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# Assisted Suicide

## *Should doctors be allowed to help terminally ill patients die?*

Decisions about sustaining life, allowing it to end or even hastening death are among the most difficult choices terminally ill patients and their families can face. Such decisions also are at the heart of a debate about what is commonly called "physician-assisted suicide" — or "aid-in-dying" by supporters. Oregon and Washington — and now likely Vermont — allow physicians to write a prescription for lethal drugs if requested by someone who is terminally ill and mentally competent. A Montana court also has allowed the procedure. Supporters of assisted suicide say it allows the terminally ill to avoid unnecessary suffering and meet death on their own terms, and they say safeguards in the laws prevent abuse of the procedure. But opponents say assisted suicide devalues life, opens patients to exploitation by relatives or others and could lead to widespread euthanasia of the sick and vulnerable.

*Vermont nurse Lynne Caulfield, whose husband Jack (pictured) died of cancer, opposes physician-assisted suicide. "It is a sad day when our lawyers are asking health care professionals to help [people] die rather than extending compassionate care to ease pain and suffering," she told state lawmakers, who approved the procedure on May 13.*

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# ASSISTED SUICIDE

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# Assisted Suicide

**BY REED KARAIM**

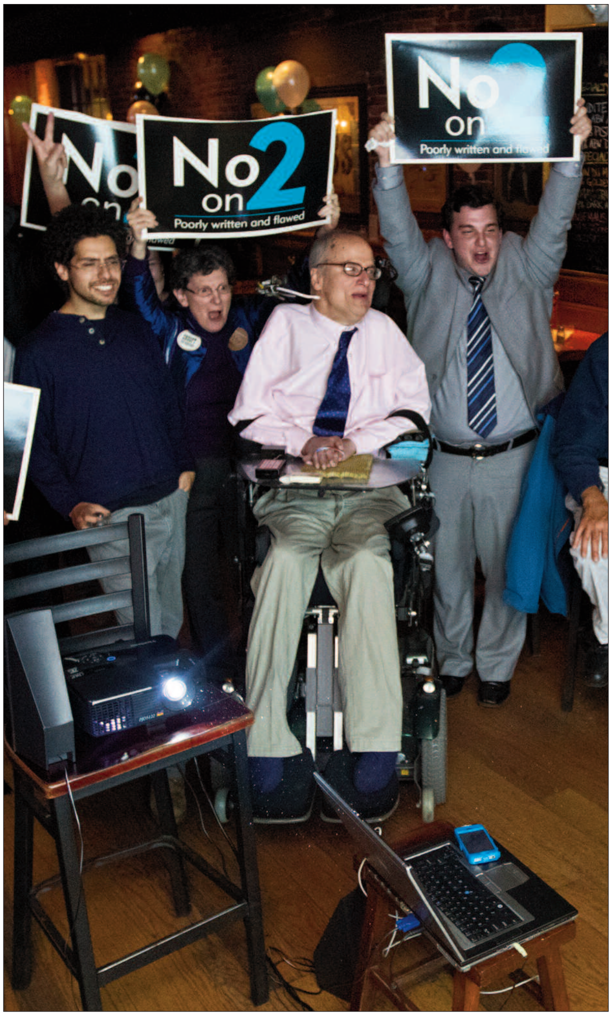
## THE ISSUES

Lee Johnson, a retired federal worker in Portland, Ore., had started a second career as a furniture maker. When he developed terminal brain cancer, he opted for radiation treatments and chemotherapy to extend his life, even though the disease "was undeniably going to kill him," says his daughter, Heather Clish.

But as his condition deteriorated and he became bedridden, with blurred vision, sores and pain, Johnson didn't want to go on, she says. In March 2011, Johnson took advantage of Oregon's Death with Dignity Act and swallowed a lethal dose of pills prescribed by a doctor.* He was 66.

Before he ended his life, Clish says, Johnson and his family talked a lot about his values. "The essence of his being was that he was a deeply independent person who really came to believe in living by choice," she says. "What he ended up doing was very consciously going about dying with dignity and grace. If this was what he needed to have as an option to be the person he is, we understood. That was okay."

Clish felt so strongly about her father's decision that when Massachusetts, where she lives, voted on an assisted-suicide** law modeled on Oregon's in a ballot initiative last November, she volunteered her family's story in support.



Getty Images/*The Boston Globe*/Matthew J. Lee

*Opponents of a measure that would have legalized physician-assisted suicide for the terminally ill in Massachusetts celebrate the measure's narrow defeat on Nov. 6, 2012. Religious, medical and disability groups said the measure was open to manipulation and relied on diagnoses that could be wrong.*

But Clish was not the only person who felt strongly about the issue. In a written statement, John Norton, a retired bus driver from Florence, Mass., offered his own life as evidence — in opposition to the measure.

When he was 18, Norton said, he noticed a twitching in his right hand. Doctors at the University of Iowa Medical School diagnosed Norton with the usually fatal amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease. "I was told I would get progressively worse, be paralyzed and die in three to five years," he wrote.

The Mayo Clinic in Rochester, Minn., confirmed Norton's diagnosis, and for awhile his condition worsened. Twitching began in his right hand and both got weaker. Then the disease's progression stopped. That was in 1960. Today Norton is 75 with a wife and family. He enjoys singing in an amateur choir and still volunteers occasionally as a bus driver.

None of that would have happened, he wrote, if assisted suicide had been available when he was initially told he had the disease. "If, when I was diagnosed with ALS, I had been given an easy way out with a doctor's prescription and support, I would have taken that opportunity," he said. "I would have missed the bulk of my life."

Johnson's and Norton's cases are not identical. Johnson was almost certainly in the final days of his life, whereas Norton's ALS stopped progressing before he reached that stage. But their stories testify to the deeply personal nature of the public debate surrounding physician-assisted suicide, currently

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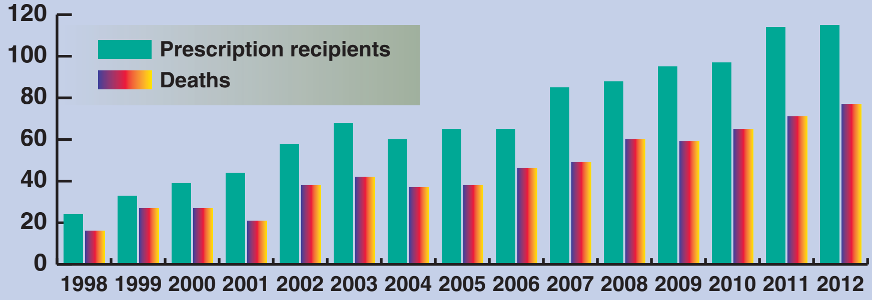
* The fatal prescription is most often a lethal dose of barbiturates, usually Seconal or Pentobarbital.

** Supporters prefer the term "death with dignity" or "aid in dying," arguing that because the terminally ill already are dying, "assisted suicide" mischaracterizes their choice. Opponents, who view the procedure as suicide, note that the Oregon, Washington and likely to be enacted Vermont laws require only a physician's diagnosis that a patient is going to die within six months. That is too far out to know when the end will occur, and thus those who take lethal doses of medicine are choosing to end their lives prematurely, the opponents contend. Physician-assisted suicide is the term most used by the media.

## Physician-Assisted Suicides Rise in Oregon Law

*Oregon enacted the Death With Dignity Act in 1994, allowing terminally ill adults to self-administer lethal doses of medication prescribed by physicians. Last year 115 people received prescriptions, compared to 24 in 1998. The number of deaths involving use of the prescriptions has risen steadily since the law took effect in 1998, to 77 last year.*

### Prescription Recipients and Deaths Under Oregon Death With Dignity Act, 1998-2012



*Source: "Oregon's Death With Dignity Act — 2012," Public Health Division, State of Oregon, January 2013, p. 1, public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf*

legal in just three states: Oregon, Washington, Montana and soon likely in Vermont, when Gov. Peter Shumlin signs a bill enacted on May 13.

