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# Euthanasia, Physician Assisted Suicide and the Dying Patient: Medical Status

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The fear of death and the difficulty in coming to terms with that fear pervade all societies and cultures. In Western societies, the fear is heightened by the availability of advanced medical technology which may maintain life long after meaning has been extinguished. The same powerful technology may also be incapable of adequate control of pain during the artificial prolongation of life.

To allay some of the terror generated by this superimposition of technological capabilities upon the dread of the death process, we have begun to articulate "goals" in dying. It is our hope that the achievement of these goals might make our contemplation of the experience and the experience itself less frightening. Thus, we would like death to be painless, dignified, humane, and meaningful. And now, we would like to be in control of the circumstances, as well.

The age-old fear of death and the recently-articulated desire for control have generated new interest in euthanasia as an antidote to the problematical aspects of dying. Euthanasia is from the Greek: *eu* meaning "good or well" and *thanatos* meaning "death." A review of the definitions of the varieties of euthanasia is helpful:

1. *Voluntary Euthanasia*
   The patient himself asks to die or agrees with his physician's recommendation that he die

2. *Nonvoluntary Euthanasia*
   A surrogate agrees, on the patient's behalf, with the physician's recommendation that the patient die

3. *Involuntary Euthanasia*
   Someone other than the person involved performs an intentional act to terminate life without the consent of the person involved

4. *"Active" Euthanasia*
   No longer in use

5. *"Passive" Euthanasia*
   Involves the withholding and withdrawing of life support, and is not technically euthanasia since the patient dies of his disease. It is a legitimatized and recognized option.

Physician-assisted suicide, a subset of euthanasia, is the intentional assistance given to a person by a physician to enable that person to terminate his own life upon that person's request.

In other words, the physician provides the means ("gun"), but the patient performs the act ("pulls the trigger.).

The double effect refers to the effect palliative treatment may have in hastening a patient's demise. The intent of palliative treatment is to relieve pain and suffering and not to end the patient's life. The patient's death may, however, be a side effect of the treatment, and a foreseeable one, at that. The administration of morphine is an example of the double effect. Morphine is an analgesic, but it is also a respiratory depressant which can lead to pneumonia, aspiration, hypoventilation, or apnea. While the original intent was to take advantage of morphine's analgesic effect, it is recognized that morphine's depressant effect on ventilation may come into play, as well, which may ultimately be harmful.

The degree of interest in euthanasia and the extent of its acceptance are reflected in recent opinion polls. In 1989, 676 physicians in San Francisco, California, were asked their opinion of the use of euthanasia. Seventy percent of the respondents said patients who had an incurable terminal illness should have the option of euthanasia. Forty-five percent said they personally would carry out the request. Thirty-five percent said they were opposed to the use of euthanasia.

In a public poll conducted in 1994, 63 percent of lay respondents favored legalizing physician-assisted suicide and euthanasia. Eighty-one percent supported the passage of laws allowing physicians to carry out patients' advance directives, including euthanasia. Seventy-six percent of respondents favored legislation permitting the withdrawal of life support from hopelessly ill or irreversibly comatose patients. Fifty-two percent said they would prefer to consider alternatives to ending their own lives if they had a terminal illness. Responses to the questions overlapped, but the sentiment of the majority of people polled supported euthanasia in some form.

Researchers in Michigan, the venue for the suicides assisted by Dr. Kervorkian, sent questionnaires to stratified random samples of physicians and lay adults in 1994 and 19953. The questionnaires included questions about whether physician-assisted suicide should be banned in Michigan or legalized under certain conditions. Usable responses were received from 1119 of 1518 physicians (74 percent) and 998 of 1307 adults (76 percent) eligible for the study. Asked to choose between legalization of physician-assisted suicide and an explicit ban, 56 percent of physicians and 66 percent of the public supported legalization; 37 percent of physicians and 26 percent of the public preferred a ban; and 8 percent of each group were uncertain.

When the range of choices for physicians was widened, 40 percent preferred legalization; 37 percent preferred "no law" (de, no government regulation); 17 percent favored prohibition; and 5 percent were uncertain. If physician-assisted suicide were legal, 35 percent of physicians said they might participate if requested; 22 percent would participate in either assisted suicide or voluntary euthanasia; and 13 percent would participate only in assisted suicide.

