

Physician-Assisted Suicide---Homicide or Death with Dignity?

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Physician-assisted suicide is now lawful in seven states and the District of Columbia. Oregon was the first state to pass legislation allowing physicians to assist in end of life activities in 1994. Oregon's adoption did not open the floodgates---the second adoption did not occur until 2008 when Washington followed Oregon's lead. Then Vermont, California, Colorado, Montana, Hawaii and DC followed suit. The state statutes apply if a person is diagnosed with a terminal illness and has less than 6 months to live. This article examines the state approaches and addresses arguments supporting and opposing these statutory approaches.

INTRODUCTION

People suffering from a terminal illness sometimes wish to end their own lives. Motivations for suicide may include avoiding pain and suffering, relieving loved ones of the burden of care, and/or reducing the financial impact of prolonged illness. Should physicians assist terminally ill patients who seek medications to end their own lives? The answer to this question is individual, complex and likely intertwined with ethical, religious, professional and societal values.

Opponents of physician-assisted suicide argue that a medical professional's role is to extend life, not assist in voluntarily ending it. Proponents of physicians assisting in suicide focus on patients' personal autonomy. Extending a patient's life when death is imminent and inevitable, they argue, violates their inherent right to control their own destiny and avoid severe negative consequences of prolonged illness. The objective of this article is not to debate these challenging moral issues. Rather, we explore the laws governing physician-assisted suicide in the United States and attempt to identify common and exceptional elements of existing requirements.

We begin by noting the important distinction between assisted suicide and euthanasia. In an assisted suicide, a physician issues a prescription for medication that will end a patient's life. The suicidal patient ingests the medication through his or her own actions. This practice differs from euthanasia in which a physician intentionally ends a patient's life or passive euthanasia, the practice of withholding life-

sustaining treatments to allow death. The federal government and each of the 50 states prohibit active euthanasia under homicide laws.

Living will provisions have allowed patients to make declarations as to whether they wish to extend their life or not since the 1980's. There are, however, no federal laws that allow physician-assisted suicides. Currently, seven states and the District of Columbia permit physician-assisted suicides. Thirty-seven states have enacted laws that specifically prohibit assisted suicide activities by physicians.

Oregon was the first state to allow physician-assisted suicide. Other states that have passed legislation allowing this activity have patterned their laws after the Oregon approach. These states include Washington, Vermont, California, Colorado and Hawaii. Hawaii's legislation, the most recently enacted, takes effect January 1, 2019. Montana has not passed legislation, but its judicial system has decided a case allowing physicians to grant protected assistance in end of life activities.

The remainder of this article explores the details, pros and cons of laws in jurisdictions that permit physician-assisted suicide and considers the key arguments for and against legalizing physician-assisted suicide.

THE OREGON STATUTE PASSED IN 1994

Because all the states that have passed physician-assisted suicide legislation have closely followed the Oregon approach, a close examination of the Oregon approach makes sense. The Oregon Death with Dignity Act (Oregon Revised Statutes, Section 127.800 to 127.897) was passed in 1994 by a narrow margin. Legal challenges delayed implementation of the statute until 1997. In a second referendum, the citizens of Oregon voted to retain the legislation by a 60% to 40% margin. The first suicides under the Act occurred in 1998.

The Oregon Act imposes specific requirements that must be satisfied before a lawful assisted suicide is possible. In order to invoke the Act a person must have been diagnosed with a terminal illness and have a life expectancy of six months or less. A healthy person who is simply tired of living cannot invoke the provisions of the Oregon statute. The process of invoking the Oregon statute requires multiple requests by the patient. An adult patient, who has been determined to be terminally ill, must first make an oral request of a physician for medication to end their life. After waiting at least 15 days, the patient must make a second oral request. Finally, the patient must request the medication in writing.

Physicians receiving such a request face multiple requirements, including:

- The attending physician must determine that the patient has a terminal illness that will result in death within six months.
- The patient must also be deemed capable of making and communicating health care decisions for themselves.
- The physician must fully inform the patient of the diagnosis and prognosis.
- The physician must discuss alternatives to suicide including comfort care, hospice care, and pain control options.
- A second physician must confirm the attending physician's diagnosis and must certify that the patient is mentally competent.
- If either doctor determines that the patient is mentally impaired, the patient must be referred for a psychological examination.
- The patient must be encouraged to notify his or her next of kin of the plan to end one's life.

