Physician-Assisted Suicide: An Ethical Way Out or An Easy Way Out

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Intro

Is it ethical, and/or should it be legal, for a terminally ill patient to substitute their will for that of God or nature by allowing them to decide when he or she is ready to die?¹

The death of Dr. Jacob “Jack” Kevorkian last summer brought physician-assisted suicide back into the public limelight.² Since 1988, the general public, the courts, legislatures, and physicians have been debating whether it is moral, ethical, or legal to allow for physician-assisted suicide.³ Recently, the state of Washington’s legislature adopted Oregon’s Death with Dignity Act and Montana’s judicial system found physician-assisted suicide to be legal.⁴ Therefore, I ask the following questions: Is this a trend that more States should follow? Is it ethical for this type of end-of-life care to be legal and does this type of practice fall within the guidelines of the American Medical Association’s (AMA) policies and the physicians’ Hippocratic Oath?

In answering these questions we will look at the history of physician-assisted suicide and the effects of implementing physician-assisted suicide laws. Additionally, we will discuss the role of patient autonomy and a doctor’s duty to be beneficent and non-maleficent. Finally, we will discuss the role of the society and if it is just to allow for physician-assisted suicide.

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History: Physician-Assisted Suicide and Death with Dignity

For over seven hundred years, common law has penalized “assisting another in the commission of self-murder.” Moreover, the act of assisting in suicide is still a crime in almost every State today. However, in the last twenty years or so, this debate been in the public forum and is at the forefront of end-of-life care discussions.

“It’s Over, Debbie,” was an anonymous article published in the Journal of American Medical Association in 1988. This article was greeted with a storm of controversy. Medical professionals were outraged by the article but the public sentiment was not necessarily the same.

In 1990, Washington State was the first State to have a voter referendum on physician-assisted suicide (Ballot Initiative 119); however, it was defeated. California, Maine, and Michigan voters followed suit and voted down physician-assisted suicide ballots in following years. However, California’s legislature has attempted to legislatively legalize assisted suicide in five different sessions. In 2007, California, Arizona, Hawaii, Rhode Island, Vermont, and Wisconsin introduced, but did not pass, bills to legalize assisted suicide.

In contrast, Oregon successfully passed the Oregon Death with Dignity Act (ODWDA) in 1994. However, an injunction delayed the implementation of the statute until 1997 after the U.S. Supreme Court’s ruling in Glucksberg and Quill. In Glucksberg, the court held that it is up to the States to decide whether or not it should be legal to allow for “competent, terminally ill

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6 Id.
7 See supra note 1, at 107.
8 Id.
9 Id. at 121.
10 Id. at 122
11 Id.
12 Id. at 123.
13 Id.
14 Id. at 125.
15 Id.
adults…to hasten their deaths by obtaining medication prescribed by their doctors.”  

Unfortunately, the court did not weigh in on any relevant ethical issues, stating: “We need not weigh exactly the relative strengths of these various interests.” Further, the court encouraged Americans to engage in the debate about the “morality, legality, and practicality of physician-assisted suicide.”

In the years following the Glucksberg decision and the implementation of ODWDA, the Bush II Administration continued to fight the ODWDA to no avail. In 2008, Washington State became the second State to legalize physician-assisted suicide (Washington Death with Dignity Act (WDWDA)) by essentially adopting the ODWDA. In 2009, the Montana Supreme Court upheld Judge Dorothy McCarter’s ruling in Baxter v. State of Montana, which held that Montana residents have the right to physician-assisted suicide.

Abroad, the Netherlands legalized the physician-assisted suicide and euthanasia in 2001. Therefore, today we have the luxury of being able to study and analyze the successes and failures of those States and countries which have legalized physician-assisted suicide.

