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Physician-Assisted Suicide: The Legal and Practical Contours

Anthony J. Dangelantonio*

Introduction

The act of allowing a patient to die from an underlying terminal illness when the treatment is ineffective is fundamentally different from endowing the terminally ill with the right to request another to assist in the act of dying. The former represents situations addressed by living wills statutes.¹ As for the latter, few issues are of greater personal or moral concern than whether to legally-sanction one person's actively assisting another who wants to end his or her life.² This is particularly true when the person furnishing the assistance is a physician.

Initiatives allowing doctor-assisted suicide are being considered in Maine, Michigan, Florida, Oregon, Iowa and New Hampshire.³ The issues raised by such legislation strike at the very heart of our societal and cultural matrix by calling into question the traditional roles of the physician and patient. By creating an explicit legal right to have a doctor assist in a patient's death, such legislation could alter forever the practice of medicine by redefining the doctor-patient relationship.

This paper will briefly consider two legislative proposals that received widespread attention and ultimately failed. It will also consider one currently pending in New Hampshire. Before doing so, however, it

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¹ A living will governs the withholding or withdrawal of life-support from individuals in the event of incurable or irreversible conditions that will cause death within a relatively short time, and when persons are no longer able to make decisions regarding their medical treatment. BLACK'S LAW DICTIONARY 1599 (6th ed. 1990).

² Susan M. Wolf, *Final Exit: The End of Argument*, Hastings Center Rept., Jan./Feb. 1992, at 30-32.

³ James Podgers, *Matters of Life and Death*, 78 A.B.A. J., 60, 61 (1992).

will consider the perspective of the medical profession and the extent to which the courts have been able to address patients' right to autonomy, including the right to die.

It will also discuss several competing policy objectives that must be resolved in deciding whether to permit a patient to have assistance in dying. Finally, focusing particularly on the New Hampshire proposal, the paper will show that even if physician assistance is to be afforded, many issues must nevertheless be resolved.

The Dilemma Faced by the Medical Profession

There is an unavoidable tension within the medical profession founded on the inability to always sustain life while relieving suffering. The traditional doctor-patient relationship, and the practice of medicine itself is transformed when a qualified patient can demand death as a treatment option.

The American Medical Association's Council on Ethical and Judicial Affairs, in accordance with the Hippocratic Oath, has held that physicians may intend to save lives and relieve suffering, but they may not intend as their primary purpose the deaths of their patients.⁴ Thus their position is that patient autonomy can never offset the mandates of the Hippocratic Oath.

For most people, there is a "viscerally felt distinction between acting to hasten death and refraining from delaying death."⁵ There is fear that allowing doctors to assist in killing patients would ultimately result in desensitizing doctors to the value of human life.⁶ It is argued that to allow such action would be "to mistakenly impute more power to human action than it actually has and to accept the conceit that nature has now fallen wholly within the realm of human control."⁷ The fear is that "if

⁴ Kenneth Kipnis, *Physician Participation in Assisted Suicide*, 263 J. A.M.A. 1197-98 (1990).

⁵ *Id.*

⁶ Robert L. Misbin, *Physicians' Aid in Dying*, 325 NEW ENG. J. MED. 1307, 1309 (1991).

⁷ DANIEL CALLAHAN, *To Kill and to Ration: Preserving the Difference*, in WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS 233 (1990).

medicine's power over life may be used equally to heal or to kill, the doctor is no more a moral professional but rather a morally neutered technician."⁸ The inherent risk is that society's faith in doctors as healers and helpers would become subverted.⁹

Whether affirmatively to assist a patient who chooses to die is a double-edged sword for the medical profession. Doctors will be called killers if they accede, selfish and paternalistic if they refuse. Either way, physicians will have to work hard to convince skeptics that they acted in accordance with patients' final wishes, and without coercion, intimidation or rashness of judgment.¹⁰

The Common Law and Constitutional Context of Personal Autonomy in Medical Decision Making

Based on the common law¹¹ of most jurisdictions, competent, terminally ill patients may request the withholding or withdrawal of life-sustaining treatment even when this decision will result in their death.¹² This right is grounded in the patient's common law right to self-determination and the right to be free from offensive, non-consensual touchings.¹³

Such rights also have state and federal constitutional underpinnings. Under the U.S. Constitution, they flow from the liberty provision of the Due Process Clause¹⁴ of the Fourteenth Amendment.¹⁵ In New

⁸ W. Gaylin, L.R. Cass, E.D. Pellegrino & M. Siegler, *Doctors Must Not Kill*, 259 J. A.M.A. 2139 (1988).

