given the apparently conditional thinking of many of the respondents, the limited conditions offered by both the Gallup and LifeWay polls seem insufficient to form the basis for firm conclusions about true public opinions as to the morality of physician-assisted suicide.

Generality and Response Bias

In opinion polling, response bias may be caused by a survey's structural order, particularly when it includes both general and specific questions. Question order is more relevant to a general question. When a general question follows a related specific question, the prior specific information influences the response to the more general question.[20]

Gallup presents a more specific and conditional question about legalization followed by a more general question about moral acceptability. Even so, the general question includes a prompt instructing the respondent to disregard his prior thinking about legalization. This may explain the Gallup finding that 68 percent of respondents first found physician-assisted suicide permissible for terminally ill patients in pain who request it, but then only 56 percent found it to be morally acceptable in general. Such an observation suggests that a number of respondents may have had pliable opinions on the permissibility and morality of physician-assisted suicide.

LifeWay presents the general concept of moral acceptability first but includes the biasing conditional of painful terminal disease. This is followed by the more specific proposition of permissibility, which again is tagged with the conditional of terminal illness. Maintaining the consistency of the conditional while progressing from general to specific may explain why the LifeWay results are more concordant.

Structural Response and Reporting Bias

The LifeWay poll is subject to structural response bias because of its Likert scale structure. For both propositions, LifeWay employs a four-point Likert scale response format: *strongly agree*, *somewhat agree*, *somewhat disagree*, and *strongly disagree*. There is no category for the undecided. However, the practice of public opinion research often employs a five-point Likert scale, with the center of the scale reserved for those who are undecided or neither agree nor disagree.[21] It is appropriate

19. Amy S. Kelley and R. Sean Morrison, "Palliative Care for the Seriously Ill," *New England Journal of Medicine* 373.8 (August 20, 2015): 753, doi: 10.1056/NEJMra1404684.

20. Norman M. Bradburn, Seymour Sudman, and Brian Wansink, *Asking Questions: The Definitive Guide to Questionnaire Design—for Market Research, Political Polls, and Social Heath Questionnaires*, 2nd ed. (San Francisco: Jossey–Bass, 2004), 146–149.

21. Michael Häder, "The Use of Scales in Surveys," in *The SAGE Handbook of Public Opinion Research*, ed. Wolfgang Donsbach and Michael W. Traugott (London: Sage, 2008), 388–397.

to use an odd number of categories with a central neutral position when the subjects may not have expertise or familiarity with the material or issue in question.[22] A four-point scale creates a forced distribution and requires those who are undecided or reluctant to take a position.[23]

This same problem applies to the dichotomous structure of the Gallup questions. It is quite possible that in both polls a number of undecided respondents who lacked a fully formed opinion about the permissibility or moral acceptability of physician-assisted suicide were forced into an opinion heuristically influenced by the information supplied or not supplied in the conditionals.

The LifeWay poll arrives at its final conclusion by grouping response rates among Likert categories. By collapsing the categories, the survey creates a structural reporting bias. As previously noted, for the proposition that physicians should be allowed to assist terminally ill patients in ending their lives, the distribution was as follows: *strongly agree*, 32 percent; *somewhat agree*, 37 percent; *somewhat disagree*, 17 percent; and *strongly disagree*, 14 percent. But LifeWay collapsed the *strongly agree* and *somewhat agree* categories in order to reach the conclusion that "7 out of 10 agree that physicians should be allowed to assist terminally ill patients in ending their life."[24] From this, LifeWay reported "widespread support for removing restrictions on physician-assisted suicide."[25] Using this same technique, however, LifeWay could have just as legitimately collapsed different categories to report that strong support for physician-assisted suicide is lacking among 68 percent of Americans or that over half of Americans do not have a strongly supported opinion on the issue.

Abstraction and Generalization Bias

It is important to reflect on the dangers of abstraction and generalization. Both polls found the strongest support for physician-assisted suicide among the young, for whom death from illness and terminal disease is rare and likely conceptually distant. Although support declines as poll respondents age, these older respondents probably still reflect a low prevalence of terminal illness, leading to abstraction and generalization of response.

A more revealing analysis, at least from a policy-making standpoint, may be to ask how many terminally ill cancer patients make use of physician-assisted suicide when it is available to them. Data from the Oregon Public Health Division indicates that from 1998 through 2015, 1,545 patients received prescriptions for physician-assisted suicide, 762 of whom were patients with malignancy who took

22. Deepak Chawla and Neena Sondhi, *Research Methodology: Concepts and Cases*, (New Delhi: Vikas, 2011), 144–174.

23. Naresh K. Malhotra, "Questionnaire Design and Scale Development," in *The Handbook of Marketing Research: Uses, Misuses, and Future Advances*, ed. Rajiv Grover and Marco Vriens (Thousand Oaks, CA: Sage, 2006), 83–94.

24. LifeWay Research, "American Views on Assisted Suicide."

25. Smietana, "Assisted Suicide Is Morally Acceptable."

the lethal doses and died.[26] During that same time, there were 133,568 cancer deaths in Oregon.[27] This indicates a 0.57 percent rate of usage for physician-assisted suicide among terminally ill cancer patients in Oregon.

Data from the Washington State Department of Health indicate that from 2009 to 2015, a total of 938 patients were given prescriptions for physician-assisted suicide.[28] During that time, there were 84,264 cancer deaths in the state.[29] This gives a usage rate of no more than 1.11 percent among terminally ill cancer patients.

Taken together, these data indicate that over a period of many years, physician-assisted suicide was rarely used by a very large population of terminally ill cancer patients in a permissive and legalized environment. The true headline concerning physician-assisted suicide could well be that it is used by only 1 percent of terminally ill cancer patients who have access to it.

Practical Application

Subtle logical fallacies and cognitive and structural biases, as effects lying well beneath the headlines accompanying recent polls, may help explain the discordance between reported support for physician-assisted suicide in those polls and its lack of widespread legislative authorization. For those in the religious community, this may provide some basis for understanding and approaching the gap between moral teachings and reported attitudes concerning physician-assisted suicide.

For all engaged in the struggle to prevent the legalization of physician-assisted suicide, the recent polls offer important lessons. Public support for physician-assisted suicide may not be nearly as strong as has been reported in the press, and it seems to be more conditional than categorical. As mirrored by the polls, proponents of physician-assisted suicide make arguments that rely on biasing conditionals and logical fallacies. Palliative and hospice care are underutilized. Even where physician-assisted suicide is legal, it is rarely requested by terminally ill cancer patients. In the course of discussion on physician-assisted suicide, the proposition that should be placed before the public is simply this: it is never morally acceptable for a physician to hasten the death or take the life of a patient as a primary end.

26. Oregon Health Authority, "Oregon Death with Dignity Act: Data Summary 2015," February 4, 2016, 2, https://public.health.oregon.gov/.

27. Oregon Health Authority, "Selected Leading Causes of Death with Rates, Oregon Residents, 1996–2015" (table 6-3), in *Oregon Vital Statistics Annual Report 2015*, vol. 2 (December 2016), 6-41, https://public.health.oregon.gov/.

28. Washington State Department of Health, "2015 Death with Dignity Act Report: Executive Summary," 2016, 4, http://www.doh.wa.gov/. The Washington report does not give a cumulative breakdown by disease process for 2009–2015, but in 2015, 72 percent had cancer.

29. Washington State Department of Health, "Leading Causes of Death for Residents 2015" (table C2), November 8, 2016, http://www.doh.wa.gov/. This report contains data from years 1980 to 2015.