**Implementation and Effects of a Physician-Assisted Suicide Law**

The Netherlands have allowed for the practice of euthanasia for several decades, even though physician-assisted suicide and voluntary active euthanasia was not officially legalized

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16 *Glucksberg*, 521 U.S. at 735.
17 Id.
18 Id.
19 See supra note 1, at 126. (The Ashcroft Directive attempted to curb Oregon doctors from prescribing lethal medication by asserting that prescribing controlled substances under the Act violated the Controlled Substance Act. The court concluded that this assumption exceeded the authority granted under the CSA and that legitimate medical practice or purpose is left for the individual States to decide.)
20 See supra note 4.
21 Id.
22 See supra note 1, at 125.
until 2001. In 1990, a Dutch government study found that in more than 1,000 cases of euthanasia the “physicians admitted they actively caused or hastened death without any request from the patient.” Also, physicians made end-of-life decisions likely to result in death without consulting their patients in 25,000 cases. Additionally, physicians only reported patient euthanasia in eighteen percent of cases, despite the regulatory guidelines requiring physicians to report all cases of euthanasia. However, this number did grow to forty-one percent in 1995 after simplifying the notification process.

In response to the 1990 study, the court in Glucksberg stated: “This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults…and regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia.” The legalization of assisted-suicide in the Netherlands in 2001 allows for those suffering from psychological distress, terminal illness, children, and individuals with mental retardation or brain damage to be eligible candidates.

In contrast to the Netherlands, the ODWDA created strict procedures which allowed only competent, terminally ill adults the ability to obtain a prescription from their attending physician for medication to allow them to end their own life. There are stringent safeguards built into the statute which requires the attending physician to, among other things, determine that the patient is terminally ill, have a consulting physician confirm the patient is terminally ill; determine that

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23 Id. at 123-25.
24 Id. at 124. (Holland only has 130,000 annual deaths).
25 Id.
26 Id.
27 Id.
28 Glucksberg, 521 U.S. at 734.
29 See supra note 1, at 125.
the patient is of sound mind, making the request to end their life voluntarily, and that the patient is an Oregon resident.\textsuperscript{31}

Additionally, the attending physician must ensure that the patient is making an informed decision by explaining the potential risks associated with taking the prescribed medication, the probable result from taking the medication,\textsuperscript{32} and the alternatives to taking their own life.\textsuperscript{33} The attending physician or consulting physician can order the patient to counseling if either physician believes that the patient may be suffering from a “psychiatric or psychological disorder or depression causing impaired judgment.”\textsuperscript{34} Moreover, the patient may not receive life ending medication until the person performing the counseling has determined the patient is not suffering from any mental disorders or depression causing impaired judgment.\textsuperscript{35}

To obtain the medication, a qualified patient must make the request in writing.\textsuperscript{36} The written request must be signed and dated by the patient and two witnesses, one of which cannot be a relative or benefit from the death of the patient.\textsuperscript{37} Once the medication is dispensed, the Act requires that the healthcare providers file reports with the state documenting their actions.\textsuperscript{38} The reporting is to examine whether vulnerable populations are put at risk and identify any other potential risks associated with the law.\textsuperscript{39} Therefore, Oregon (over the last thirteen years) and

\textsuperscript{31} See Or. Stat. §127.815 (2005). (To be classified as “terminally ill,” the patient must have an “incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months.”).

\textsuperscript{32} Id.

\textsuperscript{33} Id. at §127.800(7). (feasible alternatives include, but are not limited to, hospice care, pain control, and comfort care).

\textsuperscript{34} Id. at §127.825.

\textsuperscript{35} Id.

\textsuperscript{36} Id. at §127.810.

\textsuperscript{37} Id.

\textsuperscript{38} Id. at §127.865.

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Washington State (over the last two years) have provided extensive documentation to be analyzed and studied by the rest of the country.

In total, 612 patients have utilized the ODWDA and WDWDA to end their life with the aid of physicians. The data collected by Oregon and Washington suggests that, in contrast to Death with Dignity Act opponents’ fears, the poor, uneducated, uninsured, and most vulnerable were not unwilling participants. In fact, in 2010 most of the 59 patients that died from utilizing the ODWDA were white, over the age of 65, well educated, were enrolled in hospice care, and had cancer. Similarly, most of the participants who died in accordance to the WDWDA were white, well educated, insured, and over the age of 55. Moreover, the follow-up questionnaires suggest that most participants were concerned about loss of autonomy, loss of dignity, and less able to engage in activities that made life enjoyable. Some additional concerns that some participants mentioned were being a burden on family and friends, inadequate pain control, and financial implications on treatment.

