Medical Concerns About Physician-Assisted Suicide

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The November 8, 1994 passage of Oregon's Measure 16, which permits physicians to comply with the request of a competent adult patient with less than six months to live for a prescription for lethal drugs, has intensified the debate over the legalization of physician-assisted suicide following the defeats of similar initiatives in Washington[1] and California.[2] Subsequent legal challenge to Measure 16 and the present preliminary injunction[3] has shown that passage and popularity of a public initiative does not ensure its legality. The issue of physician-assisted suicide is most likely headed for the United States Supreme Court.

This Article is intended, however, to review the *medical* concerns of the legalization of physician-assisted suicide and its potential impact on physicians and patients. The issue merits careful study not simply because of the unique concerns of legalized euthanasia, but also because of its critical relationship to physicians and their care of dying patients.

First, some definitions. Euthanasia, or "good death," applies generally to decisions or actions that either hasten or cause the death of an individual. In the case of *passive euthanasia*, this usually applies to the withdrawal of life-support systems such as a ventilator, which allows the disease process to take its course and death to occur. At the other extreme lies *active euthanasia*, where one individual uses lethal means (such as an injection of a lethal dose of medication) to cause the death of another. *Physician-assisted suicide* refers to providing a prescription of medication and specific instructions to a patient, with the knowledge that these may be used to end his or her life. For many, physician-assisted suicide represents a type of active euthanasia.

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1. Initiative for Death with Dignity (Initiative 119) (1991).
2. The California Death with Dignity Act (Proposition 161) (1992).
3. *See* Lee v. State, 869 F. Supp. 1491 (D. Or. 1994).

I. PHYSICIAN-ASSISTED SUICIDE: WHY NOW?

Euthanasia in its many forms has been discussed at many points during this century,[4] but one marvels at the force of the current debate. What factors are behind the resurgence of assisted death *now*? In *The Troubled Dream of Life: Living with Mortality*,[5] Daniel Callahan examines the ambivalent stance of both medicine and society towards death and suggests several factors contributing to the resurgence of interest in assisted death. Primary among these is our denial of death itself.[6] Modern medicine, in its many successes against disease and its ability to forestall death, has led physicians and patients alike to see death as an option rather than an inevitable fact of life.[7] If death becomes something one can choose to do, then some would hold that an individual should have the right to select the time and the method.[8]

Callahan further notes that in our attempts to deny the power of death, we have sought some sense of control by trying to hide it from public scrutiny.[9] This trend towards the "institutionalization of death" has been recent and rapid. Currently, eighty percent of Americans die in hospitals, in contrast to only fifty percent as recently as 1949.[10] In the past patients died close to people they loved and death was familiar; now, the process of dying has become unfamiliar and dying patients themselves are too often isolated and shunned. Hospice care has only recently begun to reverse this trend, enabling dying patients to return to their homes and families.

Another factor that has contributed to a renewed interest in the debate over assisted death is the appearance of "new plagues." The successful control of acute infectious diseases has resulted in people living longer. As a result, people are experiencing significantly more *chronic* disease (such as heart disease and arthritis) as well as progressive diseases like Alzheimer's that can cause great diminution of abilities. There is also the deadly plague of HIV/AIDS, which has

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4. *See, e.g.*, 20 KENNEDY INSTITUTE OF ETHICS, BIBLIOGRAPHY OF BIOETHICS 222-40 (LeRoy Walters & Tamar J. Kahn eds., 1994). *See* volumes 1-19 for additional listings.

5. DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY (1993).

6. *Id.* at 51.

7. *Id.*

8. *Id.* at 92.

9. *Id.* at 31.

10. SHERWIN B. NULAND, HOW WE DIE 255 (1993).

brought with it a host of secondary infections that can kill in many painful and undignified ways.

Given these trends, it is not surprising that assisted suicide has gained prominence as an easier answer to the modern reality of death and dying. And although there seems to be little consensus in the physician-assisted suicide debate, important commonality does exist.

II. END-OF-LIFE ISSUES: COMMON GROUND

In medical discussions of end-of-life issues, there is a great deal of common ground. Most agree that patients have the right to refuse or withdraw from medical treatment, even risking death as a consequence of their decision. In these cases, individuals believe that the potential harm outweighs the possible benefit of continuing medical treatment. This right of medical decision-making is codified in every state. In Washington, as in many other states, the codification is known as the Natural Death Act.[11] The Act was amended in 1992 to include the treatments of artificial nutrition and hydration and the condition known as persistent vegetative state. This existing right of medical decision-making is important to bear in mind because in the age of medical high technology, the specter of patients being kept alive against their will on machines is often raised as a justification for physician-assisted suicide. But such situations need not occur if the wishes of a patient have been documented and open discussion among family members has taken place.

