Legal Status of Physician-Assisted Suicide

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While physicians generally understand the distinctions among euthanasia, physician-assisted suicide (PAS), and the withdrawal of life support, the public tends to confuse these terms,\(^7\) potentially leading to misunderstandings between physicians and patients. The withdrawal of life support when it has been deemed futile has been widely upheld as legal by US courts.\(^2\) The uncertain legal status of euthanasia and physician-assisted suicide will be determined partly by the attitudes of the public about the end of life. Although surveys have found that more than 90% of the public would endorse withdrawal of life support in the case of terminal illness, there is much less support for active euthanasia and PAS. In fact, many surveys show about one third support of PAS under most circumstances, one third support depending on the circumstances, and one third opposition under most circumstances.\(^3\) In general, these data suggest that the public is evenly divided among viewpoints despite disagreement over what those very viewpoints encompass. Some of this confusion may be due to the complex interplay between the legal system and society’s interpretation of legal and ethical behavior. A century of end-of-life jurisprudence in the United States provides the fundamental framework for understanding the differences among end-of-life options and provides an ethical framework for debates over assisted death.

In 1914, the New York Supreme Court firmly established the legal principle of patient autonomy following a case in which a surgeon removed a tumor with the patient under anesthesia and without the patient’s consent.\(^4\) Autonomy refers to a patient’s right to self-determination, now considered a central bioethical principle. Justice Benjamin Cardozo wrote in his decision: “It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault.”\(^5\) Subsequent decisions have upheld the idea of patient autonomy, including the landmark end-of-life cases of the end of the 20th century, in re Quinlan\(^7\) and Cruzan v Director.\(^8\)

The Quinlan case, in particular, firmly established the right to refuse treatment as a critical component of patient autonomy. Karen Ann Quinlan was a 21-year-old who entered a persistent vegetative state after an alleged alcohol and tranquilizer overdose in 1975. The New Jersey Supreme Court decided to uphold her father’s wish to disconnect Quinlan’s ventilator, establishing the right to withdraw life-sustaining therapy from consenting adults in certain circumstances.\(^9\) This case, along with Cruzan, not only allowed a patient to refuse life-sustaining treatment, but also allowed a surrogate to make that decision. This principle has been refined to include the right to refuse artificial nutrition and hydration, and the establishment of “best interests” standards, allowing a surrogate to substitute judgment in the best interests of an incapacitated patient when the wishes of the patient are unknown. The essence of these cases is summarized in the Natanson v Kline court decision: “Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary, but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.”\(^10\) The principles instituted by this legal history have led to increasing public awareness of end-of-life issues and the development and popularization of advance directives such as living wills and do-not-resuscitate orders.

The gradual extension of legal rights in the end-of-life arena has led to the current debate over PAS. On one side of the debate, proponents of PAS seek to show that there is no moral difference between withholding lifesaving treatment and providing a patient the means to end life. On the other side, opponents argue that the artificial hastening of death is unlike allowing the unhindered progression of a terminal illness. However, the courts have generally held that an individual’s right to self-determination, including choices about death, outweighs a societal interest in the sanctity of life.\(^9\) Indeed, PAS opponents\(^11\) and the US Supreme Court\(^12\) have already recognized the administration of escalating doses of pain relievers in order to alleviate discomfort as ethically and professionally acceptable, even when administered to achieve “terminal sedation,” where the patient is likely to die because of the dosage of medication. Physicians are generally protected in these cases under the established principle of “double effect,” wherein one act produces two inseparable effects: one good (relieving pain) and one bad (opiate sedation to the point of death).\(^2,13\) Theologists and legal scholars alike have upheld such acts as morally good despite the consequences of the “bad” effect. Similarly, in its amicus brief in Compassion in Dying v State of Washington, the American Medical Association stated that “It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.”\(^12\)

The principle of double effect leads to a nuanced difference between active and passive euthanasia, making legal resolution of the PAS debate difficult. Whereas one might legally construe a hospital’s insistence on continuing life support as assault and the unvarying avoidance of terminal sedation as unethically inadequate pain relief, the withholding of a lethal prescription does not similarly trespass against a patient’s rights.
The current touchstone for the legal status of PAS in the United States lies in Oregon’s Death With Dignity Act (DWDA). Citing the due-process protections of the 14th Amendment of the Constitution, US Supreme Court rulings in 1997 allowed Oregon to proceed with the DWDA, identifying euthanasia and PAS as issues that were neither prohibited nor supported by the Constitution. The DWDA permits PAS for terminally ill patients. Under the oversight of the Oregon Health Divisions, physicians may write a prescription for a lethal dose of sedatives (usually secobarbital or pentobarbital) for mentally capable, adult Oregon residents with a prognosis of less than six months of life. A request for PAS must be reproducible and made in the presence of witnesses; the patient must understand the alternatives; and the patient must not have impaired judgment. The DWDA notwithstanding, PAS has stalled as an item of legislation in the United States. Oregon is currently the only state that allows PAS; voters in Maine and Michigan rejected referenda on the issue, and seven other states have specifically prohibited euthanasia and PAS. An unsuccessful challenge to the DWDA was made by the US Department of Justice in attempting to convince the 9th District Circuit Court to overturn the DWDA as a violation of the Controlled Substances Act. In Europe, although the Netherlands and Belgium legalized PAS in 2002, most countries have not come to a consensus in either public or legal opinion.