Despite the abuse of the Netherlands, many believe that the success of Oregon and Washington prove that opposition to a Death with Dignity law can only be based on ethical grounds. Therefore, in the rest of this paper we will discuss whether or not it is ethical for such an option to exist in end-of-life care. In doing so, we will utilize the principle-based approach to bioethics called Principlism, which has been defended by James Childress and Tom Beauchamp

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41 See supra note 39.
44 See supra note 42 & 43.
45 See supra note 43.
46 See supra note 39, at 1603.
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since the late 1970s. Principism balances respect for autonomy, beneficence, non-maleficence, and justice.

**Autonomy: A Patients’ Right to Die?**

The American Medical Association (AMA) believes that in order to respect patient autonomy, a physician must respect a patient’s “decision to forgo [or remove] life-sustaining treatment.” In addition, the AMA has a policy whereby “physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care.” Moreover, physicians are required to provide effective palliative care even though it could foreseeably hasten death. So, the question is, if the AMA believes that patients have the right to be autonomous in their end-of-life care then why is it AMA policy for physicians not to perform euthanasia or participate in assisted suicide? Moreover, if the courts have determined that the American people have a right to refuse life-sustaining medical treatment then why shouldn’t a patient have the right to die?

According to Dr. Timothy Quill, M.D., there is a “secret practice” of physicians who assist their patients with suicide; and “the medical profession and the law look the other way as long as the practice does not become public.” Most people know of cases where, regardless of

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48 Id. at 182.
50 Id.
51 Id.
52 Id.
53 See note 1, at 120.
excellent palliative care, the patient still endured severe suffering. These types of cases make a very compelling argument to allow for some predictable escape so the patients can end their suffering. After all, ultimate patient autonomy is being able control the circumstances of his or her own death and to determine when to end the suffering.

However, when looking at other aspects of medical care in relation to patient autonomy, patients seemly find it burdensome to have to choose which medical treatments to utilize. Furthermore, despite America’s drive to promote autonomy through the formation and execution of advanced directives, very few have executed living wills. Moreover, “most patients and families don’t want to be responsible for end-of-life care decisions.” Therefore, the question becomes why don’t patients want to be responsible for these decisions and is their mental state stable enough to make such choices?

As documented by the Oregon Public Health Division, most participants are over the age of 65, yet very few are asked to seek counseling before being prescribed lethal medication. This could be due to the fact that elderly or older patients are often the hardest patients to diagnose depression because they tend to hide their symptoms. Therefore, conventional wisdom would suggest that this finding should incentive doctors to be more proactive in insuring

55 Id. at 138.
56 Id.
57 Id. at 139.
58 See supra note 1, at 131-32. (“In a study conducted by SUPPORT (see infra note 600), a group of patients were given intensive medical staff intervention and information designed to promote informed decision-making. Surprisingly, these autonomy-enhancing measures had no significant impact on patient treatment choices, nor did they increase patient satisfaction.”)
59 Id. at 132-33.
60 Id. at 133. (A study conducted by Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT))
61 See supra note 42.
62 See supra note 1, at 104.
their patients are competent when requesting lethal medication, unless it is the physicians’ will to disregard the patients’ mental state and just end their life.

Moreover, suicide rates for males are highest among those 75 years of age and older, and highest among females from the age 45 to 55.\(^{63}\) Furthermore, physical illness is one of five suicidal risk factors that the Center for Disease Control and Prevention lists.\(^{64}\) Moreover, there are several medical conditions which impact the brain and central nervous system that may contribute to a higher rate of suicide.\(^{65}\) Nevertheless, most patients suffering from severe pain are resilient and have a will to beat their illness and live.\(^{66}\) Therefore, is the competent patients seeking to end their life under the Death with Dignity Acts or is it the disease and overzealous doctors?

It is the prevailing view of most physicians that palliative care remains the standard for end-of-life care and physician-assisted suicide is of last resort.\(^{67}\) In Glucksberg, Justice O’Connor, in her concurring opinion, stated that “a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.”\(^{68}\) In other words, it is left up to the individual States to decide if patients can participate in physician-assisted suicide but patients have the right to good pain treatment, even

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\(^{65}\) See supra note 1, at 104.

\(^{66}\) Id.

\(^{67}\) See supra note 54, at 140.