There is also widespread agreement about the need for improved care of dying patients. In all assisted-death campaigns to date, one of the most compelling arguments has been repeated personal testimony about patients dying in agony due to medical inattention or ignorance. This has highlighted the need for improved education of physicians and other providers about methods of pain control, as well as the need for support of hospice programs. Physicians must be ready to shift from efforts to cure disease in dying patients to efforts aimed towards comfort and palliation. In The Netherlands, where this care transition is well established, an estimated eighty-five percent of patients withdraw their requests for euthanasia after receiving better symptom control.[12]

Finally, it is clear that our health care system must be "reformed" to ensure that every citizen has access to at least basic health care. As Yale Professor Robert Burt recently wrote: "At a time when Congress

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11. WASH. REV. CODE § 70.122 (1994).

12. Bernard Lo, *Euthanasia: The Continuing Debate*, 149 W. J. MED. 211 (1988).

has just refused to guarantee health care for everyone, it would be ironic if the judiciary selected physician-assisted suicide as the one health care right that deserves constitutional status."[13] Without the assurance of such health care access, many uninsured dying patients would be choosing physician-assisted suicide out of fear of a painful death.

III. ETHICAL CONCERNS

Euthanasia and assisted suicide raise some very important ethical questions. I will discuss some of the professional and ethical issues for medicine, as well as some of the legal concerns.

As a family physician, I commonly see patients before surgery, and am asked for my opinion about their options. Often patients have heard a great deal about the hoped-for benefits of medical treatments; it is my responsibility to make sure they understand there can be significant risks as well. I have also been involved in creating health care legislation, and have noticed a similar attitude. While legislators tend to easily focus on the intended goals of any proposal, it is just as important to consider any possible *unintended* outcomes. Harm can come from trying to do good.

Medicine has a professional and social obligation to consider the risks as well as the benefits of any proposal. So if physician-assisted suicide is gaining in the polls, why is the medical profession so reluctant about participating? It must first be acknowledged that there is wide diversity of opinion among physicians on this issue. This was substantiated by a 1994 poll published in the New England Journal of Medicine, finding that while a majority of Washington state physicians opposed active euthanasia, they were evenly split on the legalization of physician-assisted suicide.[14] Support for physician-assisted suicide appeared strongest among physicians having the least contact with dying patients; opposition was strongest among those with the most day-to-day involvement. This may be because many hematologists and oncologists, for example, believe that more effective use of available treatments to relieve pain and suffering would obviate the need for euthanasia and assisted suicide.

But still, why the professional reluctance?

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13. Robert A. Burt, *Death Made Too Easy*, N.Y. TIMES, Nov. 16, 1994, at A19.

14. *See* Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians In Washington State*, 331 NEW ENG. J. MED. 89 (1994).

A. *Dramatic Shift in Historic Professional Ethic*

The relief of suffering has always been an essential part of a physician's duty to his or her patient. Unlike the not-so-distant past, when knowledge and physical presence were about all that could be offered, modern pain control and anesthesia have greatly enhanced medical abilities to alleviate suffering. The special knowledge gained by physicians to heal, however, can also be used to actively end life. It was this duality that gave rise to one of the earliest and best-known Hippocratic admonitions: "First, do no harm." A corollary prohibition is more direct: "To please no one will I prescribe a deadly drug nor give advice which may cause his death."

This is not a hypothetical concern. Physicians have been asked to cause the death of patients for centuries, and have been ethically constrained from doing so. At the heart of these professional admonitions is concern for a fundamental value—patient trust. Physicians not only care for patients they know, but just as frequently care for total strangers who literally place their lives in the physicians' care. A recent public opinion poll confirmed that most Americans still trust their personal physician.[15] Setting aside "First do no harm" could undermine the trust which is the very foundation of the medical profession.

B. *An Inappropriate Extension of the Right to Refuse Treatment*

Many supporters of physician-assisted suicide state that its legalization would be just a small step from what physicians are already allowed to do. Examples used to support this argument include the withdrawal of life support and the giving of large doses of narcotics at the end of life to relieve pain.

Withdrawing or withholding life-sustaining treatment occurs when a patient, or patient's proxy, decides that the disadvantages of a treatment outweigh the potential advantages. When treatment is halted, the illness is then allowed to proceed along its natural course, which may result in death. However, the inability of physicians to *prevent* death does not imply that physicians are free to intentionally *cause* death.