⁹ Samuel F. Hunter, *Active Euthanasia Violates Fundamental Principles*, 262 J. A.M.A. 3074 (1989).

¹⁰ Paul A. Drey & James J. Giszczak, *May I Author My Final Chapter? Assisted Suicide and Guidelines to Prevent Abuse*, 18 J. LEGISLATION 331, 337 (1992).

¹¹ The term "common," as opposed to statutory law, refers to a body of principles and rules of action deriving from historical customs and traditions, or from judgments of the courts recognizing and applying the same.

¹² *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. App. 2 Dist. 1986); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. 1978).

¹³ *Schloendorff v. Soc'y N.Y. Hospital*, 105 N.E. 92 (N.Y. 1914).

¹⁴ In fact, the federal Constitution has two Due Process Clauses, one in the Fifth Amendment restricting the federal government, another in the Fourteenth Amendment restricting states. The latter provides that no State shall "deprive any person of life, liberty or property without due process of law."

Hampshire, for example, they are grounded in part I, articles 2 and 3 of the state Constitution, which have been interpreted as guaranteeing that “individuals have a constitutional right to privacy, arising from a high regard for human dignity and self-determination, and that this right may be asserted to prevent unwanted infringements of bodily integrity....”¹⁶

However, the right of a competent, terminally ill patient to refuse unwanted medical treatments is not absolute. Traditionally, the states have asserted specific, countervailing interests. Four commonly asserted interests are: 1) the preservation of life; 2) the prevention of suicide; 3) the protection of innocent third parties; and 4) maintaining the ethical integrity of the medical profession.¹⁷ In *Satz v. Perlmutter*, a competent, terminally ill man suffering from Lou Gehrig’s Disease¹⁸ sought to have his respirator removed.¹⁹ Notwithstanding the countervailing state’s interests which were asserted, the *Satz* court agreed with an earlier decision that:²⁰

there is a substantial distinction in the state’s insistence that human life be saved where the affliction is curable, as

Also, there is procedural and substantive due process. The former guarantees fair procedures prior to the deprivation of constitutionally protected liberty or property interests; see *Mathews v. Eldridge*, 424 U.S. 319 (1976). The latter insures that the substantive constitutional rights are protected; see, e.g., *Regents of the University of Michigan v. Ewing*, 474 U.S. 214 (1985).

¹⁵ *Cruzan v. Director, Mo. Dept. Health*, 110 S.Ct. 2841 (1990) (O’Connor and Scalia, JJ., concurring).

¹⁶ *In re Caulk*, 480 A. 2d 93, 95 (N.H. 1984) citing *Comm’r of Corrections v. Myers* 399 N.E. 2d 452, 455 (Mass. 1979).

See also, e.g., Article I, § 1, the California Constitution. It provides that all persons have certain inalienable rights among which are “enjoying and defending life and liberty... and pursuing and obtaining safety, happiness and privacy.”

¹⁷ See *Matter of Storar*, 420 N.E. 2d 64, 71 (N.Y. 1981), *cert. denied*; 454 U.S. 858 (1981); *Satz v. Perlmutter*, 362 So.2d 160,162–163 (Fla. App. 1978); *Sup’t Belchertown State School v. Saikewicz* 370 N.E. 2d 417 (Mass. 1977).

¹⁸ Amyotrophic lateral sclerosis.

¹⁹ See *Satz*, 362 So. 2d at 161.

²⁰ *Id.* at 162–63, quoting *Saikewicz*, 370 N.E. 2d, at 425–426. *Saikewicz* ruled that a guardian for a mentally incompetent, terminally ill patient has the right to refuse medical treatment if it can be determined that the patient would have refused such treatment while still mentally competent.

opposed to the state's interest where... the issue is not whether, but when, for how long and at what cost to the individual [his] life may be briefly extended.

Legislative Initiatives Generally

As mentioned earlier, allowing a patient to die by refusing treatment is one thing and allowing them to do so by affirmative acts is another. The former has been permitted on common law and constitutional, as well as on legislative grounds. However, courts are unlikely to permit the latter without legislative approval — especially in the face of statutes that forbid it. As discussed below, attempts to secure such legislative approval have so far also failed. However, before discussing them, it is useful to consider general policy arguments that have been advanced on both sides.