\(^{68}\) Glucksberg, 521 U.S. at 736-738 (O’Connor, J., concurring).
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if it hastens their death.\(^69\) In essence, a patient does have the right to die, just not the right to actively take their own life.

**Beneficence and Non-Malfeasance: The AMA Stance and the Hippocratic Oath**

*Primum non nocere* is a staple phrase in the health care community which means “first do no harm.”\(^70\) Coincidentally, this is also the definition of non-malfeasance. The definition of beneficence, attached by Childress and Beauchamp, is comprised of two principles: (1) the principle of positive beneficence, and (2) the principle of utility.\(^71\) The principle of positive beneficence is to provide benefit and the principle of utility requires the weighing of benefits and deficits to produce the best result.\(^72\) Fundamentally, the utility principle induces the principles of beneficence and non-malfeasance to be analyzed together because the concepts are “two sides of the same coin.”\(^73\) Therefore, below we will discuss the AMA’s stance of physician-assisted suicide with respect to the benefits of allowing for the practice and the deficits of allowing the practice.

“It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician’s role as a healer.”\(^74\) Nevertheless, the AMA does recognize that physicians have a duty to provide effective palliative care even if it may hasten death, and in “certain carefully defined circumstance,” death is eminent and suffering great.\(^75\) However, the

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\(^69\) See supra note 54, at 141.


\(^71\) Id. at 35.

\(^72\) Id.

\(^73\) Id. at 35-36.


AMA concludes that “the societal risks of involving physicians...to cause patients’ deaths are too great to condone.”

The Hippocratic Oath states to do no harm to anyone, and in the original and classical versions it also states, “I will not give a lethal drug to anyone if I am asked.” Most people would equate suicide with harm. Consequently, at its core, most would not view physician-assisted suicide as beneficent. Furthermore, for a physician to assist in suicide would “violate professional standards and undermine trust between physician and patient.” Trust is the foundation of the doctor-patient relationship; therefore, what is going to come of the doctor-patient relationship when the patient knows that their doctor gave up hope on another patient.

Moreover, the modern Hippocratic Oath requires physicians to benefit the sick, avoid “those twin traps of overtreatment and therapeutic nihilism,” and remember they are treating all aspects of the human being. This would encompass the emotional as well as the physical ills that a patient may have. It is the duty of the physician to guide the patient and family through the dying process, not cut the process short. Furthermore, it is a physician’s duty to administer great palliative care to ensure as painless of end-of-life care as possible, even if it hastens death.

In Vacco v. Quill, the Supreme Court made a distinction between treatment withdrawal and assisted suicide. The Court reasoned that when a physician complies with a patients request for treatment withdrawal, the physician’s intent is to only honor the patient’s wish to

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76 Id.
78 See supra note 54, at 139.
80 See supra note 77.
81 See supra note 54, at 139.
82 See supra note 1, at 118.
discontinue “futile or degrading measures.”83 Furthermore, the court found that when a physician provides aggressive palliative care, even if the drugs hasten death, the physician’s intent is to provide pain relief. In contrast, the court reasoned that a patient who is aided by a physician to commit suicide “necessarily has the specific intent to end his or her [the patient’s] own life, while a patient who refuses or discontinues treatment might not.”84 In other words, there is a natural benefit to withdrawing from futile life-sustaining treatment or from aggressive palliative care, but the only benefit from physician-assisted suicide is death, which most would agree is not a benefit nor non-malfeasant.

**Justice: Physician-Assisted Suicide a Societal Benefit?**

Even the strongest of opponents must admit that there is some form of justice in aiding a patient in suicide because physician palliative care practice and education is unacceptably insufficient. However, will this type of irrational thinking lead us down the path of the Netherlands; where, arguably, euthanasia has replaced palliative care for the “chronically sick and dying” because it is easier?85 Shouldn’t the question be: why is our palliative care so grossly inadequate?