At the end of life, physicians frequently have to give increasingly larger doses of drugs such as narcotics to relieve pain and other symptoms. The intent of such palliative treatment is to relieve the

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15. *See* AMERICAN MEDICAL ASSOCIATION, PUBLIC OPINION ON HEALTH CARE ISSUES (March 1994) (on file with *Seattle University Law Review*).

pain and other symptoms experienced by dying patients. The intent is not to end the patient's life. Yet at these high doses, side effects such as depression of respiration become a reality. It is considered professionally ethical to gradually increase the dose of medication as needed by the patient to control symptoms, even though the medication may depress respiration and cause death. The dividing line is the *intent*—to relieve pain or to induce death. While intention may only be known in the heart of the physician, it is a distinction that is as fundamental in medicine and ethics as it is in law.

C. Depression and Suicide

Everyone diagnosed with a terminal illness will have some periods of depression. Some will consider suicide. Significant depression can arise from several sources: unrelieved symptoms such as pain; a belief that one has become a burden to family and others; a sense of personal worthlessness; and fear of future suffering and/or abandonment.

An important clinical challenge is to recognize when a person is depressed. This is difficult in both healthy and dying patients, and accordingly, is notoriously underdiagnosed. The good news is that depression is often treatable, and that treatment in dying patients can markedly enhance the remaining quality of life.

The concern with regard to physician-assisted suicide is that significant depression in terminally-ill patients will be missed, and that out of this depression will arise requests for physician-assisted suicide. In an excellent review of this area, Drs. Block and Billings suggested that "helping patients to die quickly in such a situation does not represent a recognition of their autonomy; it simply confirms their sense of worthlessness and abandonment."[16]

Physicians need improved skills in pain and symptom management, as well as additional training in the recognition and treatment of depression.

D. Potential for Expansion and Abuse of Physician-Assisted Suicide

In addition to the medical concerns cited above, the legalization of physician-assisted suicide poses important social challenges for the medical profession. Two merit special consideration:

1) Is it possible to develop safeguards for physician-assisted suicide that adequately protect against abuse, or are safeguards in practice an illusion?

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16. Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death*, 154 ARCHIVES INTERNAL MED. 2039, 2041 (1994).

2) Once legalized, can the practice of physician-assisted suicide be constitutionally restricted to the terminally-ill patients who are mentally competent?

1. The Issue of Safeguards

Most recent initiatives to legalize euthanasia or physician-assisted suicide have included proposals for safeguards to protect against abuse. Examples of abuse range from families who might encourage a dying relative to commit suicide for financial reasons to provision of euthanasia to patients who have not requested it.

In looking to the effectiveness of safeguards, a good place to start would be The Netherlands, where euthanasia remains technically illegal but is tolerated if each case is reported to the public prosecutor and established guidelines are followed.[17] Dutch guidelines would sound familiar to those following the euthanasia debate in the United States. They are:

> *Substantive Guidelines*
> (a) Euthanasia must be voluntary; the patient's request must be seriously considered and enduring.
> (b) The patient must have adequate information about his or her medical condition, the prognosis, and alternative methods of treatment.
> (c) The patient's suffering must be intolerable, in the patient's view, and irreversible (though it is not required that the patient be terminally ill).
> (d) It must be the case that there are no reasonable alternatives for relieving the patient's suffering that are acceptable to the patient.
> *Procedural Guidelines*
> (e) Euthanasia may be performed only by a physician (though a nurse may assist the physician).
> (f) The physician must consult with a second physician whose judgment can be expected to be independent.
> (g) The physician must exercise due care in reviewing and verifying the patient's condition as well as in performing the euthanasia procedure itself.
> (h) The relatives must be informed unless the patient does not wish this.
> (i) There should be a written record of the case.
> (j) The case may not be reported as a natural death.[18]

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17. MARGARET P. BATTIN, THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE 130-32 (1994).

18. *Id.* at 131.

How well are the Dutch safeguards working? A recent American Medical Association analysis of the 1991 Remmelink Report profiling the practice of euthanasia in The Netherlands[19] raised several concerns. First, the estimated 3,700 annual deaths involving euthanasia that are reported are only a fraction of the actual figure,[20] implying a heavy reliance on self-policing by Dutch physicians. Of greater concern, however, is the report's revelation that a significant number of non-qualifying patients are being euthanized. Most troubling are the estimated 1,000 cases of active *involuntary* euthanasia—cases in which physicians acted unilaterally, without patient request or consent.[21]

It is possible that in each case of unsought assistance, the physicians acted with the best intentions, aimed at compassion. Yet Dutch physicians have clearly taken the guidelines as a "starting point" only, and have expanded on the scope and intention without societal approbation. These medical irregularities led the AMA Board of Trustees to conclude:

> Considering that euthanasia has been openly discussed for years in Holland and has the support of its people and of at least a portion of organized medicine in that relatively small and homogeneous country, the United States and its physicians have a forewarning that meaningful control by a society of such practices is illusionary once the patient-physician relationship has been so changed that death becomes an accepted prescription for pain and suffering.[22]

This warning on the Dutch experience casts serious doubt on so-called safeguards such as those used in Oregon Measure 16.

