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by

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The issues surrounding Physician-Assisted Suicide (PAS) currently remain very complex and are a source of much confusion. The people of Oregon went to the polls to vote on whether or not PAS should be legal in the state of Oregon. They answered affirmatively. In 1997, two cases went before the United States Supreme Court in an effort to determine whether or not there was a "constitutional right" to PAS in this country. This paper will review the arguments and issues surrounding PAS in these two cases which the Supreme Court has ruled upon.

The Two Cases Before the U.S. Supreme Court

On January 8, 1997, the United States Supreme Court heard oral arguments in *Vacco v. Quill* and *Washington v. Glucksberg*. The first case challenged New York's assisted suicide ban and listed the petitioners as Dennis Vacco, Attorney General of the State of New York; George Pataki, Governor of New York; and Robert Morgenthau, District Attorney of New

York County. The respondents were listed as Timothy Quill, M.D.; Samuel Klagsburn, M.D.; and Howard Grossman, M.D. The second case challenged Washington's law barring assisted suicide and listed the petitioner as Christine Gregoirie, Attorney General of Washington and the respondents as Harold Glucksberg, M.D.; Abigail Halperin, M.D.; Thomas Preston, M.D., and Peter Salit, M.D., Ph.D. The patient-plaintiffs before the court all have a single, well-defined disease: three suffer from AIDS, two from cancer, and one from emphysema. One should note that these cases of individuals fail to reflect the multiple disease and prognoses that are more common in advanced age.

A number of amicus curiae briefs were filed before the court in one or both cases. Specifically, forty-one were filed against the idea of a constitutional right to suicide and assistance in committing suicide. Nineteen briefs were filed favoring assisted suicide. I will review and provide a summary of the Verbatim by Richard Coleson, M.A.R., J.D., who summarized many of the arguments made in the amicus curiae briefs which were filed in one or both cases. Mr. Coleson is an attorney in the firm Bopp, Coleson & Bostrom in Terre Haute, Indiana. He also represents staff counsel at the National Legal Center for the Medically Dependent & Disabled, Inc.

Reasons for Requesting PAS

Many reasons have been set forth as to why patients request PAS. One of the most common reasons is the fear of prolonged, unendurable pain. One should take note that there is no evidence that increasing numbers of patients are dying in severe pain. Pain management has greatly improved through the development of better techniques and through hospice and palliative care efforts (AMA Council on Scientific Affairs at 474, 475). The pain of most terminally ill patients can be controlled throughout the dying process without heavy sedation or anesthesia (Byock, 1993 at 25, 26) (Foley at 289) (Levy at 1124). For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain (N.Y. State Task Force at 40 & n.21). Catholic doctrine, under the principle of double-effect, clearly sees this as morally licit as long as it is the only way to control pain and death is in no way intended or sought. When pain medication is properly administered, for most patients the risk of respiratory depression that hastens death is minimal. (N.Y. State Task Force at 162). It is recognized that not all patients have access to and actually receive adequate pain relief and good palliative care. The delivery of such care is grossly inadequate today, and efforts to make such care

universally available have not yet succeeded (N.Y. State Task Force at 43-47) (Conners, at 159). Obstacles to adequate pain management include a lack of professional training and knowledge about the risks of addiction and respiratory depression, inadequate communication between health care professionals and patients or their families and concern over criminal or licensure actions against the prescribing physicians (N.Y. State Task Force at 44-47) (AMA Council at 476). What is truly at stake in the controversy surrounding PAS is the denial of distinction between withdrawal of life-sustaining treatment and euthanasia or physician-assisted suicide. Put another way, refusing life-sustaining treatment and ingesting poison are not the same. The refusal to make this distinction threatens the well-established right to refuse treatment. We must continue to emphasize the rational distinction between "killing" and "letting die."

Why do most patients request PAS? One significant reason is out of concern that in the future, the pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families (Back, et al., at 921) (Emanuel, et al., at 1807). While these concerns of suffering are very real, they can often be effectively alleviated (Foley at 289-90) (N.Y. State Task Force at x, 181). What surfaces over and over again is that clinical depression is the single factor found to be a significant predictor of the desire for death (Emanuel, et al. at 1809) (Chochinov, et al., at 1185, 1190). In one study of terminally ill patients, all but one of the eleven patients with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish (Brown, et al., at 208, 210) (AMA Council at 475) (Chochinov, et al., at 1185). Conwell and Caine report that "of 44 patients in the last stages of cancer, only 3 had considered suicide, and each of them had a severe clinical depression" (Conwell & Caine at 1100, 1101). Those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which is generally treatable (Hendin at 285) (N.Y. State Task Force at 13, 180). It is clear that "a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression" (Chochinvo, et al., at 1190). The elderly appear more prone than younger victims to take their lives during acute depressive episodes that respond most effectively to available, modern treatment (Conwell & Caine at 1101). Many elderly patients and those dying from cancer experience delirium, a syndrome in which they are confused, unable to maintain attention, and unable to master new information. Depression, delirium, and mood disorders strongly correlate with suicide. Treatment of depression substantially alters an initial inclination to refuse life-sustaining treatment (Ganzini at 1631-36).