The Oregon statute mandates that prescription medications used to end the patient's life must be dispensed by the physician or a pharmacist. The law requires a minimum 48- hour waiting period after the patient's written request before the medication may be dispensed. The medication, typically a lethal dose of barbiturates, must be administered personally by the patient. No one else can inject or administer medication to end the patient's life. Only residents of Oregon can make use of the Death with Dignity statute. Oregon residency must be proven for a patient to obtain a lethal prescription. Under the express

provisions of the statute, doctors and pharmacists who facilitate the suicide cannot be held legally liable either in a civil or criminal action. The statute clearly provides that doctors are not required to facilitate suicides under the act. Physicians can simply choose not to facilitate this activity by their patients.

Extensive public records are kept pursuant to the Oregon Statute. As of early 2018, 1,967 prescriptions had been issued. Since the Act was passed, 1275 persons have committed suicide under its provisions. The highest number of deaths in a single year was in 2017 when 143 people died. The average age of those dying is 72. Slightly more males make use of the statute than females. About half of those dying were married at the time of their suicide. Over 75 percent of the patients who used the Oregon statute had at least some college education in their background. Most were white, and the vast majority were suffering from cancer.

The three most common reasons given for ending life are: (1) decreasing ability to participate in activities that made life enjoyable, (2) loss of autonomy and (3) loss of dignity. More detailed data are provided by the Oregon Department of Human Services in the 2017 Data Summary Report on Oregon's Death with Dignity Act. The report may be accessed at:

<http://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year20.pdf>.

The validity of the Oregon Death with Dignity statute was challenged in 2006. The United States Supreme Court upheld the Oregon Statute in the case of *Gonzales v. State of Oregon* (546 US 243) (2006), citing principles of federalism, which gives States great latitude to regulate the practice of medicine within their state.

FIVE STATES AND THE DISTRICT OF COLUMBIA (EVENTUALLY) FOLLOW OREGON'S LEAD

The passage of the Oregon statute did not prompt other states to immediately follow suit. Washington passed a voter initiative to allow physician-assisted suicides in 2008—fourteen years after Oregon—with support from 58 percent of voters. The remaining four states that legislatively allow physician-assisted suicide have enacted laws in relatively short order. Passage occurred in Vermont (2013), California (2015), Colorado (2016) and Hawaii (2018). In addition to the six states, the District of Columbia passed a Death with Dignity Act in 2016. Washington DC laws are subject to Congressional oversight.

Each of the five states listed and the District of Columbia share key features of the Oregon model. Candidates for legal, physician-assisted suicide must be diagnosed with a terminal illness and have a life expectancy of six months or less. Patients must make two oral and one written request of their physician. A confirming diagnosis from a second physician is also required.

California's End of Life Option Act took effect on June 9, 2016. This act specifically states that use of the act to end one's life intentionally cannot affect the validity of health insurance, life insurance, or annuity insurance policies. The California Act also provides translators for non-English speakers. The only other provision that does not match the Oregon approach is that there is no 48-hour waiting period to obtain medications after the prescription is issued by a physician.

Colorado passed a voter Proposition in 2016 adopting the End of Life Options Act. A unique requirement under the Colorado Act is that the physician must refer the patient to a licensed mental health professional before a prescription can be issued. The Colorado Act also requires that the patient must be advised that the medication should be taken in a private place with another person present.

The most recent state to adopt legislation is Hawaii, which passed the Hawaii Our Care, Our Choice Act in 2018. Under Hawaii law, a counselor also must determine that the patient isn't suffering from conditions that may interfere with decision-making, such as a lack of treatment of depression. Hawaii also requires two witnesses to the written request by the patient. One of the witnesses cannot be a relative, a healthcare professional, or a person who could gain from the estate of the patient.

A DIFFERENT APPROACH IN MONTANA

Montana has followed a different and interesting path to physician-assisted suicide. In 2008, a Montana resident who was dying of leukemia petitioned a Montana court with his doctors for the establishment of a constitutional right to obtain medical aid and receive a lethal dose of medication to aid death. A Montana judge issued a ruling allowing the patient to receive the medication and noting that there is constitutional right to die with dignity. The court decision also specifically held that the physician who assists the patient is protected from criminal liability for his/her actions under Montana law. In 2011 several legislative proposals were introduced to establish an approach like Oregon's, but the proposals were not implemented.

