Should American health care include assisted suicide?

Timothy Quill, MD, wrote a prescription for barbiturates and made sure that his patient knew how much to take to induce sleep, and how much to die. As Quill passed the slip to Diane, he had the uneasy sensation of stepping beyond personal as well as legal bounds. Yet he was convinced that he would do wrong to refuse the middle-aged woman’s firm and repeated requests for a means to kill herself.

Diane had declined cancer therapy that would have offered a 25 percent chance of cure. She was unwilling to accept the inverse of that hope: the 75 percent chance that the ordeal of radiation and chemotherapy would be useless—that she would die without ever again experiencing a day in which pain and drug effects did not severely restrict her faculties and energy. Surely, Quill reasoned, it would be cruel to abandon her to agonies such as might attend the final onslaught of her acute myelomonocytic leukemia.

Not many weeks later, Diane retired to a room by herself and made use of Quill’s prescription. Had anyone accompanied her, that person would have been subject to legal action for assisting in a suicide. Afterwards, Quill was so convinced that he had taken the only defensible course, and so upset by Diane’s ultimate isolation, that he decided to challenge the law. In early 1992, he published his story in The New England Journal of Medicine. Soon after, together with two other physicians and three patients, he filed suit to challenge New York’s law forbidding any person from helping another commit suicide. In January, the U.S. Supreme Court heard arguments on that suit, along with a second, similar one from the state of Washington.

The proposition to grant physicians a legal right to help patients die obviously has profound ethical implications—none of which is seriously encountered in the well-publicized activities of Jack Kevorkian. Does a person’s right to self-determination extend to the point of self-destruction? Is the injunction “Thou shalt not kill” absolute in all circumstances except for self-defense? Should we tolerate grim suffering—either physical or psychic—without hope of recovery or epiphany?

Ultimately, say many experts, we must consider these difficult issues not
in the abstract, but in the light of what we know and intuit about ourselves and our institutions. Can we be sure that freedom rather than coercion, and compassion rather than socioeconomic motives, would drive the writing of legal prescriptions for death?

Is there a right to suicide?
Today's debate over physician-assisted suicide grows out of the right-to-die movement. With the coming of age of intensive-care medicine in the 1960s and 1970s, caregivers and the public became alarmed over the plight of some patients who were being kept alive by the new techniques. Some of these patients had no hope of ever leaving their hospital beds and wished to die. But the moral tenets of medicine, as traditionally understood by many physicians, forbade disconnecting ventilators and feeding tubes.

With a growing number of individuals tethered indefinitely to pumps and monitors in intensive-care networks, patient advocates and ethicists argued that patient autonomy is a primary ethical principle in medical decision making. After intense professional and public debate, a consensus emerged that a patient's normal right of self-determination entails a right to refuse medical treatment or demand that it be stopped—even if death is a sure result.

To proponents of assisted suicide, self-determination logically extends to taking one's life. "We all agree that it's all right to take the patient off the ventilator," says Peter Ubell, MD, an internist and bioethicist at the University of Pennsylvania School of Medicine. "But sometimes it's going to take 48 hours of slow, miserable respiratory failure before the patient dies. How many times have I been asked, 'Is that really humane? If we know the patient is going to die in the next couple of days, why don't we help them?'

From another perspective, however, suicide and refusal of treatment differ with respect to the issue of patient autonomy. The right to refuse treatment is important in large part because it enables patients to protect themselves from unwanted medicine. The catalyst for establishing this right was the sight of unlucky patients sentenced to semiperpetual dependency on machines. In some of the worst instances, individuals were allegedly preserved so that medical students could practice venipuncture and other techniques upon living human beings.

Thus, asserting the ability to refuse treatment transferred power from the medical system to patients. In contrast, legalizing physician-assisted suicide will give the system more power.

In a similar vein, some advocates of assisted suicide point to the use of opiates to abolish pain even when the necessary doses are high enough to hasten the patient's demise. What ethically substantive difference can be drawn between this common practice and that of assisted suicide? they ask.

This argument applies forcefully to cases in which a terminally ill patient wishes to die because of incontrollable pain. It may not be as relevant when psychic distress is the motivation, since psychotherapeutic drugs reach peak effectiveness in doses that fall far short of lethality.