Nevertheless, most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment (Conwell & Caine at 1101-1102).

Alternatives to PAS

The answer to those who are suffering or terminally ill is to be found in hospice care. Hospices understand the psychological dimension of suffering and are committed to treating the depression and fear that surround terminal illness. When patients suffering from terminal illness are given proper palliative care and support, the desire for assistance with suicide generally disappears. Families are also able to receive significant help in dealing with issues surrounding their loved one. The hospice way of dying offers a middle path between two undesirable approaches in caring for the terminally ill patient – curative, high technology medicine on one hand, and death by euthanasia on the other hand (Campbell, et al., at 36, 37). While admission to hospice is contingent on a diagnosis of six or fewer months to live, a recent study showed that 15% of hospice patients survived longer than six months and 8% survived longer than one year (Christakis & Escarce at 172). It is simply incorrect to assert that terminally ill adults who wish to die are unable to enjoy the presence of family and friends. The clinical literature documents that even those who have expressed a desire to die are usually able to spend their last days in meaningful and pleasurable interchange with family and friends. Also at risk are those individuals who have disabilities. In the United States alone, there are 23,588,000 noninstitutionalized people with severe disabilities. Census data is not available for people with severe disabilities who are institutionalized. These represent "categories of individuals" who are the actual and potential victims of a right to assisted suicide as we will see when we examine the practice of euthanasia in Dutch Holland.

The Practice of Euthanasia in Holland

One cannot begin to predict the possible impact of euthanasia in America without a thorough review of the empirical data from the practice of euthanasia in Holland where it has been legally practiced for approximately 20 years. The Van der Mass Survey is the official study of euthanasia commissioned by the Dutch government. It demonstrates that more than half of Dutch physicians consider it appropriate to introduce the subject of euthanasia to their patients. More requests for euthanasia came from families than from patients to accept euthanasia by a feeling that the patient's situation is "hopeless." Pressure or encouragement from family,

friends, and caregivers may cloud or overwhelm the patient's independent judgment and thus amount to inappropriate coercion (Chocinov, et al., at 1185-90). These pressures effectively communicate to the patient that his life is not worth living. This has a very powerful effect on the vulnerable patient's outlook and wishes.

The Dutch established protocol by which the practice of euthanasia was to be regulated:

> (1) The request for euthanasia must come from the patient and must be entirely free and voluntary.
>
> (2) The patient's request must be well considered, durable, and persistent.
>
> (3) The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.
>
> (4) Euthanasia must be a last resort, and other alternatives must have been considered and found wanting.
>
> (5) Euthanasia must be performed by a physician.
>
> (6) The physician must consult with an independent physician-colleague who has experience in this field.

The data for the practice of euthanasia in Holland comes from the official Van der Maas survey. We know that in 1990 there were reported 13,506 cases of euthanasia by omission. Out of 13,506 cases, 8,750 (65%) were killed without patient consent. Also in 1990 there were 11,800 cases of active euthanasia. We know that 5,941 individuals out of 11,800 were killed without patient consent. This constitutes 50% for active euthanasia (Fenigsen at 283-97). What does this tell us? What we know is that the legalization of euthanasia on request has led in the Netherlands to acceptance of nonvoluntary euthanasia. It has become commonplace in Holland for physicians to make decisions to kill their patients with the patient having absolutely no knowledge or consent whatsoever. The Van der Maas Survey documents cases where "physicians prescribe, supply, or administer a drug with the explicit purpose of hastening the end of life without the explicit request of the patient." Overall, most of the Dutch guidelines are routinely violated in the practice of euthanasia. The experience of physician-assisted death in the Netherlands suggests that a progression from patient self-administration of lethal medication to

physician assistance with intravenous routes is a likely consequence of allowing PAS (Van der Maas, PJ, et al., at 669). What we know from the Dutch experience is that legal sanction for assisted suicide and euthanasia actually increases the power and control of doctors who can suggest or encourage it, refrain from proposing obvious alternatives, ignore patients' ambivalence about suicide, and even put to death patients who have not requested it.