Supporter Perspectives

Proponents of assisted-death legislation herald it as the most humane and dignified way to treat competent, terminally ill patients. They point to the sanctity of the person and the right of self-determination by ending “medical paternalism which sometimes leads to the imposition of coercive life-prolonging measures in a manner insensitive to the patient’s autonomy.”²¹ Indeed, some supporters of doctor-assisted suicide assert that such legislation would in fact send a positive message to the public that doctors care and are willing to help a patient carry out their final wishes. The corollary of this message is that the medical profession cares enough to prevent dying patients and their families from enduring the emotional and economic hardships caused by the continuation of hopeless medical and technological intervention. Moreover, it is argued that assisted-death laws would put an end to the cold and depersonalizing experience of dying in a health care facility, thereby ending blind compliance with the technological imperative which dictates that all available medical or technological means, whatever their chance for success, should be attempted.

²¹ Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 N. ENG. J. MED. 1100 (1991).

Other proponents have argued that it would be unethical not to assist patients in dying after a doctor has brought a patient to a state of extended suffering and can do no more.²² The point of this argument is that it would be ethically and professionally inconsistent for doctors to bring a patient to a point of painful existence with no hope for cure or relief from the suffering, and then abandon such a patient because assisting in their death violates the principles of the profession.²³

Some supporters assert a qualified acceptance of assisted-death laws provided three prerequisites are met: 1) the request to die must not stem from a treatable depression; 2) the request for death must not stem from treatable discomfort, symptoms, or pain; and 3) the exploration of the request to die must take place within the context of a relationship between physician and patient of some duration, depth, and intimacy.²⁴ The danger exists in whether the relationship between the patient and an acute care physician ever develops into one of any depth or intimacy prior to the patient's request for assisted death from that physician.

Arguments of Opponents

Those who oppose assisted suicide point to the fact that once the suicide boundary is crossed, it marks the beginning of systematic devaluation of human life and would likely be the initial step toward the gradual performance of assisted suicides on mentally or physically disabled persons, or on non-terminally ill patients whose wish for death stems from depression or poor quality of life.²⁵ Many opponents of such legislation argue from the position that there is no absolute personal autonomy over one's life, and that the fabric of law and society is founded on this principle. In addition, detractors posit that assisted suicide laws would transform the *right* into an implied *duty*; that is, terminally ill persons might feel pressured to die sooner so as to not

²² Guy I. Benrubi, *Euthanasia: The Need for Procedural Safeguards*, 326 N. ENG. J. MED. 197 (1992).

²³ *Id.*, at 198.

²⁴ R.C. Klagsbrun, *Physician-Assisted Suicide: A Double Dilemma*, 6 J. PAIN SYMPTOM MGMT. 325–28 (1991).

²⁵ Breo, *MD-Aided Suicide Voted Down*, 266 J. A.M.A. 2895 (1991).

consume scarce and valuable medical resources, and to avoid imposing substantial hardships on, e.g., their families. Opponents point vigorously to the absence of some form of universal health care insurance as the impetus behind families and health care facilities exerting subtle pressures on patients to end their own lives because of the costs associated with life-sustaining treatment.²⁶ They argue that the risks of abuse by physicians is too great, and that pain management and care might not be pursued as vigilantly where assisted death is an alternative.²⁷

Failed Legislative Proposals

Initiative 119: The Washington Aid-In-Dying Measure

In November 1991, the issue of doctor-assisted suicide made national headlines when voters in Washington state defeated Initiative 119 (I-119), also known as the “aid-in-dying” proposal, by a 55-45% margin.²⁸ That measure was proposed as part of a three part amendment to the state’s living will statute.²⁹ Two parts — broadening the definition of “terminally ill” to include patients in a persistent vegetative state and irreversible coma, and allowing removal of artificially administered food and water — received widespread support from the state’s medical society.³⁰

The third, however, would have given competent, terminally ill patients the right to have:³¹

aid in the form of a medical service provided in person by a physician, that will end the life of a conscious and mentally competent qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided.

²⁶ See Podgers, *supra* note 3.

²⁷ David Orentlicher, *Physician Participation in Assisted Suicide*, 262 J. A.M.A. 1844-45 (1989).

²⁸ See Breo, *supra* note 25.

²⁹ Wash. Rev. Code. Ann. §§ 70.122.010-70.122.905 (Natural Death Act).

³⁰ Breo, *supra* note 25, at 2896.