The most important personal characteristic of Michigan physician and lay adult respondents in relation to their views on physician-assisted suicide and voluntary euthanasia was religion. Those who considered religion to be very important in their lives were much less likely to support legalization and to consider personal involvement in assisted suicide, either as providers (physicians) or requestors (the public), than were people for whom religion was less important.

The Oregon Death with Dignity Act, legalizing physician assisted suicide, was passed in November 1994(2). Although the constitutionality of the bill is being contested in the courts, researchers in Oregon conducted a cross-sectional mailed survey in early 1995 of all physicians who might be eligible to prescribe a lethal dose of medication if the Oregon law is upheld (16). Of the 3944 physicians who received the questionnaire, 2761 (10 percent) responded. Sixty percent of the respondents thought physician assisted suicide should be legal in some cases, and nearly half (46 percent) said they might be willing to prescribe a lethal dose of medication if it were legal to do so. Thirty-one percent of the respondents indicated they would be unwilling to prescribe a lethal dose of medication on moral grounds. Twenty-one percent had previously received requests to assist in a patient's suicide, and 7 percent had complied.

The physicians who responded expressed concerns about the lack of information on oral medications and their lethal doses, the patients' possible financial incentives for choosing physician assisted suicide in the absence of universal access of - dying patients to comprehensive care, and the complications' of suicide attempts. They also had doubts about their ability to predict survival at six months accurately and to diagnose depression, two requirements of the Oregon act, and wondered about methodology for protecting the patient's right to privacy and the physician's right to refuse to participate in a practice he or she finds morally objectionable.

The characteristics associated with the attitudes of physicians in Oregon toward assisted suicide included religious affiliation, specialty, population of the area in which the practice is located, age, and sex. The variables that were significantly associated with the physicians' willingness to participate in physician-assisted suicide included Jewish affiliation (odds ratio 2.94), no religious affiliation (odds ratio 2.87), other non-Christian affiliation (odds ratio 1.92), and age, which demonstrated a 13 percent increase in willingness to participate for each 10 year increase in age.

Surprisingly, the Jewish respondents' willingness to participate in physician-assisted suicide, while similar to the results of an Australian survey correlating professed religious affiliation and the willingness to practice euthanasia(5), is the antithesis of the Jewish teaching that:

1. Man is created in the image of God
2. In every human being there is a Divine spark
3. Each human life is sacred
4. Each human life is of infinite worth.

In consequence, a human being must be treated as a personality and not as chattel. As a personality, every human being possesses the right to life, honor, and the fruits of his labor.

True justice in Judaic terms is respect for the personality of others and for their inalienable rights, including the right to life. In Judaism, justice is akin to holiness. As Isaiah declared for all time:

> *"The holy God is sanctified by justice"* (Isaiah V:16).

Justice is a positive conception in Judaism and includes charity, philanthropy, and our endeavors to bring out the best in people. "Loving kindness" always precedes the mention of "justice" in the Scriptures to teach that strict justice must, in its execution, be mitigated by pity and humanity. The Prophets sum up our human duty to others as:

> *To do justly and to love mercy*.

In the Oregon survey, an unwillingness to participate in physician-assisted suicide was associated with a Catholic affiliation (odds ratio for willingness 0.43) or other Christian affiliation (odds ratio for willingness 0.33) and a small town or rural locale (odds ratio for willingness 0.67). Sex, specialty, and whether or not the respondent had cared for terminally ill patients were not significant predictors of the willingness of physicians to participate in physician-assisted suicide.

The rationales cited in support of physician-assisted suicide are numerous. First and foremost is the conferring of relief from pain and suffering. The patient, in securing the help of a physician in dying, is said to "retain control" in an otherwise fearful situation because of a perceived ability to determine the time of death. In assisting with the patient's suicide, the physician does not "abandon" the patient at the time of greatest need. Help is thus readily at hand for patients who are unable to take their own lives. Through the assistance of their physicians, patients may also avoid victimization by medical technology in the form of prolongation of suffering.