In 1997 the U.S. Supreme Court declined to recognize the right to assisted suicide but invited the states to address the issue. In his majority opinion, the late Chief Justice William Rehnquist concluded, "Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society." [1]

The debate is still going strong. Supporters cast the issue as one of individual choice, believing the terminally ill have a right to decide whether to obtain prescriptions that allow them to avoid final days stricken with pain or other debilitating conditions and choose the manner in which they meet an inevitable death. Opponents see the practice as a threat to some of the most vulnerable Americans, including the elderly and disabled, fearing some could be coerced or manipulated into making the decision to end their lives. They believe physician-assisted suicide devalues life, encourages a premature halt to medical treatment and could open the door to cutting off medical care for other patients who aren't terminally ill but may be severely disabled or incapacitated.

The Roman Catholic Church has been a leading, politically active opponent of assisted suicide. But several disability-rights groups also actively oppose it. The American Medical Association has adopted a position against the practice but does not actively lobby against it. Two public-interest groups are the leading voices supporting legalization: the Denver-based Compassion & Choices, and the Portland-based Death with Dignity National Center, which originally organized to work for the Oregon law. Some smaller religious denominations such as Unitarian Universalism also support the right of terminally ill individuals to choose assisted suicide.

Despite the passion surrounding the issue, physician-assisted suicide remains rare, even in the states where it is legal. Oregon, which passed its Death with Dignity Act through a voter referendum in 1994 and began allowing the practice in 1998, has the longest track record. The number of Oregonians who choose physician-assisted suicide has been slowly climbing; 673 cases were recorded between 1998 and 2012. In 2012, the 77 cases reported to the Public Health Division amounted to about 0.2 percent of the total deaths recorded in the state. [2] (*See graphic, at left.*) In Washington, where the law — also passed by referendum — has been in effect only since 2009, 70 people took lethal doses of prescription medicine in 2011. [3]

The number of individuals requesting the prescriptions is higher in both states, but in Oregon a little more than a third haven't used the drugs after obtaining them. "I think it's a peace-of-mind thing," says Peg Sandeen, executive director of the Death with Dignity National Center. "You're terminally ill and you're facing the possibility of some pretty tremendous suffering, and just the idea that you have this [prescription] and tomorrow you can take it if it gets really bad provides some comfort."

Montana does not spell out as clearly the requirements for assisted suicide to occur legally. The state's Supreme Court ruled in 2009 that a physician helping a terminally ill patient die was protected by existing state law. [4] But the state has not passed a specific law regulating the practice, and it is unknown how many people have died with the assistance of their doctor. [5]

Supporters of assisted suicide point to national opinion polls and the fact that Oregon's and Washington's laws were passed by referendum in arguing that the public backs their cause.[6] “I think it’s fairly clear the public believes this is a right they have,” says Sandeen.

But similar laws have been defeated by referendum or failed to advance through legislatures in roughly half the states, including Massachusetts, where a ballot measure was defeated last November, 51 to 49 percent, despite leading in early polls. “It doesn’t gather a lot of attention, but there’s been a lot of rejection of physician-assisted suicide,” says Marilyn Golden, a policy analyst with the Berkeley, Calif.-based Disability Rights Education and Defense Fund, one of several disability groups opposing assisted suicide. “Once the problems are brought out on legalization, it’s very common for public opinion to shift.”

However, on May 13 the Vermont House gave final approval to a bill that would make Vermont the first state to legalize physician-assisted suicide by legislation. Democratic Gov. Peter Shumlin, a supporter of the measure, is expected to sign it into law.

As advocates, physicians and the general public debate the question of whether assisted suicide should be legal, here are some of the questions they are discussing:

### *Do the terminally ill have a right to choose when to end their lives?*

Supporters of what they call aid in dying align their cause with American values of individual liberty and freedom of choice. Barbara Coombs Lee, Compassion & Choices president, says the organization believes individuals should have options as they near the end of their lives, including expanded hospice and palliative care, which focus on relieving patients’ pain and discomfort.

“We don’t promote just one choice (in end-of-life decisions). We think people deserve an entire spectrum of choices,” says Coombs Lee. “But people who are mentally alert and who are making a rational decision to choose — not life or death, because that decision has already been made — but when and how they will meet death, those people deserve a peaceful and gentle option in the dying process.”

## Americans Slightly Divided on Assisted Suicide

*Slightly more Americans say physician-assisted suicide is morally wrong than acceptable. However, in another poll, when the question about assisted suicide was worded differently — “Do you think people have the right to end their own lives?” — a strong majority approved.*

### Percentage Who Say Assisted Suicide is Morally Acceptable, 2011, by Age, Political Party

| **Overall** | |
|---|---|
| Morally acceptable | 45% |
| Morally wrong | 48% |
| **By Party** | |
| Democrats | 51% |
| Republicans | 32% |
| Independents | 50% |
| **By Age Group** | |
| 18 to 34 | 46% |
| 35 to 54 | 45% |
| 55+ | 43% |

*Source: Lydia Saad, “Doctor-Assisted Suicide Is Moral Issue Dividing Americans Most,” Gallup, May 2011, www.gallup.com/poll/147842/doctor-assisted-suicide-moral-issue-dividing-americans.aspx*

But Golden with the Disability Rights Education and Defense Fund believes considering the issue simply as a matter of individual rights ignores the implications for society as a whole. “Public policy is about weighing benefits and harms,” she says. “Proponents of assisted suicide would want you to believe there [are] only benefits and no harms. . . . But if you look at everything, I think the risk of harms vastly overwhelm the benefits.”

By supporting the idea that there is a class of people whom doctors can legally help die and by legitimizing one form of suicide, Golden and other opponents say, physician-assisted suicide potentially harms many more people than it helps both because it makes suicide more culturally acceptable and because it involves doctors in the process of ending lives, which ends a prohibition that could eventually make other forms of assisted-death acceptable, such as euthanasia.

Supporters, however, say the relatively small number of people who choose physician-assisted suicide where it is legal shows the procedure does not threaten the larger population. “Modern medicine, palliative care, pain release, hospice care can provide relief for most people,” Sandeen says. “But not all people, and the Death with Dignity Act can provide relief for them.”

Sandeen, who was a social worker before joining Death with Dignity, says her experience was that too many “people die badly in this country. The way modern medicine works is that they can keep people alive for a very long time past what any natural death would be, and people die badly.” Individuals should have a right to escape a bad — in other words painful or lingering, debilitating — death, she says.

But opponents believe advances in palliative care including at the end of life, means a “bad death” need no longer be the case. “It is a national and international scandal that so many people do not get adequate pain control,” writes Rita Marker, the founder of the Patients Rights Council, a nonprofit group in Steubenville, Ohio, that opposes assisted suicide. "But killing is not the answer to that scandal. The solution is to mandate better education of health care professionals." [7]

Some opponents say that in the most extreme cases, palliative sedation, in which a patient is drugged into unconsciousness to escape pain until he dies, provides a legal alternative. But David Mayo, a bioethicist and professor of philosophy emeritus at the University of Minnesota, Duluth, who is on the Death with Dignity board, believes such an intervention amounts to assisted dying. (*See "At Issue," p. 465.*) "The practice of terminal [palliative] sedation — which is, 'now I can't give you the drugs to kill yourself, but we can put you in a coma while you starve to death' — the idea that's somehow better is just crazy," Mayo says.

In their statement on the issue, the United States Conference of Catholic Bishops rejects the idea that assisted suicide represents an expression of freedom. "The assisted-suicide agenda promotes a narrow and distorted notion of freedom, by creating an expectation that certain people, unlike others, will be served by being helped to choose death," the statement declares. "One cannot uphold human freedom and dignity by devaluing human life. A choice to take one's life is a supreme contradiction of freedom, a choice to eliminate all choices." [8]

Orthodox Judaism, Islam and most major Protestant denominations also oppose physician-assisted suicide, although they generally have not been as active politically as the Catholic Church on the issue. Some Christian denominations, however, have not taken a position, or they support the practice as one end-of-life option.