³¹ Wa. Legis. I. M. 119 (1991), § 2 (9) (LEXIS, State library, Wa-Legis file).

Although the term “medical service” was left undefined, materials distributed by the Washington Citizens For Death With Dignity indicated that it would include prescriptions for an overdose of barbiturates for patients who could swallow or intravenous administration of medications to sedated patients who could not.³² Also, I-119 required assisted-death directives to be executed at the time service was to be provided and precluded incompetent patients from receiving aid on the basis of previously executed directives. Moreover, the service was to be rendered in the presence of the assisting physician.

The state’s medical associations opposed such assistance by a 5-1 margin.³³

Proposition 161: The California Death with Dignity Act

Moreover, on November 3, 1992, California voters, 54-46%, defeated a similar initiative. The California Medical Association, the Roman Catholic Church and various nurse, hospital and senior citizen groups contended that the proposal was flawed because it lacked important procedural safeguards, including requirements for a psychological examination, a waiting period and family involvement in the decision.³⁴ Such opponents raised over \$3 million, more than four times the amount raised by supporters, and waged an aggressive, high-profile radio and television campaign right up to the last minute.³⁵ However, supporters, including the American Civil Liberties Union, Unitarian clergy and Californians against Human Suffering, were buoyed by a rapidly-growing right-to-die movement and seem to be convinced that such legislation will eventually pass.³⁶

Proposition 161 would have provided “mentally competent and terminally ill adults the legal right to voluntarily request and receive physician-aid-in-dying.”³⁷ Doctors or other health care professionals

³² Misbin, *supra* note 6, at 1307-08.

³³ *Id.*

³⁴ Paul Jacobs & Virginia Ellis, *Proposition 65 and Right-to-Die Measure Trail*, Los Angeles Times, Nov. 4, 1992, A1, col. 1.

³⁵ Miiranda Ewell, *Voters Reject Contrversial Measure*, San Jose Mercury News, Nov. 4, 1992, EL17.

³⁶ *Id.*

would not have been required to participate, but those doing so would not have been liable in any criminal, civil or administrative proceeding for complying with a patient's directive.³⁸ The proposition also required a patient's requests to be enduring and his or her revocable directive to be witnessed by two persons meeting specified requisites.³⁹ Ultimately, the patient would have determined the time and place for dying⁴⁰ by telling the treating physician that the time had arrived.⁴¹

The New Hampshire Death with Dignity Act

What it Provides

Yet another proposal is being considered in New Hampshire. If passed, it would allow mentally competent persons, at least 18 years of age and suffering from a terminal condition,⁴² to execute written directives witnessed by two independent persons.⁴³ Such directives would instruct attending physicians to "prescribe medications which will enable the patient to self-administer such medications and so control the time, place and manner of his or her death."⁴⁴

The attending physician or the health care facility where the patient resides may choose not to comply. Should a physician or facility choose not to comply, good-faith efforts must be made to transfer the patient so as to satisfy the patient's request.⁴⁵ However, were the attending

³⁷ Proposed California Death with Dignity Act, Cal. Civil Code, Title 10.5, § 2525.1. Hereafter cited as California Proposal §....

³⁸ California Proposal, §§ 2525.8, 2525.9.

³⁹ California Proposal, § 2525.3.

⁴⁰ California Proposal, § 2525.7.

⁴¹ California Proposal, §2525.24.

⁴² H.R. 1275, 1992 Sess., §137-K:2 (III).

⁴³ *Id.*

Moreover, § 137-K:6 (III) contains a pregnancy exception. A patient's request cannot be honored if the patient is pregnant and the attending physician has knowledge of the pregnancy.

⁴⁴ H.R. 1275, 1992 Sess., § 137-K:3 (I). This section of the bill contains a sample written directive.

⁴⁵ H.R. 1275, 1992 Sess., § 137-K:5 (I).

physician to choose to comply, the terminal condition would have to be certified in writing by a second physician competent in the particular disease category. Also, the attending physician would be required to consult, e.g., an appropriate medical ethics committee⁴⁶ before complying. The ethics committee would then be obligated to review the patient's prognosis, competence and knowledge of all relevant facts, as well as to determine that the decision was truly voluntary and give the patient a chance to be heard.⁴⁷ Nevertheless, "the decision to fulfill the patient's request is solely the responsibility of the attending physician."⁴⁸

Afterward, persons assisting attending physicians, including hospital or facility staff and members of the ethics committee, would be immune from civil, criminal, and administrative liability, provided they act in accordance with reasonable medical standards.⁴⁹

Problems with the New Hampshire Proposal

The drafters of the New Hampshire bill seem to seek a compromise by lessening the involvement of physicians in patient assisted suicide. The only thing that patients are clearly entitled to, if they can find a cooperating physician, is a prescription adequate to their needs. This raises several problems.