One-third of all medical expenses occur in the last year of life and approximately eight percent of people who die annually are insured by Medicare.86 Therefore, society as a whole is largely vested in the dealings of end-of-life care. Currently, Medicare only pays for palliative care in a “hospice benefit.”87 Therefore, in order for a provider to be reimbursed, the patients

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83 Id.
84 Id. at 125.
85 Id. at 125.
86 Pat Stanfill Edens et al., Developing and Financing a Palliative Care Program, 25 Am. J. Hospice Care and Med. 379 (Oct./Nov. 2008), available at [http://ajh.sagepub.com/content/25/5/379](http://ajh.sagepub.com/content/25/5/379), (Discussing the importance of palliative care in the United States).
87 Helen L. Smits, MD et al, Palliative Care an Opportunity for Medicare, Institute for Medicare Practice Mount Sinai School of Medicine 1 (2000), available at [www.mssm.edu/instituteformedicare](http://www.mssm.edu/instituteformedicare).
must have a prognosis of death within six months or less and cease all treatment towards curing the ailment.\textsuperscript{88}

Experts make a distinction between palliative medicine and palliative care.\textsuperscript{89} Palliative medicine restricts the services provided and is reimbursed by Medicare.\textsuperscript{90} Palliative care, on the other hand, is not usually reimbursed by Medicare because it utilizes multiple healthcare resources to “control symptoms, manage distress, and help patients define end-of-life directive that impact treatment, to assist in the patient to maintain optimal quality of life.”\textsuperscript{91} Moreover, when a patient is terminally ill, palliative care should begin long before hospice care is needed because the goal should be to guide the patient to a “compassionate death, free of unnecessary suffering.”\textsuperscript{92}

Consequently, when palliative care is not linked directly with hospice services reimbursement is a struggle.\textsuperscript{93} Therefore, in an acute care setting reimbursement for palliative care is almost impossible.\textsuperscript{94} There are clear benefits to having a palliative care program; however, without identifiable reimbursement administrators will continue to struggle in developing, offering, and paying for palliative care services.\textsuperscript{95} Moreover, if there are few palliative care programs, how are physicians supposed to improve palliative care for their patients.

Accordingly, it is irrational to say that it is just to allow for physician-assisted suicide when our nation’s medical insurance policy is to not to pay for palliative care. Even the strongest

\textsuperscript{88} Id.
\textsuperscript{89} Id. at 2.
\textsuperscript{90} Id.
\textsuperscript{91} See supra note 86, at 380.
\textsuperscript{92} Id. at 379.
\textsuperscript{93} Id. at 380.
\textsuperscript{94} Id.
\textsuperscript{95} Id. at 382-83.
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of proponents for physician-assisted suicide must admit that physician-assisted suicide should be of last resort and that palliative care should be the standard of end-of-life care. Therefore, is it not more just to create an environment conducive to enhancing palliative care instead of creating an environment where it is easier to replace it?

**Conclusion**

The physician-assisted suicide data produced by Oregon, Washington, and the Netherlands renders mixed results. Patient autonomy is very important, however, the lack of psychiatric consultations for Death with Dignity participants is very concerning considering the difficulty in diagnosing mental illness and stability in the elderly. Furthermore, the argument for physician-assisted suicide based on patient autonomy and deficiencies in palliative care fall short when adequate palliative care is present. Therefore, a better alternative is to remove governmental regulations and policies hampering the development and improvement of palliative care. In fact, expanded palliative care program may actually improve patient autonomy because palliative care will be an option for terminally ill patients sooner and will not require them to stop fighting their disease.

Physicians have a duty to do no harm, not abandon their patients, and guide their patients through the dying process. By legalizing physician-assisted suicide physicians are put in a no win situation. On one hand it offers a patient a way out that is quick and painless, but on the other hand it goes against the very oath physicians’ promise to uphold. Furthermore, I would contend that the practice of physician-assisted suicide is the very definition of abandonment.

Finally, the ethical and legal debate of physician-assisted suicide is only going to continue to become more intense as our nation’s population continues to age. Therefore, with an

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96 See supra note 1, at 140.
97 See supra note 49 & 77.
aging population and surmounting national debt, it would be unwise for more States to adopt Oregon and Washington’s Death with Dignity Acts. Palliative care should be the standard of end-of-life care; however, as it stands currently, Medicare does not pay for good palliative care. Consequently, it is not out of the question to see that America could follow the Netherlands down the slippery slope of replacing palliative and hospice care with euthanasia because it is easier and more cost effective.98

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98 See supra note 1, at 125.