The United Church of Christ, for instance, considers the right to choose aid in dying a legitimate decision under certain circumstances. The Unitarian Universalist Association adopted a resolution in 1988 stating, "Unitarian Universalists advocate the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths." [9]

The Oregon and Washington laws do not require the participation of a doctor or pharmacist who, for religious or any other reason, objects to physician-assisted suicide. "The underpinning of this law is the concept of self-determination," says Sandeen. "There is no way we would want someone who believes this is wrong to have to participate. My struggle with the religious-based opposition is that they want everybody else not to be able to participate because of their [own religious] beliefs."

### *Does permitting assisted suicide lead to abuse?*

Oregon's Death with Dignity Act and the Washington law that followed have safeguards that supporters believe clearly prevent abuses of the process. (Vermont's pending law has similar provisions.)

The laws require that a physician diagnose a terminally ill patient as having a life expectancy of six months or less. A second doctor must concur with the diagnosis. Patients must request the lethal prescription twice verbally and once in written form with a waiting period of at least two weeks between the first and last request, and the doctor who writes the prescription must believe the patient is mentally competent to make the decision. The law also requires that patients be able to take the pills on their own.

State health agencies are required to provide annual reports on how often physician-assisted suicide is used, and by whom. Outside researchers also have conducted several studies on the laws' impact. "There has never been a medical treatment that has been so closely, comprehensively and continually studied as this one," says Coombs Lee of Compassion & Choices. In all that examination, she says, there have been no substantiated cases of abuse.

But opponents question the safeguards in the laws, saying compliance is self-reported, so there is no way to be sure what's really happening. "Do we have any evidence of abuse? No, but we have a lot of circumstances that show that abuse is very possible," says Golden of the Disability Rights Education and Defense Fund.

Opponents note the laws don't require an independent witness present when a person is taking the prescription, so there is no way to be sure every dose is self-administered or taken by free will. Opponents also point out that the law does not require an outside psychological evaluation of patients who request the drugs.

"It's bad psychiatry and bad medicine," says Dr. Herbert Hendin, a professor of psychiatry at New York Medical College and executive officer of Suicide Prevention Initiatives, a nonprofit group. "The weakness of the laws is that they don't enforce the practice of ordinary medical standards. They could insist on a palliative care [discussion with the patient as an alternative to assisted suicide]. They could insist on a psychiatric consult."

The idea that hundreds of people have received aid in dying without formal psychiatric evaluation or counseling undercuts the claim the law is being used solely by people making competent choices, Hendin says. "An awful lot of people who are physically ill are also depressed, and if you relieve their depression, they're no longer interested in ending their life early," he says.

But Dr. Marcia Angell, a senior lecturer in social medicine at Harvard Medical School, says the terminally ill are in a different situation from other seriously ill patients. "This is not a question of life versus death," she says. "It's often misconstrued that way. These people are going to die. Who are we to tell them they must soldier on?"

Critics, however, believe the laws' lax definition of terminally ill invites abuse of the intent to limit assistance to those in their last weeks of their lives. "Terminal illness is a meaningless term," says Dr. Rex Greene, a longtime oncologist now semi-retired in Elida, Ohio. "The law in Oregon says a six-month prognosis. There's no physician on Earth [who] can make a six-month prognosis. The best we can do is in the last weeks of life we can be pretty close."

The issue strikes a nerve with disability groups. "Anytime I'm doing training on this issue within the disability community, I ask, 'Who of you here were first diagnosed as terminally ill and are still going strong?' " says Golden, "and every time, hands go up."

Advocates for the disabled are among the most vocal in arguing that the laws could encourage some people to end their lives to save loved ones trouble. Ben Matlin, an author born with a neuromuscular condition so debilitating that he has never been able to stand and now is unable to hold a pencil, explained his opposition to the laws. "I've lived so close to death for so long that I know how thin and porous the border between coercion and free choice is, how easy it is for someone to inadvertently influence you to feel devalued and hopeless — to pressure you ever so slightly but decidedly into being 'reasonable,' to unburdening others, to 'letting go,' " he wrote. [10]

Getty Images/Matt Cardy

*Australian physician Philip Nitschke, a supporter of voluntary euthanasia, displays a drug kit used in assisted suicides following a workshop he gave on May 5, 2009, in Bournemouth, England.*

Opponents also raise the possibility that the nature of the health care system could lead to abuse. "The frightening potential for profit-driven health care organizations to drive people toward assisted suicide for cost control is something we can't ignore," says Golden.

But supporters respond that all these concerns have proved unfounded through years of experience with the Oregon law. "When we talk about aid in dying, a tactic of those who oppose end-of-life choice is to raise unreasonable doubt, to cast aspersions on the situation in Oregon," says Coombs Lee of Compassion & Choices.

Supporters point to a study of cases published in the *Journal of Clinical Ethics* that found no unreported cases of physician-assisted suicide in Oregon. In addition, the researchers found that terminally ill people in Oregon were no more likely to consider assisted suicide than people in states where the procedure was illegal. [11]

Supporters also cite a study led by Margaret Battin, a distinguished professor of philosophy and an adjunct professor of internal medicine in the Division of Medical Ethics, at the University of Utah in Provo. The study found no evidence that physician-assisted suicide has had a disproportionate impact on patients in vulnerable groups, including the physically disabled, the poor, individuals with low educational status or racial minorities. "Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges," Battin and her team concluded. [12]

### *Does the Hippocratic Oath ethics code prevent doctors from helping patients die?*

Physicians have been pledging themselves to the principles of the Hippocratic Oath, named after an ancient Greek physician, since the 4th century BC. The classical version of the oath includes this prohibition, "I will never give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect." [13]

## Cancer Most Prevalent Malady in Oregon Cases

*Of the 77 people who died last year under Oregon's Death With Dignity Act, 75 percent suffered from cancer. The median age for all deaths under the law was 69. More than 90 percent said they were concerned about losing autonomy and finding life's activities no longer enjoyable.*

### Characteristics of Deaths Under Oregon's Death With Dignity Act, 2012

| | | |
|---|---|---|
| Sex | Male | 50.6% |
| | Female | 49.4% |
| Age | 18-34 | 0% |
| | 35-44 | 1.3% |
| | 45-54 | 10.4% |
| | 55-64 | 20.8% |
| | 65-74 | 29.9% |
| | 75-84 | 23.4% |
| | 85+ | 14.3% |
| Marital status | Married | 42.9% |
| | Widowed | 29.9% |
| | Never married | 7.8% |
| | Divorced | 19.5% |
| Underlying illness | Cancer | 75.3% |
| | Amyotrophic lateral sclerosis | 6.5% |
| | Chronic lower respiratory disease | 2.6% |
| | Heart disease | 2.6% |
| | HIV/AIDS | 1.3% |
| | Other | 11.7% |
| End-of-life concerns | Losing autonomy | 93.5% |
| | Activities no longer enjoyable | 92.2% |
| | Loss of dignity | 77.9% |
| | Losing control of bodily functions | 35.1% |
| | Burden on loved ones and caregivers | 57.1% |
| | Inadequate pain control | 29.9% |
| | Financial implications of treatment | 3.9% |

*Source: "Oregon's Death With Dignity Act — 2012," Public Health Division, State of Oregon, January 2013, pp. 4-5, public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf*

Most graduating U.S. medical students still swear to some form of the oath, although the modern version used by most medical schools does not include that prohibition.[14]

The American Medical Association (AMA) code of ethics, however, rejects the idea of doctors providing deadly prescriptions. "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks," the code states.[15]

Some bioethicists, however, believe medical care must include recognizing when death is inevitable and respecting a patient's wishes at that time. "While doctors in general want and should work to extend life, suppose that's no longer possible?" says Angell of Harvard's medical school. "That's the case here, and if that's the case, then they must shift their objective to relieving suffering in accordance with the patients' wishes."