Only six states and the District of Columbia currently permit physician-assisted suicide. Whether these jurisdictions remain a small minority or represent the early data points of a growing trend is uncertain. As is often the case with tough moral/legal decisions, powerful supporting arguments can be made both for and against physician-assisted suicides. The next sections of this article review some of the lines of reasoning offered on both sides of the debate.

ARGUMENTS IN FAVOR OF LEGAL, PHYSICIAN-ASSISTED SUICIDE

Perhaps the most compelling arguments in favor of legal physician-assisted suicide depend on the notion of personal freedom. Supporters of this viewpoint are committed to the principle that individuals should have the right to decide how to live their own life. Only an individual can measure his or her own quality of life, and only an individual can determine when that life is not worth living. For many people, issues of life and death are connected to religious beliefs. Because the free exercise of religion is protected under the First Amendment, the argument can be made that individuals have a constitutional right to determine how they wish to live—or end—their life in accordance with their religious beliefs.

Another argument in favor of physician-assisted suicide focuses on using scarce health care resources effectively. This line of reasoning suggests that it is preferable to deploy medical professionals, equipment and hospital beds serving the needs of patients who wish to live, rather than prolonging the lives of those who would prefer to die. Aside from resource issues, it can be argued that allowing patients to choose death is a compassionate option. The Oregon approach allows for self-control and provides a viable legal alternative to suffering. The benefits of self-determination may also extend to loved ones who share in the suffering of terminally ill patients and assume the burden of end-of-life costs, either directly or through diminution of the patient's estate. Proponents of assisted suicide also point out that allowing physician assistance provides a viable, peaceful alternative to traumatic suicides (and suicide attempts) employing firearms or other painful methods.

Finally, residents of a state should be free to decide if their state will allow assisted suicides. It is not up to the courts or the federal government to intrude into the affairs of a state in matters of personal welfare. If residents of a state that allow assisted suicides do not wish to use the Death with Dignity Act, the residents are free to ignore the provisions of the Act.

ARGUMENTS AGAINST LEGAL, PHYSICIAN-ASSISTED SUICIDE

Opponents of legalizing assisted suicide offer many reasons why physicians should not be allowed to help patients end their life. Medical doctors, they argue, should save—not end—lives. Their role is to heal and comfort the ill. Individuals may view assisted suicide as murder, and the practice conflicts with the beliefs of many religions. Some argue that assisted suicide weakens society's respect for the sanctity of life.

Persons who are physically suffering may also suffer from depression. A person suffering from depression is arguably not capable of making rational life and death decisions and is more likely to seek an end-of-life alternative. Pain may lead to hasty decisions that are obviously not reversible. Further, the

current approach is arguably flawed because psychological evaluations are not mandatory before prescriptions are authorized.

Opponents generally believe that hospice and palliative care are more appropriate than ending one's life. The emphasis, they assert, should be on making the end-of-life experience pain-free rather than simply ending life. Opponents of assisted suicide are quick to point out that not all physician-assisted suicides are peaceful--some prescriptions cause severe medical reactions that result in a very traumatic death. Nausea and extended hours of time before death have been reported, fueling speculation that death by prescription is not as pain-free as supporters often suggest.

Another concern is that current approaches place too much control in the hands of physicians and limit input from concerned family members. Discussing life-ending plans with family is not required in many states; physicians are merely required to encourage the patient to discuss their plans with their family. So far, the states that have adopted assisted suicide statutes do not make use of an ethics oversight panel to better protect the process.

Minimization of costs may become an overriding objective for heirs, patients and physicians. From the hospital perspective, most medical costs for the average person occur within the final months of life. This perspective may flow from hospitals to physicians and to family members. Finally, it can be argued that suicide precludes the possibility of miraculous recoveries or miracle cure discoveries. No one can predict the future of medical research.

CONCLUSION

Only seven states and the District of Columbia have chosen to allow its terminally ill citizens to decide if they wish to live or die. However, four of these states and the District of Columbia have adopted statutes within the last five years. The United States Supreme Court supports the state's ability to decide moral issues such as assisted suicide without interference from the federal government. Thus, the door is open to states who choose to follow the approach initiated by Oregon over twenty years ago. Given that the sanctity of life is a uniquely polarizing issue in American society, the only certainty about the future of this issue is that there will be passionate arguments on both sides.