First, one should consider patients who are incapable of self administration. If the provision is truly designed to prevent assistance, this is difficult to understand. If respect for individual autonomy and dignity is the underlying rationale and physicians can assist by prescribing, it seems arbitrary to deny additional assistance to quadriplegics or others incapable of self-administration.⁵⁰

⁴⁶ H.R. 1275, 1992 Sess., § 137-K:4.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ H.R. 1275, 1992 Sess., §137-K:5 (II).

⁵⁰ *See, e.g.,* McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990) and State v. McAfee, 385 S.E. 2d 651 (Ga. 1989) (both granting the request of a competent, non-terminal, but irreversibly ill, respirator-dependent quadriplegic to have his respirator removed and to be administered a sedative to ease the pain of his inevitable death). *See also,* Matter of Farrell, 529 A. 2d 404 (N.J. 1987) (right of competent, terminally ill adult physically paralyzed by Lou Gehrig's Disease to have her husband remove her respirator outweighed the state's interest in sustaining her life).

Second, insofar as mentally competent patients can receive medication and choose when, if ever, to use it, there is a possibility that they will no longer be competent when they choose to do so. Is a physician obligated to retrieve medication from such a person? In its present form, the bill does not address the durability of an assisted-death directive; there is no explicit guidance regarding the validity of an executed directive upon the patient's subsequent incompetence.⁵¹ Also, the New Hampshire bill does not address whether a patient's wish to die can be effectuated by a surrogate decision maker.

Finally, because the New Hampshire proposal does not require a physician to be present at the time the patient plans to die, two additional problems are presented. Requiring a doctor's presence would reduce the incidence of failed attempts and the occurrence of painful and inhumane situations which the bill aims to prevent. Moreover, making the death a strictly private affair also seems to make it less likely that patients will die in caring and supportive surroundings.⁵² Minimally, the presence of a physician would lessen the emotional and psychological burdens of the patient at this critical time.

Such problems should be addressed by legislatures rather than left for the courts to resolve as best they can.⁵³

⁵¹ By comparison, Washington I-119 defined "aid-in-dying" as a medical service to be provided "in person by a physician... when requested through a written directive... at the time the medical service is to be provided." *Supra* note 31.

⁵² See, e.g., In the Matter of Beverly Requena, 517 A. 2d 886 (N.J. Super. Ch. 1986), *aff'd*, 517 A. 2d 869 (N.J. Super. App. Div. 1986) (competent, terminally ill patient has right to die by refusing of artificial food and fluids in the hospital where she had resided for the last seventeen months notwithstanding hospital's policy against withholding such treatment).

⁵³ Recently, world-wide attention has been focused on the Netherlands. See Jerome Socolovsky, *Most Liberal Mercy-Killing Guidelines in Europe Adopted*, an Associated Press report appearing in, e.g., the Concord (N.H.) Monitor, Feb. 10, 1993, at A3.

Although the legislation approved by parliament stops short of legalization, it guarantees physicians immunity from prosecution if they follow strict guidelines for mercy killing. ... The compromise represents a middle ground between Prime Minister Ruud Lubbers' Christian Democratic Party, which faced fierce opposition from a religious flank, and the Labor Party, which sees the right to euthanasia as a fundamental personal choice.

Conclusion

Proponents of legislation permitting others to help patients commit suicide must overcome a host of policy objections. They must also overcome strong opposition by, e.g., health care professionals who see undesirable change in the nature of their relationships with patients.

Yet, once those hurdles are cleared, the job is not over. First, laws recognizing mentally competent patients' rights of autonomy and self-determination with regard to time and manner of death must also contain safeguards to ensure that patients receive equal treatment and are not coerced, as well as to ensure that patient requests are carried out in the most compassionate manner. Second, such laws must recognize the rights of health professionals to decline to do what they find morally or professionally unacceptable. The New Hampshire bill seems to demonstrate that, if legislation attempts to satisfy the second objective by minimizing the involvement of health care professionals, it may well fail to achieve its primary objectives.