But many physicians believe assisting in death, even of a terminally ill patient, undermines their essential covenant with the public. "It's in the seminal code of medicine, that physicians are not to do anything to take the patient's life," says Greene, the retired oncologist, referring to the Hippocratic Oath. "One of the reasons medicine has endured all these centuries is that we have remained trustworthy in that regard. I personally don't see any way physicians can maintain that trust if they're involved [in] ending people's lives."

Greene is the current chairman of the AMA Council on Ethical and Judicial Affairs but emphasizes that he is expressing his personal opinion. He spent more than 30 years as an oncologist and now consults on palliative care.

The AMA, along with most opponents of assisted suicide, supports the removal of life-sustaining devices in the last stages of life, if patients have indicated such a preference. But Greene sees a crucial distinction between removing life-sustaining medical equipment and actively assisting patients in killing themselves.

By removing devices such as ventilators or respirators, in accordance with their wishes, a physician is allowing the patient to assume the natural risk of dying that is part of their condition, he says. The physician is not taking action that has the specific intent of killing the patient, he says. "That's not the intent," Greene says. "If we take on the responsibility of deciding who lives and who dies, we have so overstepped the bounds of human experience."

Other physicians, however, believe fulfilling a patient's wish to end his or her suffering at the end of life is part of the responsibility a doctor assumes when caring for the person. Dr. Eric Kress, who practices family medicine and hospice care in Missoula, Mont., says an experience with one particular patient persuaded him of that.

The patient was terminally ill with ALS; he had lost 100 pounds, couldn't walk and was being fed through a tube. "He used to be a vigorous guy, but now he was wasting away, and there was no question where he was headed," Kress recalls. His patient, whom Kress considered of sound mind, felt very strongly that he did not want to wait a few more weeks for the disease to end his life. He requested lethal medication.

Kress told him he couldn't provide it. A few weeks later the patient had stockpiled enough pain medication to kill himself anyway. But before he died, Kress says, "He called me a coward and said, 'Who are you treating here? Are you treating yourself or are you treating me?' And he got me thinking, what kind of doctor am I? Am I going to do what I want or what my patients needs?"

Kress became one of the few doctors to speak openly about providing lethal prescriptions when testifying before the Montana state legislature. He says several patients have raised the possibility of assisted suicide with him, but he has ended up providing medication to only three patients. In each case, Kress says, he obtained a written second opinion from another doctor that the patient's condition was

AP Photo/Jessica Hill

AP Photo/Charles Dharapak

**To Assist or Not to Assist**

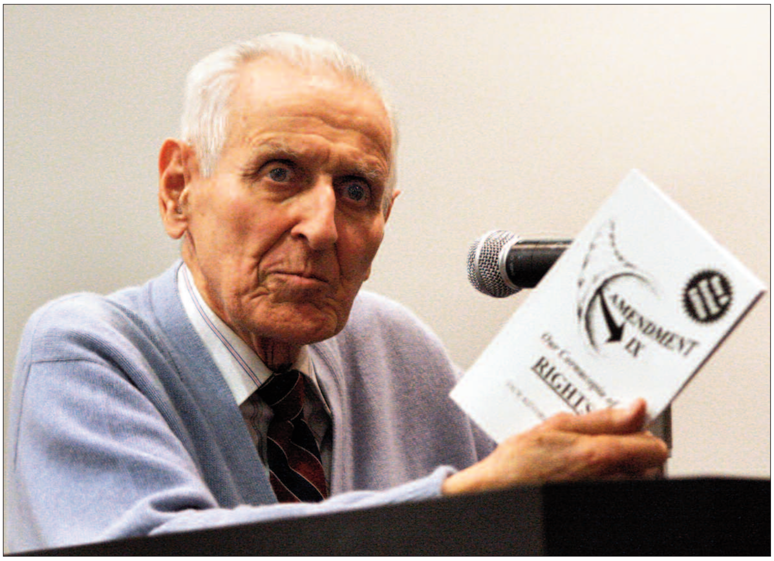
*Cathy Ludlum, a disabled-rights activist in Manchester, Conn., is concerned that physician-assisted suicide is being considered by her state's legislature. Lawmakers should focus more on "giving people a good life than giving people a good death," says Ludlum, who has spinal muscular atrophy (top). Opponents of the measure to permit assisted suicide in Connecticut succeeded in April in derailing the proposal. Supporters of Oregon's physician-assisted suicide law demonstrate in front of the U.S. Supreme Court (bottom) on Oct. 5, 2005, as the court heard Bush administration attorneys argue that the law violated the Controlled Substances Act. The court later ruled against the administration, allowing the law to stand.*

terminal and would result in death “in a few months or less.” He also says he met with the patients several times over extended periods to make sure they understood what they were doing. Moreover, he says, he sought to make sure they could self-administer the drugs.

Kress says he checked with attorneys to make sure he was in accordance with Montana law, but he says his primary concern was fulfilling his obligation to care for his patients. “This is really an issue about aiding people in the dying process. It’s not about letting people commit suicide,” Kress says. “One of the questions I asked everyone was, ‘If you didn’t have this [terminal] disease, would you want to die, and they all universally said no.”

Even with all such steps, some bioethicists believe legalizing physician-assisted suicide places too much power in the hands of doctors. Daniel Callahan, president emeritus of the Hastings Center, a leading bioethics research institution in Garrison, N.Y., says he become opposed to physician-assisted suicide after studying the situation in the Netherlands, where it is legal.

An anonymous survey of doctors there revealed abuses, he says, including the euthanasia of patients without their permission. “I don’t like the idea of empowering physicians to do this sort of thing,” Callahan says. “They’re too good at it.” ■



*Physician-assisted suicide supporter Jack Kevorkian talks to college students about prison reform at Detroit’s Wayne State University on Nov. 29, 2007, not long after his release from prison. Nicknamed Dr. Death, the controversial pathologist spent eight years in prison following his conviction in 1999 for second-degree murder for helping in an assisted suicide. He died in 2011, at age 83, of natural causes.*

Getty Images/Bill Pugliano

# BACKGROUND

## ‘Robes of the Executioner’

Assisted suicide has been part of human culture since antiquity, and so have prohibitions against it, as Hippocrates’ oath shows. A forerunner of Compassion & Choices was the Hemlock Society, named after the poison the ancient Greek philosopher Socrates drank to fulfill his death sentence.

In 1870, schoolteacher Samuel D. Williams was one of the first U.S. proponents of using an overdose of morphine, then a new pain-relieving drug, to assist death “in all cases of hopeless and painful illness.” [16] Williams’s euthanasia proposal was reprinted in newspapers and magazines over the years, creating enough of a stir that in 1885 the *Journal of the American Medical Association* attacked the idea, saying it made “the physician don the robes of the executioner.”

The contemporary movement in support of assisted suicide can be traced to Derek Humphry, a British journalist, who in 1978 wrote the best-selling memoir, *Jean’s Way*, about assisting the suicide of his cancer-stricken wife. In 1991, Humphry published *Final Exit*, a how-to guide on assisted suicide that became a bestseller and has been translated into 12 languages.

Humphry, now 83, remains controversial. Critics charged that *Final Exit* could be used by anyone to commit suicide, not just the terminally ill. Humphry responded that many commonly known means of suicide existed and there was no evidence that the book had raised the suicide rate. The suicide of Humphry’s second wife, Ann, after a bitter divorce in which she denounced him and the assisted-suicide movement she had previously supported, led to further controversy. [17]

Humphry believes assisted suicide should be available to more than just those with advanced terminal illnesses, but also for those with what he terms “hopeless illness,” meaning debilitating and without cure, but not necessarily terminal. He acknowledges his position puts him on “the radical left” of the movement. [18] Many of the leading organizations, now focused on physician-assisted suicide for the terminally ill, have distanced themselves from his views.

Still, Humphry, who co-founded the Hemlock Society and is a past president of the World Federation of Right to Die Societies, continues to promote assisted suicide publicly and through

*Continued on p. 460*

# Chronology

## 1960s *As medicine advances, the question of how long and under what circumstances life should be sustained by medical means gains new urgency.*

**1967**
After watching a friend die a slow, painful death, human-rights attorney Luis Kutner writes the first "living will," specifying under what conditions a patient should be taken off life-sustaining devices. . . . A right-to-die bill fails in Florida.