2. A Limited Right to Die?

Another important societal question to consider is whether a constitutional "right-to-die" can be limited, as in Oregon Measure 16, to mentally competent dying patients who are in pain despite everything medicine can do. Although this is a legal question, its answer has profound implications for the practice of medicine. Many physicians who now express comfort with a limited right-to-die would

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19. REPORT OF THE BOARD OF TRUSTEES OF THE AMERICAN MEDICAL ASSOCIATION, EUTHANASIA/PHYSICIAN-ASSISTED SUICIDE: LESSONS IN THE DUTCH EXPERIENCE, *in* 10 ISSUES IN L. & MED. 81 (1994).

20. *Id.* at 87.

21. *Id.* at 86-87.

22. *Id.* at 89.

be more hesitant with euthanasia broadly applied. Is this faith that physician-assisted suicide will remain limited justified?

Dr. Kevorkian has repeatedly shown that there are non-terminally-ill people who desire and seek out physician-assisted suicide. A challenge on limitations such as those expressed in Measure 16 might come from patients who otherwise qualify under the statute, but are unable to swallow or self-administer medications, and request more "active" assistance. A challenge might also come from patients who are not dying, but because of the suffering and indignity arising from a chronic illness or chronic pain, believe that their life is not worth living.

What about requirements for mental competency? Initially, advance health care directives might be modified to allow a person to request assisted suicide should he or she become mentally incompetent. But relatives or guardians who are distressed by the perceived quality of life of a mentally incompetent loved one might later challenge these modifications.

Euthanasia opponents were troubled by Hemlock founder Derek Humphry's characterization of Measure 16 as just the first step, and that when people become "comfortable with this form of assisted dying . . . we may be able to go to the second step," which is euthanasia.[23]

IV. Death With Dignity

We stand at the precipice of important legal decisions. Oregon's Measure 16 and the decision in *Compassion in Dying v. Washington*[24] will take the issues of physician-assisted suicide and euthanasia to higher courts of law, and almost assuredly to the United States Supreme Court. Heated debates will continue in state legislatures and town meetings, as they will among medical ethicists and physicians.

And yet, the discussion and action should not end with the debate over euthanasia. Turning to the medical model, physicians are taught to see attempts at suicide as a "cry for help." I believe that the "Death with Dignity" debate reflects such a plea on a societal level, and if we stay only with the issues of individual autonomy and self-determination, we will be overlooking other important values in how we approach death and care for the dying.

We all want a death with dignity. How that is best attained is at the heart of this debate. In *How We Die*, Dr. Nuland suggests: "The

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23. Diane M. Gianelli, *Oregon Voters Face "Rx-Only" Suicide Initiative*, AM. MED. NEWS, Sept. 12, 1994, at 1, 34.

24. 850 F. Supp. 1454 (W.D. Wa. 1994), *rev'd*, 49 F.3d 586, (9th Cir. 1995).

greatest dignity to be found in death is the dignity of the life that preceded it. This is a form of hope we can all achieve, and it is the most abiding of all."[25]

Society as well as medicine is challenged to rethink its conception of what death means in a community. The dying need to be brought back into the heart of our community, not hidden away and abandoned. Both the physical and spiritual needs of the dying should be our highest priorities. Given the real inequities of our current health system, physician-assisted suicide would not be a panacea. Instead, as the New York Task Force on Life and the Law concluded, legalizing assisted suicide would "pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care."[26]

Clearly, the medical and other healing professions have a long way to go in improving the care of dying patients. We need to listen to our patients, take time to discuss their wishes and fears about their dying, and encourage them to consider advance directives and to share them with their families. We need to commit ourselves to learning and applying modern methods of pain and symptom control, so that whatever can be done to bring comfort is offered. We need to broadly apply the same vigor we use in seeking medical cures, so that we naturally turn to *caring* when curing is no longer possible.

25. SHERWIN B. NULAND, HOW WE DIE, 242 (1993).

26. George J. Annas, *Death by Prescription: The Oregon Initiative*, 331 NEW ENG. J. MED. 1240, 1243 (1994) (quoting NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994)).