These two issues—of patient autonomy, and of whether there is a meaningful difference between certain existing end-of-life interventions and helping a patient commit suicide—were the crux of the arguments before the Supreme Court. The Justices and the litigators also explored the ways in which assisted suicide might fit in with our institutions and system of incentives.

The physician's role
"Part of the continuum of care is to relieve suffering, be it by palliative care, helping a patient who refuses treatment or nutrition or hydration, or providing a patient with something to end his or her life," says Faye Girsh, executive director of the Hemlock Society.

"To ask physicians to assist in suicide fundamentally contradicts our role as healers," counters Thomas Reardon, MD, chair of the American Medical Association (AMA) Task Force on Quality of Care at the End of Life: "We have been opposed to this since the time of Hippocrates."

Mainstream caregivers' organizations have nearly all come out against legal physician-assisted suicide. Along with the AMA, the American Neurological, Psychiatric, and Nursing associations, several hospice associations, and approximately 45 other groups jointly filed an amicus curiae brief to present to the Supreme Court with their arguments against legalization.

The American College of Physicians pronounced facilitating suicide unethical, then shifted to a neutral position in order to avoid prematurely polarizing or stifling debate. The College is now reading a third edition of its Ethics Manual, in which it will probably renew its opposition.

In contrast to this organizational unanimity, individual caregivers split sharply over helping terminally ill patients take their lives. In a recent nationwide poll of oncologists, 51 percent said they had received requests to make a suicide possible or
easier, and about a quarter of these stated that they had complied at least once. In a sample of Washington State physicians in all specialties, some 15 percent reported being asked to help someone die, and about 20 percent of these had done so. A survey of critical care nurses disclosed a small but significant involvement in euthanasia and assisted suicide.

Given these figures, proponents of legal assisted suicide maintain that caregivers' organizations are out of step with their memberships. That may be true, but there is more to the explanation.

A physician who is willing to facilitate a suicide still may not wish to see the laws changed. As things stand, physicians and patients can discuss values and options within the intimacy and shelter of their unique relationships. Although helping to arrange a suicide is forbidden, and caregivers who defy the law run some real risk of malpractice and wrongful death charges, no physician has ever been strongly sanctioned for doing so.

Legalization would bring with it limitations on which patients can be helped and under what circumstances. Well-meaning statutes designed to protect patients might prohibit action in some cases where compassion and the patient's wishes are compelling. Why risk such complications?

The reason, Girsh responds, is that unenforced laws create an ambiguous zone where communication is inhibited. Nurses have complained that some physicians may give a signal to administer a lethal overdose, but be unwilling to document the order. Clearly, communication that seeks to be undocumentable can be susceptible to tragic misinterpretations.

Further, some patients are afraid to broach the subject of suicide, and some who do may run into barriers of wariness and misunderstanding. Girsh says, "Many patients have told us their doctor said, 'Don't worry, I'll take care of it.' They thought this meant they would have help, but when the time came, the doctor said, 'No, that's against the law.'"

In such cases, the patient can end up dying in precisely the conditions he or she has most desperately feared. Or worse. Alexandra Beckett, MD, a psychiatrist and director of HIV psychiatric services at Boston's Beth Israel Hospital, says, "A number of providers I know have been close to cases where someone tried to commit suicide with the help of a nonphysician, was unsuccessful, and ended up hospitalized or more severely impaired." Although Beckett personally rejects legal assisted suicide and has never knowingly abetted a suicide attempt, she notes, "People ask themselves, 'If someone chooses to take control of their circumstances by dying this way, don't physicians have an obligation to protect them from disaster?'"

The money motive
Current laws force physicians and patients who consider collaborating in a suicide to do so privately, even furtively. Negative consequences ensue, but so does a degree of protection. Should legalization occur, many people conjure bleak visions of ways that powerful socioeconomic forces might influence these life-and-death deliberations.

Public and private entities alike are preoccupied with spending less on health care. According to studies, the 5 percent of the population who will die within one year incur some 30 percent of all medical expenses.