**1969**
The Hastings Center is founded in New York to study ethical problems in biology and medicine, including end-of-life decisions.

* * *

## 1970s *The idea that patients have a right to refuse treatment gains acceptance. In England, a best-selling memoir starts a debate about assisted suicide.*

**1973**
American Hospital Association recognizes the right of patients to refuse treatment.

**1976**
California Gov. Jerry Brown signs nation's first law giving terminally ill people the right to authorize withdrawal of life-sustaining medical treatment when death is imminent. Eight other states pass similar laws within a year.

**1978**
British journalist Derek Humphry writes a best-seller, *Jean's Way*, a memoir about helping his terminally ill wife commit suicide, kicking off international debate.

## 1980s *Right-to-die movement gains strength; Catholic Church issues objections.*

**1980**
Humphry helps form the Hemlock Society to support assisted suicide. . . . Pope John Paul II opposes "willful suicide," but supports the use of pain-relieving medicines and the right to refuse extraordinary means to sustain life.

**1988**
Unitarian Universalist Association becomes first religious body to support a right to die and call for those who assist in that act to be free from criminal or civil penalties.

* * *

## 1990s *The first state approves physician-assisted suicide; Detroit physician Jack Kevorkian further spurs debate over the procedure.*

**1990**
Kevorkian helps Alzheimer's patient Janet Adkins commit suicide, he will help more than 130 others die before being convicted of murder in 1999.

**1991**
Washington state voters reject physician-assisted suicide.

**1992**
California voters defeat a similar measure.

**1994**
American Medical Association opposes physician-assisted suicide. . . . Oregon voters approve nation's first law permitting terminally ill patients to obtain a prescription to end their life; challenged in court, the law doesn't go into effect for four years.

**1997**
U.S. Supreme Court rules there is no constitutional right to die, but invites states to continue debating the issue.

* * *

## 2000-Present
*Three more states join Oregon in allowing physician-assisted suicide, but opponents win in Massachusetts.*

**2005**
Terri Schiavo, a Florida woman who doctors say is in a persistent vegetative state, dies after her feeding tube is removed, ending a controversial seven-year battle between her husband and parents that generates international debate on end-of-life decisions.

**2008**
Washington voters make the state the second to allow physician-assisted suicide.

**2009**
Montana Supreme Court effectively allows physicians to provide lethal prescriptions to terminally ill patients who request it.

**2012**
Massachusetts voters reject physician-assisted suicide.

**2013**
Vermont House and Senate pass differing version of a physician-assisted suicide measure (April); governor indicates willingness to sign a final bill modeled on Oregon's law. . . . Vermont House approves bill legalizing physician-assisted suicide (May 13). Democratic Gov. Peter Shumlin is expected to sign the measure into law.

## Researchers Seek Advances in Pain Management

*"Death isn't a medical condition."*

Medicine is making advances in pain management and end-of-life care that some say may eliminate one of the reasons patients may choose assisted suicide.

Advances in the relatively new discipline of pain management known as palliative care can go a long way toward relieving unbearable pain and making people more comfortable in their last days, according to researchers.

"When we talk about palliative care, we're talking about relief of suffering," says Nancy Berlinger, who teaches ethics at the Yale School of Nursing and is co-author of *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life*. "The field of palliative care and hospice care has greatly taken off in the last 20 years. There are now specialized palliative care units in children's hospitals and adults' hospitals. It's still a work in progress, but it's growing."

The Center to Advance Palliative Care, based in New York City, reports that more than 1,500 hospitals now have palliative care teams — twice as many as six years ago. [1] A palliative care team includes doctors, nurses and other specialists who provide relief from the symptoms, pain and stress of serious illness.

A 2010 *New England Journal of Medicine* study found palliative care can make a significant difference in the life of patients. The study found that patients receiving early palliative care experienced less depression and survived an average of 2.7 months longer than those who did not receive the same kind of care. [2] Medical researchers also have been exploring new approaches to pain management that go beyond the typically prescribed drugs such as Oxycontin, Vicodin or morphine. Researchers at the University of Colorado in Boulder are studying the glial cells, which wrap around the neurons that transmit pain sensations and are thought to amplify chronic pain. Scientists are working on drugs that could block that effect. [3]

At Stanford University and other institutions, researchers are exploring the use of magnetic fields to cause electrical changes in the brain. The process, called "transcranial magnetic stimulation," involves putting an eight-inch electrical coil around the head. Originally developed to treat severe depression, the procedure can also reduce pain, most probably by disrupting the pain signals traveling along the neurons in the brain, early results indicate. [4]

Less intrusive pain management techniques being studied focus on mental activity and biofeedback. A project at Stanford allows patients to see on a screen when the part of the brain that handles pain is activated. "They then use this information to learn to control their brain activation in a specific region associated with the processing and perception of pain," according to an article on a Stanford website. [5]

*Continued from p. 458*

the Final Exit Network, which provides counseling and support to individuals considering assisted suicide. [19]

If Humphry was the movement's inspiration, Dr. Jack Kevorkian was its first American celebrity. Kevorkian, a pathologist dubbed "Dr. Death," attracted national attention in the 1990s when he built devices that allowed the patient to self-administer lethal injections. At least 130 people used the devices, which allowed people to kill themselves by pulling a trigger that sent either a lethal dose of drugs or carbon monoxide into their blood. Early on, Kevorkian tried to advertise in Detroit newspapers for volunteers. Janet Adkins, who had been a college instructor, was the first. Adkins decided to kill herself on the day she was diagnosed with Alzheimer's disease and later did so in Dr. Kevorkian's van. [20] She was 54.

Kevorkian was brought to trial four times on various cases, but was acquitted three times and the fourth case was declared a mistrial. Eventually, he was found guilty of second-degree murder in a case in which he was shown on CBS' "60 Minutes" administering a lethal injection to a patient himself, after he had lost his license to practice medicine. [21] He served eight years in prison, and the conditions of his parole prevented him from participating in other assisted suicides. Kevorkian died of natural causes in 2011 at age 83. [22]

After-the-fact examinations of Kevorkian's patients found that many did not have terminal diseases, and five did not have any diseases at all. [23] His actions are cited by opponents of physician-assisted suicide as an example of the dangers of allowing the practice to spread. "He was just, in my opinion, a serial killer with an M.D.," says Greene, the retired oncologist, who participated in a review of Kevorkian's cases.

The next highly public battle over the life and death of a critically ill patient did not involve direct physician assistance, but it galvanized Americans about end-of-life decisions. Terri Schiavo, a young woman from St. Petersburg, Fla., originally suffered extensive brain damage in 1990 and doctors had diagnosed her condition as a "persistent vegetative state" by the time her husband sought to have her feeding tube removed in 1998. [24]

Her parents objected, believing her condition was not beyond hope, and went to court to have the feeding tube reinserted. The ensuing legal and political battle lasted seven more years and eventually involved several court rulings, the Florida legislature, the U.S. Congress and President George W. Bush, who flew back to Washington from a vacation to sign a law giving Schiavo's parents one

Dr. Ray Barfield, a pediatric oncologist who directs the Pediatric Quality of Life/Palliative Care Program at Duke University's Medical Center, says many new approaches being studied have great potential, especially those involving techniques to mentally manage one's own pain. "Some of the advances that we're making in hypnosis, biofeedback and medication that some people scoff at are tremendously effective," he says.

A major problem in managing pain, says Barfield, is the reluctance many doctors feel about prescribing pain drugs for fear of potential negative effects or of the patient becoming addicted. And patients often resist taking drugs they feel will dull their senses.

"One of the biggest advances that we need is not coming up with new medicines; we need to get people educated about the stuff we already have," Barfield says. "We have some good pain medicines and good experiences with them, and we still can't get people to use them the right way."