Those opposed to physician-assisted suicide cite cogent arguments. Pain and other symptoms causing discomfort and suffering are treatable. There is frequently prognostic uncertainty, even when patients are considered to be terminally ill. Rather than the expression of a desire for death, the request by a patient that the physician assist in the patient's suicide may be a cry for help to which the physician may respond in a number of (non-lethal) ways. Focusing on physician-assisted suicide also diverts patient-care and research energies away from palliation. There are societal concerns that patients may feel coerced to die or that they have a duty to die. Further, the introduction of physician-assisted suicide may lead to abuse through the singling out of the disenfranchised who have no voice— the poor, the disabled, the elderly, and the very young— for such orchestrated conclusions to their lives.

The legalization of physician-assisted suicide requires the establishment of criteria for patients' participation to avoid errors and abuses. The patient must be competent to decide that suicide is the best solution to current health problems. The patient's physician must know the patient well enough to understand the patient's motivation in choosing suicide. The patient must be judged to be terminally ill and to have a dismal short-term prognosis, which must be corroborated by a second (and third) physician. The patient's physician determines that no alternative exists for relief of the patient's suffering, and that the patient's decision is not influenced by utilitarian considerations of the patient's economic or social situation.

Clinical criteria have also been developed for physician assisted suicide. These include the requirement that physician assisted suicide be carried out in the context of a meaningful physician-patient relationship. Consultation with another physician experienced in the delivery of comfort care should be required. Documentation of the closeness of the physician- patient relationship and the consultation with other physicians is necessary, as well as the clear indication of the cause of death which should be filed with the appropriate authorities.

The patients must further, of their own free will and at their own initiative, clearly and repeatedly request to die rather than to continue suffering. The patients' judgment must not be distorted by illness, medication, social or economic circumstances, or depression. The patients must have a condition that is incurable and associated with severe, intolerable, unrelenting suffering. The physician must ascertain that the patients' requests for death are not being made because of inadequate comfort care.

A major part of the physician's role in physician- assisted suicide is to determine what the patient is really asking when framing the question, "Doctor, I want to die. Will you help me?" The exploration of such requests by the physician is fundamental to the care of the dying patient. The physician's willingness to talk about death signals to the patient that the patient is no longer alone and opens unanticipated avenues of support that do not involve the physician's active assistance in dying.

The patients' requests that the physician aid in suicide may be their way of drawing attention to problems for which solutions short of death may be readily available. The patient may, recognizing the seriousness of the situation, desire a change in the goals of treatment from cure to comfort. The patient may be asking for relief of pain. The patient may desire resolution of psychosocial problems so that the giving of care is no longer a burden to the caregiver. The patient may be asking for— and willing to respond to— spiritual consolation. The patient may be suffering from a depression amenable to psychiatric treatment.

Thus, when the patient expresses a desire to die, the physician should listen to the patient and ascertain the dynamics of the particular situation before responding. The physician needs to be compassionate, caring, and creative and to promise to be there until the end~. When patients ask, physicians should be honest about their openness to the possibility of assisted suicide. While physicians should approach the possibility of intolerable end-of-life suffering with an open mind, they must also advise their patients early on of their unwillingness to participate in physician-assisted suicide and euthanasia. Confronted as physicians are by the moral and ethical dilemmas posed by these issues, they need to develop their own support systems for dialogue and affirmation of their positions.

The fact that their physicians will talk about death, acknowledge patients' fears, and actively seek alternatives greatly reassures patients, even when the physicians will not directly assist in their patients' suicide. For some patients, the possibility of a "controlled death" is often more important than the reality. Other patients, however, undoubtedly will continue to view a lethal prescription or their physicians' pledge to assist their suicide as the only "escape" if things become intolerable.

The movements to legalize physician-assisted suicide and euthanasia reflect the poor state of palliative and terminal care in the United States and elsewhere. The physicians' knowledge of pain control and symptomatic relief of distressing conditions including nausea, vomiting, and dyspnea is very limiteditі9. This dismal state of medical affairs reflects the fact that there is little or no residency training in palliative care since programs are typically centered in acute care or outpatient settings with no experience offered in hospice care=~. There are no formal training curricula in palliative care, no formal assessments on board certifying examinations', and an absence of physician role models for trainees.