Intuitively, if a significant number of these people were to die sooner, perhaps before receiving the most costly end-of-life treatments, the nation's bottom line might improve. Some people ask whether public or

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**A troubling implication**

Not surprisingly, people with chronic medical conditions have a higher risk of developing major depression—an illness with suicide rate nearly 11 times that of the general population. Such statistics suggest a troubling question about physician-assisted suicide: Is a terminally ill patient with depression in a sufficiently sound state of mind to make such a choice?

**Suicide rates**

| People with major depression | 15% |
| General population           | 1.4% |

Source: *Diagnostic and Statistical Manual—IV* and National Institute of Mental Health.

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private policy makers might be tempted to create suicide incentives for caregivers, patients and families.

In fact, intuition is misleading in this case. A careful economic analysis published in *The New England Journal of Medicine* in 1994 indicated that little money would be saved by reducing care at the end of life. Primary author Ezekiel Emanuel, a Boston-based oncologist, explained that this is partly because more than half of such expenditures pay for heroic but futile treatments for young people with traumatic injuries. This population will never include a significant number of candidates for physician-assisted suicide.

Although physician-assisted suicide will not affect overall medical expenditures, individual insurance or provider organizations might conceivably save money if suicide rates were to rise among high-resource-using clientele. Ubell contends that even on the debatable assumption that corporate conscience was swayed by such considerations, "Managed care companies are going to look elsewhere for savings. The end-of-life setting is highly visible and emotional, and companies couldn't get worse publicity than by encouraging physicians to kill off their patients."

Another physician, however, who has extensive experience with managed care, sees a role for creative marketing: "The companies would present the option of assisted suicide as an extra benefit, something good. Rather than overtly pressuring people to choose this service, they might simply narrow the alternatives. Patients would find, for instance, that their contract no longer allowed a third round of chemotherapy."

Fifty or a hundred thousand dollars may make only a moderate difference in a corporation's bottom line, but it is likely to have a momentous effect on a family's resources. Karen Kaplan, Executive Director of Choice in Dying, an educational organization that has filed a neutral amicus curiae brief with the Supreme Court, envisions a troubling scene: A terminally ill patient overhears her children in the corridor saying, "Well, if Mom stays alive much longer, there won't be any money left to send Junior to college." According to Marc Berk, director of the Project Hope Center for Health Affairs, catastrophic health insurance would obviate such pressures, but those proposals lie cradled in the congressional deep with many other aspects of health reform.

Whether or not they are concerned with being a financial liability, observes Daniel Callahan, former director of the Hastings Center for Ethics, people with serious illness typically feel that they are a burden. "A worst-case scenario," says Callahan, "is that some people would feel that it was almost their duty to choose suicide to relieve the family."

In fact, surveys have found that more people request a physician's help in dying because of "feeling like a burden" than to escape severe pain. Ironically, Callahan notes, other studies indicate that when patients feel that they are burdens, their families often do not feel burdened at all.

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**Life's sticks and death's carrots**

If suicide becomes a response to economic and social pressures, say opponents of legalization, social stigmatization could amplify the effect in members of devalued subgroups.

A case in point: In the Netherlands, 25 percent of the people who receive legal euthanasia or assisted suicide have AIDS. This is an outsized portion, considering that people with AIDS account for only a small percentage of total deaths in that country. It suggests that the feelings of shame and rejection associated with this disease may help precipitate many individuals' decisions to preempt natural death.

Even physicians may—unwillingly or unwittingly—reinforce patients' socially instilled feelings of worthlessness. Suppose, for example, that a physician does not understand what enriches life for a person who is not elderly or otherwise different. He or she might then introduce the option suicide sooner or more positively.

Legal assisted suicide would automatically become a medical service that can be sold like any other—hence an opportunity for entrepreneurship. It requires no special imagination to conjure stacks of brochures on hospice bedside tables, next to Gideon Bibles, extolling the ease and virtue of a particular way out. One can imagine burgeon "thanatopic medical practices, with specialists offering a spectrum of scientifically tested, foolproof and esthetic self-administered lethal interventions.