Barfield is a leading advocate for an end-of-life approach that focuses on medical interventions, pain management and careful attention to the physical and mental journey the patient is taking — the questions they need answered and the help they need facing what is happening to them.

Doctors, he believes, can get too focused on treatment as an end in itself and lose track of the larger needs of patients and their families. "Death isn't a medical condition," Barfield says. "Death is experiential. Your last day is still a day meaningful things can happen."

Combining careful attention to a patient and family's larger needs with proper palliative care and pain management, Barfield says, can "go a long way to reducing the need for [physician-assisted suicide] as an option." If palliative medicine continues to advance, he believes, that's where end-of-life care is headed.

***— Reed Karaim***

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[1] "Palliative Care FACTS AND STATS," Center to Advance Palliative Care, www.capc.org/news-and-events/press-kit/.

[2] Jennifer S. Temel, *et al.*, "Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer," *The New England Journal of Medicine*, 2010, www.nejm.org/doi/pdf/10.1056/NEJMoa1000678.

[3] Michelle Andrews, "Advances Against Chronic Pain," *U.S. News & World Report*, Sept. 5, 2012, http://health.usnews.com/health-news/articles/2012/09/05/advances-against-chronic-pain.

[4] *Ibid*.

[5] Sean Mackey, "The Strain in Pain Lies Mainly in the Brain," Stanford Systems Neuroscience and Pain Lab, http://med.stanford.edu/snapl/research/.

last attempt to appeal their case.[25]

Schiavo's feeding tube was removed, then reinserted on a judge's order, removed again on another judge's order, then reinserted once again after the Florida Legislature passed "Terri's Law," which gave Gov. Jeb Bush authority to order the tube reinserted. The tube was removed a final time when the U.S. Supreme Court decided not to hear a final appeal of the case.[26] She died on March 31, 2005, but by then the battle had become a touchstone both for right-to-life and right-to-die advocates around the world.[27]

Coombs Lee of Compassion & Choices believes it also had an impact on the public view of physician-assisted suicide. "We were all privy to the very difficult battle that family was going through and how our politicians reacted, how completely tone-deaf they were to the real views and concerns of the public," she says. "And I think the public learned from that as well that this type of decision shouldn't be political; it's personal."

## Battle in the States

Before the Schiavo case became public, Oregon voters had made their state the nation's first to allow physician-assisted suicide. In 1993, Oregonians organized Oregon Right to Die to lobby for an assisted-suicide law, led by Portland attorney Eli Stutsman, whom Sandeen and others cite as its principal author.

The state's Death with Dignity Act was adopted after voters approved a referendum on the issue by a 51 to 49 percent margin in 1994. Because of legal challenges, however, it did not go into effect until 1998.

In 1997, opponents placed another initiative on the ballot — one that would overturn the measure — but it failed 60 percent to 40 percent. There have been no serious repeal efforts since.

In 2001 U.S. Attorney General John Ashcroft attempted to block the law by declaring that he had the authority to prevent doctors from prescribing lethal drugs through the Controlled Substances Act. But in 2006 the U.S. Supreme Court ruled against Ashcroft's claim, allowing the Oregon law to continue.[28]

Oregon's initiative, however, was not the first attempt by supporters of physician-assisted suicide to get voters to back a law. Similar efforts in Washington and California failed in 1991 and 1992, respectively. The Hemlock Society of Oregon also backed a bill in the state legislature in 1990 that failed to get out of committee. Bills introduced in several other states also failed to gain sufficient support throughout the 1990s.

In Oregon, a key figure in helping to overcome resistance to the referendum was Dr. Peter Goodwin, a physician who spoke up on behalf of the idea at a meeting of the Oregon Medical Association.

Goodwin argued in part that doctors already were taking actions to help terminally ill patients die but were acting "often without the family knowing enough, without the patient knowing enough because it's all illegal," he told ABC News. "I wanted the patient in control, not the doctor." [29]

Goodwin later recalled that after he spoke, the medical association's incoming president met his eyes as he returned to his chair. The president-to-be then took the podium and suggested to the association that they "let the people of Oregon tell us what they want." Goodwin said, "What happened then was that the Oregon Medical Association was neutral throughout the campaign, and I think that had a huge influence on the outcome." [30]

The argument that assisted-suicide laws merely illuminate what has been going on in the shadows all along has continued to be an important one for supporters. But despite their success in Oregon, proponents of similar laws did not win in another state until Washington residents approved a law based on Oregon's in November 2008.

Supporters were optimistic that Massachusetts would provide a similar victory in 2012, and pre-election polls showed majority support for an assisted-suicide measure. After its defeat, supporters blamed heavy outspending by opponents. "I think it was four to one or even six to one," says Steve Crawford, who was a spokesman for the Massachusetts Death with Dignity Coalition during the campaign.

Public campaign-finance records indicate Catholic dioceses and organizations from around the country contributed heavily to opposition efforts, and supporters of the proposed law say they believe Catholic opposition made a crucial difference. "It's a very Catholic state," Crawford says. "I'm Roman Catholic myself, and I knew early on, based on some of the reaction we were getting from the Church, that they saw this as a red line [that could not be crossed] and they were going to put everything they could into defeating this question."

But opponents, especially disability-rights activists, believe Massachusetts voters changed their minds as they came to understand the lack of safeguards in the law. "The ballot question was defeated last year in large part by the antidiscrimination and social justice arguments of progressives in the disability community," says Denise Karuth, a spokesperson for Second Thoughts, a group that opposed the measure. "We described — with examples from our personal experience — how misdiagnosis, inaccurate terminal diagnoses and coercion could cause people to lose years of their lives," says Karuth, a peer counselor for people with disabilities who is, herself, a blind wheelchair user. "We were adamant that no one should ever have to die to have dignity."


Getty Images

*The case of Terri Schiavo, a severely brain damaged young woman in Florida, galvanized Americans about end-of-life decisions. After doctors said she was in a persistent vegetative state, her husband sought to have her feeding tube removed in 1998. Her parents went to court to have the tube reinserted, and during a seven-year court battle Florida's legislature enacted Terri's Law, which gave Florida Gov. Jeb Bush authority to have the tube reinserted. Ultimately, the state Supreme Court ruled the law unconstitutional, and the U.S. Supreme Court declined to hear a final appeal of the case. Schiavo died on March 31, 2005.*

## Global Measures

The Netherlands, Switzerland, Belgium and Luxembourg all allow assisted suicide. In all but Luxembourg, people who are not terminally ill are eligible for an assisted death if doctors agree their suffering is lasting and unbearable.

In Belgium and the Netherlands, euthanasia, in which a doctor puts a patient who requests it to death by directly administering drugs, is legal under certain conditions. [31]

The request must be made voluntarily by a patient once again suffering from a condition considered lasting and unbearable. In the Netherlands, acceptable conditions include an incurable disease or "hopeless psychological problems," according to the Radio Netherlands website. [32] A second doctor must concur in a written opinion that the patient meets the criteria.

The Netherlands law is generally considered the most liberal. U.S. opponents of assisted suicide often cite it as an example of how allowing doctors to assist in suicide can lead to more and more conditions being considered acceptable for requesting death.

The Netherlands has a series of guidelines intended to ensure that euthanasia meets the wishes and is in the best interest of patients. [33] But Callahan, the Hastings Center president emeritus, says a survey that provided doctors anonymity found the rules were widely ignored and that "somewhere near a thousand people had been euthanized without their permission."

Hendin, of Suicide Prevention Initiatives, also spent time in the Netherlands studying its system. "The more I was there, the more I saw that end-of-life care was abysmal . . . there was no interest in end-of-life care," he says. Netherlands doctors, he says, had come to see assisted suicide and euthanasia as "a quick solution" when dealing with the dying.

U.S. supporters of physician-assisted suicide respond that the situations are not comparable. "The Netherlands is a completely different culture," says Sandeen. "The 15 years of stability with Oregon's Death with Dignity Act is what we need to look at. The law has stood the test of time. It works as written."