Several high-profile legal battles, both in Europe and in the United States, have further dissected the differences among PAS, euthanasia, and the withdrawal of life support. In March 2002, Ms B, a 43-year-old quadriplegic in the United Kingdom, first won the right to have her ventilator turned off against the wishes of her hospital. The court agreed to insulate the National Health Service (NHS) from legal liability in withdrawing life support, creating a landmark judgment regarding end-of-life care—it reasoned, as US courts have long maintained, that a competent patient could refuse ongoing treatment regardless of the consequences, even if these consequences include death.

Soon afterward, the NHS denied a request made by a physically incapacitated 43-year-old British woman, Diane Pretty, that her husband be allowed to administer lethal narcotics to end her life. The British High Court and House of Lords dismissed Pretty’s appeal for a reversal of the NHS decision, holding that “human rights legislation was in place to protect life, not to end it.” The Pretty’s lawyers made a legal appeal to the European Court of Human Rights, arguing that the UK government had failed in its duties to value human rights and to protect patient autonomy and the freedom of choice. The European Court denied the appeal. The deciding factor in the final decision was that, although paralyzed below the neck by motor neuron disease, Pretty was not receiving life support and therefore could not ask for the mere withdrawal of care. British law is willing, as in Ms B’s case, to allow the unchecked progression of a fatal illness, but, as in most of the United States, unwilling to allow the active termination of a human life.

Meanwhile, the Ninth Circuit Court in Compassion in Dying v State of Washington has pointed out the inconsistency in according these kinds of cases different moral status: “We see no ethical or constitutionally recognizable difference between a doctor’s pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life.” Furthermore, it is unclear how effective antisuicide legislation has been. Physician surveys have shown significant rates of PAS requests and subsequent lethal prescriptions. Meier et al identified 81 cases of assisted suicide among almost 2000 physicians, and Emanuel et al found even higher rates among oncologists surveyed (38 cases among 355 physicians). Both of these studies were completed before PAS was legal anywhere in the United States.

Within the legal scope of practice, however, many concerns exist regarding the extent of assisted-suicide protections. While the laws in Oregon and the Netherlands require a second physician as a consultant, many psychiatrists feel that psychiatric consultation should be required by law as a check against depressed patients’ requests for assisted suicide. Proponents of PAS counter that effective guidelines, including protocols for consultation, can improve the selection of patients so as to obviate a psychiatric evaluation. Oregon's experience with the DWDA seems to confirm the effectiveness of rigorous screening. A survey of Oregon physicians revealed that while 20% of 165 patients who requested PAS showed symptoms of depression, none of those patients was granted a lethal prescription. On average, only 1 in 60 requests for PAS actually resulted in suicide.

Another concern regards the treatment of minors. By Dutch law, minors between 12 and 16 years of age can request suicide as long as they have parental consent, prompting concern among American parents that similar laws might be passed in the United States to extend these rights to minors. Finally, bioethicists worry about “disparate impact,” a legal term that refers to the possibility that the legalization of assisted suicide would lead to its disproportionate utilization among vulnerable populations like minorities, the elderly, and the poor. Members of vulnerable groups might feel pressured to accept death sooner than desired for financial reasons; they may also be less informed of the consequences of PAS. As the New York State Task Force on Life and Law argued: “Like the availability of pain relief or the skills needed to diagnose depression, the kind of doctor-patient relationship envisioned by those who advocate legalizing suicide will simply be unavailable to many patients.” Preliminary evidence from Oregon indicates no obvious biases based on race, sex, or educational level. In fact, the only significant demographic trend over time was that PAS requesters tended to be better-educated patients. Nonetheless, practical issues continue to affect the moral debate on PAS—concerns about vulnerable populations and patients with depression highlight the importance of rigorous screening. For some le-
gal scholars, however, the gains from granting a positive right to PAS outweigh the negative right to be kept free from potential abuse, especially if assisted suicide is considered a “critical life choice.”

An end-of-life jurisprudence focusing on the distinctions between acceptable and unacceptable approaches to palliative care has gradually been built. While a patient’s right to require the withdrawal of life support has been consistently upheld by the courts and public consensus, support for PAS is limited, and euthanasia remains illegal in the United States and in most other countries. The future of PAS is uncertain—policy trials are occurring abroad and in Oregon, and the data subsequent to these initiatives are slowly becoming available. Preliminary evidence has found PAS under controlled circumstances to be relatively free from abuse and bias, but it is impossible to predict the applicability of such data to the United States as a whole. The PAS debate has at least prompted a renewed appreciation for improving palliative care, clarifying patient wishes through advance directives, and bringing patient self-determination to the forefront of end-of-life care.

REFERENCES
6. Schloendorff v Society of New York Hospital, 211 NY 125 (1914).

If all the arts aspire to the condition of music, all the sciences aspire to the condition of mathematics.
—George Santayana (1863-1952)