The most prestigious of the medical journals rarely include articles on palliative care. Dr. Gomez of the Department of Medicine of the University of Virginia conducted a Medline search of the contents of 12 years of articles from the New England Journal of Medicine, Journal of the American Medical Association, Lancet, and the Archives of Internal Medicine in 1995. The study revealed that the number of articles pertaining to palliative care was 269:

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| **Hospice and palliative care** | *69* |
| **Policy and economics** | *64* |
| **Ethics and legal aspects** | *136* |

Legalization has been proposed in the United States to confer legal sanction on euthanasia. The emphasis in these attempts is on patient self-determination and on continuity with and similarity to other end-of-life decisions which are currently legal. Common legislative restrictions on euthanasia include the type of oversight, the imposition of a waiting period, and the requirements that the illness be terminal and that the patient be competent. Such attempts at legislation are being played out against a backdrop of economic uncertainty in this era of sharp reductions in health care dollars.

The recent legislative movements to legalize euthanasia in the United States have taken the form of voter referenda, thus bypassing direct law-making. In the states of Washington and California, voters defeated the referenda permitting physician assisted suicide in 1990 and 1992, respectively. Voters in Oregon passed the Oregon Death With Dignity Act legalizing physician assisted suicide, but not euthanasia, on a November 1994 ballot initiative by a vote of 51 percent to 49 percent. The act was declared unconstitutional by a federal judge in August 1995 because of its alleged violation of the due protection clause of the Fourteenth Amendment of the United States Constitution. The judge ruled that the act failed to offer terminally ill persons the same protections against suicide offered to the majority. An injunction was issued to prevent the act's taking effect. The ruling is currently under appeal.

The legal progression of euthanasia in the United States has also -included a number of significant judicial rulings. The opinion in the Quinlan case in 1976 established that life-sustaining treatment may be withdrawn. In 1991 it was determined in the Wanglie case that arguments of medical "futility" made by an institution may not override the request of the patient or the patient's proxy for treatment. Physicians made similar arguments about futility -in the Basyk case in 1994, but the Fourth Circuit Court of Appeals (Virginia) ruled that the mother could, as the patient's proxy, have the patient's care continued. The United States Supreme Court refused to hear arguments against the appellate ruling.

Courts in Michigan have also acquitted Dr. Kevorkian of breaking the state law against physician-assisted suicide on three separate occasions. Current laws banning physician-assisted death in the United States may thus be unenforceable, because of the unwillingness of juries to convict physicians who are perceived as coming to the aid of the suffering. It may be that statutes promulgating blanket prohibitions against physician-assisted death would only drive the practice further underground and create even more concern about abandonment among the terminally ill.

Most recently, in 1996, two other Federal appeals courts have held that assisted suicide is a constitutionally protected act in 12 states, including New York and California. The Ninth Circuit modeled its analysis on Roe versus Wade, the landmark United States Supreme Court decision that legalized abortion as an expression of the constitutional right to privacy. The Ninth Circuit assumed in its decision that, because physicians "have a strong bias in favor of preserving life," they will function as "impartial and professional" third parties in making a decision to end someone's life.

The Parliament of the Northern Territory of Australia passed the Northern

Territory Rights of the Terminally Ill Act on May 25, 1995, legalizing voluntary euthanasia26. The act permits physicians to prescribe and administer lethal substances to terminally ill patients who formally request assistance in ending their lives. The Northern Territory occupies 1.35 million square kilometers and has a population of 170,000 residents, 46 percent of whom live in Darwin, the capital. In the 1991 census, 22.7 percent of the residents identified themselves as either Aborigines or Torres Strait Islanders. Like all other Australians, residents of the Northern Territory have universal health insurance that is funded by the government.

The Rights of the Terminally Ill Act specifies that the patient must be at least 18 years old, of sound mind, suffering from a terminal illness, and "experiencing pain, suffering and/or "distress" that is severe and "unacceptable to the patient." A terminal illness is defined as "an injury or degeneration of mental or physical faculties [that] in reasonable medical judgment will, in the normal course, without the application of extraordinary measures or of treatment unacceptable to the patient, result in the death of the patient." The physician must be satisfied that "any medical treatment reasonably available to the patient is confined to the relief of pain, suffering and/or distress with the object of allowing the patient to die a comfortable death."

The patient must thus be fully informed about the illness, its prognosis, and all available treatment options, including the availability of palliative care by a specialist in that field. The physician is specifically prohibited from assisting in the patient's death if he or she believes "there are palliative care options reasonably available to the patient to alleviate the patient's pain and suffering to levels acceptable to the patient.