Proponents of legal physician-assisted suicide doubt that worries about such eventualities are realistic. There have been few documented complaints. Girsh notes, about venti-lator-dependent patients being coerced or inveigled into asking for termination. Should assisted suicide become legal, says Thomas Delbanco, director of general and primary care at Beth Israel Hospital Boston: "It will be like everything else. Ninety-nine percent of physicians will be conscientious, and a few will abuse it."

Strict libertarians argue that concerns about "undue influences" are not even relevant. They hold that everyone has a perfect right to end his or her life to save money for the next generation, or because they feel ashamed of the way they have behaved, or for any reason whatever. To question anyone's motives is to constrain the very autonomy that is the basis for ethical doctor-patient relationships.

Moreover, to say that terminally ill patients should not take anyone else's interests but their own into account when considering their course of action is to deny them the right to act upon social and altruistic impulses that are vital components of humanity.
What will the court decide?
The Supreme Court is expected to publish its ruling on physician-assisted suicide early this summer. The Court's specific business is to review two lower court decisions that held that individuals have a constitutional right to physician-assisted suicide.

In the case brought by Quill et al., the 9th District Court of Appeals started from the premise that a physician who turns off life support for a terminally ill patient helps that patient die. This being so, the court said that a law denying assistance in dying to terminally ill patients who are not dependent on machines violates the 14th amendment principle of equal rights. In the second case, the 2nd District Court of Appeals held that taking one's own life is an "intimate personal decision," and so immune from governmental interference.

Kathryn Tucker, JD, is one of the team of lawyers who presented arguments in favor of physician-assisted suicide. Interviewed in December, Tucker was optimistic that the Justices would favor her position, saying, "I think this is a Court that will be able to protect an individual choice of this nature."

In support of her optimism, she cited the 1990 case of Cruzan v. Director, Missouri Department of Health. There, the Court ruled that the family of a comatose patient could order her ventilator removed based on their knowledge that she would have preferred dying to living in a vegetative state. Implicitly, Tucker interpreted, "The Court recognized the profoundly personal nature of end-of-life decisions."

Tucker also asserted a second line of precedent: "In its decisions surrounding reproductive freedom, the Court has recognized that personal decisions about your health care, your body and the future course of your life are reserved for the individual."

In the January hearing, however, Justices Antonin Scalia and Ruth Bader Ginsburg differed on the worthiness of the reasoning of the 9th Circuit Appeals Court. Scalia said flatly, "Declining medical treatment is quite different from committing suicide," and noted that the common law tradition has countenanced the second but not the first. Justice Ginsburg asked rhetorically how a physician's withdrawing food and water is "rationally distinguishable" from physician-assisted suicide.

"I'm not aware of any doctor being convicted of this... and I can't believe it's not happening," said Justice Stevens.

Observers of the issue and the Court generally concur that a ruling in favor of a constitutional right is unlikely. Along with Justice Scalia, Justice Anthony M. Kennedy seemed less than eager to tamper with the traditional legal status of suicide, pointedly noting to proponents, "You're... asking us to declare unconstitutional the laws of 50 states." Justice Ginsburg also asked, "Is this ever a proper question for courts, as opposed to legislatures, to decide?" In addition, Justice David Souter expressed misgivings that legal assisted suicide for terminally ill patients might eventually "gravitate down to those who are not terminally ill... [and] into euthanasia."

After the ruling
The Supreme Court's decision will not end the debate over assisted suicide. If the Court describes a constitutional right, then every state will need to draft legislation to regulate the circumstances under which people can exercise the right and protocols for helping them die. If the Court rejects a constitutional right to assisted suicide, states would still be allowed to pass laws permitting or forbidding the practice. Currently, lawmakers in Massachusetts, Michigan and New York are considering permissive bills, while the legislatures in Michigan and Rhode Island are deliberating sanctions.

Two years ago, voters in Oregon, a state that has set the pace for the nation on several sweeping issues of medical policy, approved a referendum allowing physician-assisted suicide. As safeguards against precipitate
acts and abuse, the law specifies that a patient must be terminally ill to be eligible for assistance in dying. He or she must request assistance twice, once in writing. In addition to the attending physician, a second doctor must confirm the diagnosis and prognosis and certify that the patient does not seem to be suffering from clinical depression or other psychiatric illness. A 15-day waiting period is required between the second suicide request and the act.