The Practice of Euthanasia in Nazi Germany

The beginnings and the advancements of euthanasia in Nazi Germany are very significant in understanding the beginning of this movement in America. The foundation for euthanasia in Nazi Germany was begun by the German medical and legal professions and was instigated by a publication entitled *Permitting the Destruction of Unworthy Life* by Binding and Hoche. Professor Binding was one of Germany's leading specialists in constitutional and criminal jurisprudence; Dr. Hoche was a psychiatrist.

Binding argued that it should be permitted to kill three groups of persons:

> 1) Those irretrievably lost as a result of illness, or injury, who, fully understanding their situation, possess and have somehow expressed their urgent wish for release.
>
> 2) Incurable idiots from whom there is no valid consent to be killed but whose lives are completely without purpose and a fearfully heavy burden both for their families and for society.
>
> 3) Formerly competent patients who, due to trauma, have become unconscious and who, if they should ever rouse again from their comatose state, would waken to nameless suffering.

The application of the individual would go to a government board composed of a physician, a psychiatrist, and a lawyer, and unanimity would be required in granting permission. The decree of permission would indicate that a thorough investigation had been undertaken, that the patient seems beyond help and that there is no reason to doubt the sincerity of his consent.

One must recognize that in Nazi Germany the euthanasia program was carried out by the medical profession that viewed killing the incurable and those who were mentally defective as a healing act. Direct medical killing

began with permission for PAS in the case of infants who were incurable and adults but rapidly expanded to other categories of patients. In 1938, a man named Knauer wrote the German government asking that his blind and mentally retarded daughter, born without an arm and leg, be granted a merciful death. The chancellor instructed his personal physician, Dr. Karl Brandt, to investigate and, if the letter were true, to grant the request. Brandt found a child who he testified was born blind, an idiot – at least it seemed to be an idiot – and it lacked one leg and part of one arm. Brandt stated that the parents should not feel themselves incriminated at some later date as a result of this euthanasia – that the parents should not have the impression that they themselves were responsible for the death of this child. Many parents subsequently wrote asking for their children to be granted euthanasia. Both doctors and nurses preferred to use euphemisms, to allow for psychological defense mechanisms of rationalization and denial of what was really happening. It was determined by polls that parents preferred if they were told that their child had succumbed to this or that illness. As many as 6,000 children were provided euthanasia in this first phase of PAS in Germany (Lifton at 561). In May 1939, a program for euthanizing adults who were terminally ill, disabled, and mentally defective was set up in Berlin. The adult project was housed in Berlin at number 4 Tiergartenstrasse, giving rise to its code name "T-4." The T-4 physicians did not consider themselves to be killers, but ministers of medical treatment. Euthanasia was considered a "private matter" between a physician and his patient. Morphine, scopolamine, and prussic acid (cyanide) injections were initially used for the T-4 project because they had more of a medical aura than gas. Objections to the use of carbon monoxide gas were soon overcome because not only was it more efficient, but Brandt said that carbon monoxide was painless and would be the most humane form of death. We see that in Nazi Germany they argued that not killing those who were incurable who longed for death was the opposite of the sympathy.

Conclusion

There is no question that the foundations have already been laid in America for PAS and this type of euthanasia. It is both alarming and tragic that the Attorney Generals for both Washington and New York have had to institute litigation against physicians claiming a constitutional right to assist their patients in committing suicide. How incongruous it is that physicians who are obliged to preserve life – *primum non nocere* – have allowed themselves to simultaneously promote the killing of patients who have requested it. The Hemlock Society in December of 1997 claimed the

right to put to death individuals who are not able to ask for death themselves. Also at the beginning of 1998, two separate nurses at different institutions were charged with killing numbers of patients who were elderly and under their care. We already know that in America PAS has begun. We also know that there are numerous cases on individuals who were not brain dead and were killed by withholding and/or withdrawing food/fluids. We must learn from the history and practice of euthanasia in both Nazi Germany and Dutch Holland in order that we can prevent even worse injustices from being perpetrated – namely, leaping from withdrawal of treatment and tube feeding in order to cause death, to the prescription of lethal doses, and under the equal protection doctrine as established in various precedents, the administration of lethal injections by syringes or intravenous line for those unable to take lethal doses by mouth.

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