The act is viewed by its supporters as placing a strong emphasis on palliative care, since assistance with death is determined to be warranted only when the best palliative care has not succeeded in relieving the pain, suffering, or distress of a terminally ill patient. The language of the act, however, requires that the patient be informed of the available palliative care services, but not that the patient be given the best palliative care before becoming eligible for euthanasia.

This emphasis on informing patients of the available palliative care services is cited as evidence that the act addresses the concern that euthanasia might become an alternative to palliative care. The fact is, however, that, in the Northern Territory, palliative care services are almost nonexistent: there is only one part-time physician trained in palliative care, and there is no hospice. Of interest, the passage of the act has served to call attention to the inadequacies of palliative care in the Northern Territory, and has elicited a commitment to improve these services. The effective date of the act was delayed to July 1, l996 to allow time for the upgrading of palliative care services.

A waiting period of nine days is mandated in the Northern Territory Act from the time the patient first requests euthanasia to when the physician actually terminates the patient's life. Revisions to the act in February 1996 include the addition of a third physician to confirm the diagnosis and prognosis and the restriction of the psychiatrist's role to a determination of the presence or absence of clinical depression. The latter provision reflects the fact that, without psychiatric training, physicians may not recognize the presence of psychiatric disorders such as depression and cannot always rule out the possibility that the desire for euthanasia reflects an underlying and possibly treatable psychiatric disorder.

The assistance provided by the physician in ending the patient's life can include, according to the Australian statute, prescribing or preparing a lethal substance, providing such a substance for self- administration, and administering the substance directly to the patient. While physicians are not obligated to assist patients in dying, once they decide to participate, they are required to provide the assistance personally or remain present while the assistance is given by someone else and until the patient dies. The act thus permits the physician to administer the lethal substance and not just prescribe it, as with the Oregon legislation.

Proponents of the Northern Territory Act point out that legalizing voluntary euthanasia means lethal substances may be given intravenously with improvement in absorption, rapidity of death, and the ability to titrate dose to effect. The prohibition of voluntary euthanasia would make physician-assisted death unavailable to patients who are competent to request assistance but physically unable to administer the necessary substances themselves. The act thus identifies the crux of the distinction between physician-assisted suicide and voluntary euthanasia and comes down on the side of voluntary euthanasia.

The prospect of the availability of euthanasia raises numerous concerns. Will euthanasia and physician-assisted suicide prevent us from developing and advancing alternative methods of end-of-life care? Will euthanasia and physician-assisted suicide become the tools of economic efficiency in an era of increasing health-care cost containment Hospice care is less expensive than treatment in the intensive care unit), but the obviation of the need for any care by euthanasia is even less expensive than that. And, will euthanasia and physician-assisted suicide promote death as the solution to health- and societal-problems other than terminal illness?

Because of the current emphasis on health care reform and cost control, the role of the physician as patient advocate and counselor must be strengthened and not compromised in any way in the public mind. Not only must there be no conflict of interest, perceived or otherwise, but the physician must endeavor to offer comfort where cure is beyond the power of medicine. The American Medical Association has thus gone on record to reject euthanasia and physician-assisted suicide as being incompatible with the nature and purpose of the healing arts. As the oath of Hippocrates from the fifth century B.C.E. states:

> *I will give no deadly medicine to anyone, even if asked.*

The American Medical Association recommends preparing patients to use the mechanisms of medical decision making that support the patients' exercise of control over end-of-life decisions

1. *Living wills*
2. *Durable powers of attorney*
3. *Advance directives*

These methods for the clarification of people's concluding wishes do require a thorough explanation of the options to ensure that the effort is not wasted. The mere completion of advance directives by the elderly does not guarantee that the surrogate decisionmakers will be aware of the patients' wishes or that the surrogates will act in accordance with them. Indeed, a study by social workers indicated that the surrogates' predictions of the patients' wishes were accurate in only 28 to 75 percent of cases. It is therefore essential to educate the elderly about their rights and to facilitate communication between patients and their surrogate decision makers to ensure that what patients would like to have happen on their behalf actually does happen.

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Source: The Institute for Jewish Medical Ethics.