Political leaders in several other Western nations do not seem to share the same concerns about the record in the Netherlands or other countries where assisted suicide is legal. A recent poll in the United Kingdom found strong support for legalization, and a member of Parliament is expected to introduce such a bill later in the year. [34] Other nations, including New Zealand, along with parts of Australia, are contemplating similar measures. [35]

Cultural and religious prohibitions against assisted suicide remain strong in predominantly Islamic and Catholic countries, however, and physician-assisted suicide or euthanasia remain against the law in most of the world. [36] ■

# CURRENT SITUATION

## Landmark Legislation

Vermont is set to become the first state to approve physician-assisted suicide by legislation, following action by the state House on May 13. Democratic Gov. Peter Shumlin, who supported the measure, has pledged to sign it.

"I am grateful that the legislature had such a thoughtful, respectful debate on this deeply personal issue," Shumlin said. "We will now offer Vermonters who face terminal illness at the end of life a choice to control their destiny and avoid unnecessary suffering. I believe this is the right thing to do." [37]

Several safeguards are built into the measure. Two doctors, the patient's primary physician and a second doctor, must agree the patient has a terminal illness and is able to request death-inducing drugs. The law also requires two requests for the drugs by the patient, with 15 days separating the first and second requests.

The patient must have less than six months to live, and must self-administer the drugs.

Furthermore, drugs would have to be prescribed by doctors in Vermont for state residents only, and the patient's request for drugs would have to be witnessed by two disinterested people who are not relatives or potential heirs, employees of health care facilities where the patient is being treated, nor the patient's doctor.

The Roman Catholic Diocese of Burlington fought the legislation and urged residents to press lawmakers to defeat it. "Physician-assisted suicide will forever transform the role of physician from one who preserves life to one who takes life," the diocese said in a statement earlier this year. [38]

Vermont's action would represent a landmark in the battle over physician-assisted suicide. No such law has made it through any other state legislature since the effort to legalize assisted suicide in the United States began. Vermont, however, is considered one of the nation's most liberal states, and Shumlin pledged to sign the law after it is reviewed.

Bills modeled after Oregon's law also have been introduced this year

**Vermont is set to become the first state to approve physician-assisted suicide by legislation. Bills modeled after Oregon's law also have been introduced this year in Connecticut, Hawaii, Kansas, Montana, Massachussetts and New Jersey.**


Getty Images/*The Boston Globe*/Suzanne Kreiter

*Patrick the hospice dog visits a resident on Sept. 12, 2012, at the Kaplan Family Hospice House, a 20-bed facility run by the Hospice of the North Shore & Greater Boston. The facility provides end-of-life care, along with grief resources, for terminally ill patients and their families.*

in Connecticut, Hawaii, Kansas, Montana, Massachusetts and New Jersey. Similar bills have been introduced many times in other states in the past, however, and prospects differ widely. Massachusetts lawmakers, for example, would be unlikely to pass legislation a year after a similar measure was rejected in a referendum.

After the Vermont House voted on May 13, Coombs Lee of Compassion & Choices said "this historic legislative victory proves that the aid-in-dying issue is no longer the third rail of politics. In fact, it's a winning issue on which Gov. Shumlin campaigned."

## In the Courts

Lawyers for Compassion & Choices served as co-counsel in the case that finally led the Montana Supreme Court to declare physician-assisted suicide legal under certain conditions in the state. The organization is pursuing a case in New Mexico that could similarly result in legalization. "This is a case brought by two physicians and a terminally ill patient that asks the court to clarify that an old criminal statute [applying to suicide] does not have application to the conduct of a physician providing aid in dying," says Kathryn Tucker, Compassion & Choices director of legal affairs. "The argument of the case is that the choice of a dying patient for a peaceful death is no kind of suicide." The New Mexico case is expected to get a hearing in December.

In Hawaii, the state chapter of Compassion & Choices is arguing the state's existing laws on patient rights and advance medical directives, along with the privacy clause in the state constitution, effectively mean that physician-assisted suicide already is legal in the state.[39] "We contend in Hawaii that patients can choose aid in dying there," says Tucker.

In 2011, Hawaii Attorney General David M. Louie issued an opinion to the contrary, saying that physicians who wrote lethal prescriptions with the intention of assisting in death could be charged with manslaughter. In 2012, however, several physicians in the state indicated their willingness to offer assisted suicide to patients to test the ruling.[40]

Compassion & Choices' emphasis on fighting in court to establish the legality of assisted suicide in states where the group believes existing laws make it possible reflects a different strategy than that of the Death with Dignity National Center.

Death with Dignity supports replicating the Oregon law in other states, including provisions that spell out the steps doctors must take before participating in an assisted suicide. Mayo, the Death with Dignity board member, says the organization believes this is the best way to make sure the procedure has adequate safeguards.

But Tucker says, "I don't think the provisions in the Oregon statute are a Holy Grail in any sense." The ruling in Montana established "three bright lines" that must be legally respected, she says. "The patient must be mentally competent and also terminally ill, and physician involvement is limited to providing a prescription."

But within these lines, Compassion & Choices argues that doctors should be able to work out the parameters of physician-assisted suicide within their professional standards, as they would any other procedure.

"Medicine is not typically governed by statute," says Tucker. "I think what is happening in Montana is reflecting the normalization of aid in dying, and that's the direction it's appropriate to go at this point in time. Will Montana doctors incorporate all the procedures there are in Oregon and Washington state? Probably not. There will be some organic evolution."

That evolution is one of the things that most worry opponents, who fear it will become too easy for people to receive medical assistance in killing themselves, even crossing the line to allow non-terminal cases to request and receive such help.

*Continued on p. 466*

# At Issue:

## *Should the terminally ill have the right to assisted suicide?*

**DAVID J. MAYO, PHD.**
***PROFESSOR OF PHILOSOPHY EMERITUS, UNIVERSITY OF MINNESOTA, DULUTH; BOARD MEMBER, DEATH WITH DIGNITY***

**WRITTEN FOR *CQ RESEARCHER*, MAY 2013**

yes

My father, 93 and dying of colon cancer, remarked to the nurse enrolling him in hospice care that "the sooner this is over with, the better." At that point, his final life-projects were closing down. His only remaining fundamental interest and concern were the time and circumstances of his death. In Oregon or Washington state — and probably soon in Vermont — he could have ended his life peacefully, with dignity and on his own terms. As it was, he quit eating. Self-starvation struck him as his least-worst option.

Two arguments for death with dignity leap from this experience. The most intuitive derives from compassion: What possible good is served by denying escape from those final weeks of slow decline and suffering? And what horrible fear haunts many more terminal patients, not brave or determined enough to starve themselves but terrified of how their final days might play out as circumstances strip them of every shred of control? This suggests the second argument: The supreme value we place on self-determination in matters that are both private and also of fundamental concern to the individual.

Critics argue that embracing death with dignity would be a risky departure from the value we in general, and medicine in particular, place on prolonging human life — that allowing death with dignity would invite horrible abuses. But consider:

- Current law and medical practice already recognize the right of competent adults to refuse life-prolonging therapies, however trivial (for example, an antibiotic to end a life-threatening pneumonia), and even feeding tubes and hydration via IV.
- The law also recognizes a terminal patient's right to adequate palliative care, even if this requires doses of powerful analgesics high enough to hasten death by suppressing respiration. The fundamental proviso is that the earlier death must not be intended, but merely foreseen by the physician. In practice this often means the line between "optimal palliative care" and culpable homicide is drawn in terms of the invisible intentions of the physician (on which even he may not be clear). Few patients or family are informed (or ask) whether lethal doses are administered. If ever there was a situation ripe for abuse, surely this is it.
- The question of risk is always an empirical one. It's our good fortune that Oregon's 15-year experience with legalized death with dignity provides such conclusive data: The threatened abuses simply have not materialized.

As these considerations become more widely understood I expect death with dignity to gain wider acceptance.