Legal challenges have so far prevented implementation of the Oregon Death With Dignity Act. Critics contend that its supposed safeguards could easily become merely routine protocols for physicians running “suicide mills.”

Lois Snyder, JD, a lawyer with the American College of Physicians (ACP), finds fault with the eligibility requirements, too. She points out that one reason why people are interested in suicide is fear of Alzheimer’s disease. Yet Alzheimer’s abolishes competence long before it becomes terminal (in the accepted sense of leading to death within six months). Therefore, under the Oregon rules, people who develop it would never be eligible for a physician’s help in dying. “This raises constitutional issues,” Snyder says. “The ACP, like many medical organizations, has argued that patients who become incompetent should retain the right to have a surrogate speak for them in right-to-die situations.”

If the Oregon law’s requirements are inadequate, can effective safeguards ever be generated for physician-assisted suicide? Callahan thinks not: “The practice is inherently unregulatable because of physician-patient confidentiality. If neither wants to tell, no one will ever know what happens.”

Callahan also predicts that physician-assisted suicide, if approved, will not be the end of the line in death-dealing interventions. If logic leads from withdrawal of treatment to putting lethal drugs into a suicidal patient’s hand, how can it not continue on to injecting those drugs into terminally ill individuals who ask for them and cannot self-administer them—say, patients with motor disabilities? Then people might ask, if euthanasia is a right, why shouldn’t somebody—terminally ill or not—be able to ask for it just because they don’t like their life?

**Life and death in the balance**

The number of people who truly wish to preempt their natural demise is presumably small. Specialists in pain control say that health care workers can reduce this number considerably further by becoming more adept at recognizing and treating pain and depression. Yet most specialists also acknowledge that even the best pain control interventions still cannot extricate certain patients from physical distress so intense and encompassing that they would rather die than bear it any longer.

Similarly, depression is widely considered to be one of the most underdiagnosed of all medical problems as well as a contributor to many suicides. More physician attention to signs of depression, particularly among the terminally ill, can lower this burden and prevent many suicides. But there will remain a small population of individuals who are not depressed and wish to end their lives because illness is preventing them from carrying on with most or all of the activities that have sustained their attachment to life.

Faced with the plight of such patients, advocates of legal physician-assisted suicide invoke principles of compassion and liberty. Opponents fear a sacred breach with the principle of reverence for life and describe forebodings of lethal chaos.

Imagine the two positions placed in a balance scale. The advocates’ pan holds the ethical principle of autonomy—our right to do what we wish with our own lives, consistent with our personal values, free of undue restraints. The thesis naturally ensues that if we decide our lives are not worth living, we should be able to end them and have help in doing so.

This pan also contains Quill’s example of what might be for advocates an ideal and for opponents a least objectionable instance of assisted suicide. Quill had been Diane’s physician for eight years and knew her personality and values well when he helped her die. Moreover, Quill is a general internist with training in psychiatry as well as experience in hospice care. In addition to his compassion and thoughtfulness, he was competent to determine that Diane’s illness was terminal, that the possibilities she feared were real and that she was not clinically depressed when she asked to die.

In the pan opposing physician-assisted suicide lies the fear that legalization will pit the patient’s will to live against social and economic interests that are indifferent to his or her best interests.

Emanuel notes that today’s debate recapitulates one that occurred in the 1890s up to the 1930s. “That was the Gilded Age—Social Darwinism, Standard Oil, railroad trusts, celebrating big business, busting unions, limited government intervention. That is the kind of social milieu in which calls like this can find fertile ground. It is a time that closely parallels ours. The point is that this movement is not born out of the best, the most compassionate aspect, of America.”

Finally, the opponent’s pan holds the example of Kevorkian, who has helped more than 40 people die since 1988. Kevorkian is a retired pathologist who has little experience treating patients and never met any of the patients he helped die before the consultations that led to their suicides. Some of these patients did not have a terminal diagnosis. One did not have any definite diagnosis.

Kevorkian’s energy, efficiency and magnetism for publicity exacerbate unease about his motives. To some people, he seems obsessed with death. Soon to undergo a trial in Michigan, he has promised to starve himself to death if imprisoned.

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