**DANIEL CALLAHAN**
***PRESIDENT EMERITUS, THE HASTINGS CENTER; CO-DIRECTOR, YALE-HASTINGS PROGRAM IN ETHICS AND HEALTH POLICY; AUTHOR,* THE TROUBLED DREAM OF LIFE: IN SEARCH OF A PEACEFUL DEATH**

**WRITTEN FOR *CQ RESEARCHER*, MAY 2013**

no

Few of us want to die, and no one wants to die a poor death, one marked by pain and suffering. But modern medicine has brought us to a difficult place: We now live longer than earlier generations, but there are ever more clever technological ways to prolong our dying, well beyond what we may desire. One solution to that kind of end is physician-assisted suicide, giving us the power to end our life on our own terms. And it has a common-sense attraction: "It's my body, isn't it?"

I believe it is a bad solution to an unnecessary problem. We now have good home and hospital palliative care programs, effectively able to eliminate or greatly reduce pain and suffering. Making good use of those medical skills is the hospice program, now helping more than a million persons a year receive sensitive care in dying. Physician-assisted suicide is thus rarely needed, as the citizens of Oregon and Washington state, where it is legal, have demonstrated. They make use of it in exceedingly small numbers.

But what of that minority who believe they can't be helped and who even reject hospice care? By and large, research shows, they are those mainly drawn to physician-assisted suicide by a loss of autonomy and self-control in their dying — that is, not by a medical problem but by a set of values about what they consider a life worth living. Doctors should not be empowered to provide that kind of relief, which never was and is still not a valid goal of medicine. Nor is the implicit message of physician-assisted suicide one our society needs: that suicide is a good way to deal with the suffering life can bring.

We all die. Death is not an indignity. It is simply our human fate. With the help of advance directives or the appointment of a surrogate — and a final enrollment in hospice care — the odds of dying in a really bad way have been extraordinarily reduced, even if not to the vanishing point. The most important need is to greatly reduce the present aggressive medical war against death. Greater prognostic candor on the part of doctors is needed with those clearly on the way to death even if not yet clearly dying. The good doctor is one who balances the goal of saving life and seeking a patient's peaceful death.

*Continued from p. 464*

## Health Care Costs

Opponents of physician-assisted suicide argue that pressure to cut costs could make assisted-suicide more attractive to health care providers. In the Massachusetts debate, "We said, 'If private insurance companies and [health-maintenance organizations] have a choice between expensive care or a cheap lethal prescription, what do you think they will be tempted to choose?' " says Karuth of Second Thoughts.

But supporters counter that there is no evidence medical costs have played a role in encouraging assisted suicide in either Oregon or Washington. "In 15 years there's not been one incidence of coercion," says Sandeen of the Death with Dignity National Center, "for the disabled or any other vulnerable population." She adds that doctors who participated in such lobbying pressure would risk losing their license.

Analysts differ over whether cost savings would be significant enough to encourage the practice. In a 2011 study, the New York State Department of Health concluded, "Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process." [41]

However, in a 1998 article published in *The New England Journal of Medicine*, Ezekiel Emanuel, chair of the Department of Clinical Bioethics at the Warren G. Magnuson Clinical Center, National Institutes of Health, and the University of Utah's Battin concluded, "Physician-assisted suicide is not likely to save substantial amounts of money in absolute or relative terms, either for particular institutions or for the nation as a whole." [42] ■

AFP/Getty Images/Jacques DeMarthon

*Demonstrators in Paris lie in simulated body bags on Jan. 25, 2011, to protest a bill that would legalize euthanasia in France. The protest in front of the Luxembourg Gardens was organized by the Right to Life Alliance. The French Senate defeated the bill the next day, 170-142.*

# OUTLOOK

## Young Movement

Coombs Lee of Compassion & Choices thinks the aging of the baby boom generation is likely to boost support for physician-assisted suicide in coming years. As the generation has watched its parents struggle at the end of their lives, "too many of us have witnessed really horrific deaths, and from those experiences comes a vow that this will not be how I'm meeting my death," she says. "I think there's sort of a determination to make it different for ourselves."

In 10 or 15 years, Coombs Lee contends, "There will be a growing acknowledgement that this is a medical treatment, just like disconnecting feeding tubes or providing palliative sedation."

But Callahan, the Hastings Center president emeritus, notes that resistance to assisted suicide based on religious beliefs remains strong in much of the United States, and he doesn't see that changing. "It's certainly not going anywhere very fast," he says. "If it has trouble in places like Massachusetts, it's not going to fly in places like Louisiana or Mississippi down in the Religious Belt."

However, Sandeen of Death with Dignity contends the effort to legalize assisted suicide nationwide is just getting started: "We are a very young social movement," she says. "We can really trace our roots back to 1990, and if you look at movements surrounding things like gay marriage or abortion, they go back way farther than that. . . . We look like we haven't had as many accomplishments, but give us 20 years, and we'll be there."

Karuth of Second Thoughts says people close to her and close to those she has counseled have asked, "If you really are this sick, why don't you just kill yourself and get it over with?" If assisted suicide becomes more widely available in coming years, Karuth says, more people who are seriously ill or living with disabilities will face those kinds of questions.

Hendin of Suicide Prevention Initiatives believes the future of the assisted-suicide movement depends on whether the nation makes further advances in pain management and palliative care. "If end-of-life care improves, I think the issue [of assisted suicide] is going to become irrelevant," he says. "If you had proper palliative care, I'm persuaded at least half of [the patients who have chosen physician-assisted suicide] would not have dreamed of going that way."

Although she found the narrow defeat in Massachusetts disappointing, Clish, the Massachusetts woman whose father chose assisted suicide in Oregon, thinks that because the referendum focused attention on the issue it will benefit the cause in the coming years. "People had to go and mark a box for something that most people don't even want to talk about," Clish says. "It definitely opened up a conversation, and I believe more will come of that conversation, now that we're finally talking about it." ■

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## About the Author

**Reed Karaim**, a freelance writer in Tucson, Ariz., has written for *The Washington Post*, *U.S. News & World Report*, *Smithsonian*, *American Scholar*, *USA Weekend* and other publications. He is the author of the novel, *If Men Were Angels*, which was selected for the Barnes & Noble Discover Great New Writers series. He is also the winner of the Robin Goldstein Award for Outstanding Regional Reporting and other journalism honors. Karaim is a graduate of North Dakota State University in Fargo.

# FOR MORE INFORMATION

**Center to Advance Palliative Care**, 1255 Fifth Ave., Suite C-2, New York, NY 10029; 212-201-2670; www.capc.org. Works to increase the availability of quality palliative care services for people facing serious, complex illness. Website includes information for health care professionals and the general public.

**Compassion & Choices**, P.O. Box 101810, Denver, CO 80250; 800-247-7421; www.compassionandchoices.org. Advocates legalization of "assisted dying" and other end-of-life options; has 60 chapters nationwide.

**Death with Dignity National Center**, 520 S.W. Sixth Ave., Suite 1220, Portland, OR 97204; 503-228-4415; www.deathwithdignity.org/. Leads the defense of Oregon's Death with Dignity Act; promotes education about the law and supports passage and implementation of similar laws in other states.

**Disability Rights Education and Defense Fund**, 3075 Adeline St., Suite 210, Berkeley, CA 94703; 510-644-2555; http://dredf.org. Disability-rights group opposed to legalizing physician-assisted suicide.

**The Hastings Center**, 21 Malcolm Gordon Rd., Garrison, NY 10524; 845-424-4040; www.thehastingscenter.org. Nonpartisan research center that studies ethical issues in health, medicine and the environment.

**Patient Rights Council**, P.O. Box 760, Steubenville, OH 43952; 740-282-3810; www.patientsrightscouncil.org/site/. Provides information on end-of-life decisions and works with other groups to oppose physician-assisted suicide.

## CITING *CQ RESEARCHER*

Sample formats for citing these reports in a bibliography include the ones listed below. Preferred styles and formats vary, so please check with your instructor or professor.

### MLA STYLE

Jost, Kenneth. "Remembering 9/11." CQ Researcher 2 Sept. 2011: 701-732.

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# The Next Step:

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