

Findings



Dedicated to the
Preservation of the Family

Physician-Assisted Suicide

Examining a Critical End-of-Life Issue

By Kristin Smith and Stephen Daniels



What authority do we have over the termination of our own life? Do we in any way have a particular power or right to make the decision to dispose of our own life? How far is it necessary

for us to go in order to protect and sustain our life and the lives of those around us? These are questions that are emerging as the medical community and governments around the world confront a growing movement to legalize physician-assisted suicide.

The debate over the sanctity of human life extends much further than the abortion issue. Issues surrounding end-of-life care and death have become paramount in the public policy arena. Words and key phrases such as “choice,” “self-determination,” and “rights” used throughout the abortion debate have been gradually brought into the right-to-die movement and have broadened the debate.¹ Patients and licensed health care professionals are caught in the midst of this debate, and lawmakers and courts are determining the long and short-term constitutional ramifications of the legalization of physician-assisted suicide.

Assisted suicide is an issue that is being debated in both legal and medical fields and is being confronted and challenged in many states, including North Carolina. This paper will explore the realities behind physician-assisted suicide, the legal and medical considerations and what the government’s role in regulating it should be.

What is Physician-Assisted Suicide

Physician-assisted suicide is defined as medical assistance provided to enable a patient to perform an act that is specifically intended to take his or her own life.² An example of assisted suicide would be a physician prescribing medication so that a

patient could take his or her own life by administering the drugs in a manner that would result in death.³ In assisted suicide, the patient is the one who takes his or her own life, but the physician’s assistance is a required component of this form of suicide. Physician-assisted suicide should be distinguished from euthanasia, in which the method of death is a direct action by the physician himself.⁴ Such direct action could involve the administration of a lethal injection, which would then cause the patient to die.⁵ To distinguish between assisted suicide and euthanasia, one must look at the last act leading to death in order

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to determine which took place. Using this distinction, it is clear that assisted suicide has taken place if the person who dies is also the person who performs the last act.⁶ This paper will only examine physician-assisted suicide.

With the procedure defined, one clarification must be made before making a case against it. Opposition to assisted suicide does not mean that therapies and treatments should be exhausted beyond reasonable means in order to keep the patient alive. There comes a time when a person has gone through every means necessary to preserve and prolong life. At that point, when extra medical care would prove futile, the natural process should be allowed to take the next step and the patient should be allowed to enter the dying phase.⁷ Most opponents of assisted suicide recog-

nize the desire for a natural death under the care of a physician who is using commonly accepted end-of-life care. This is not the problem. Instead, opponents of assisted suicide object to physicians taking a proactive role in providing a patient with the resources necessary for the patient to take his or her own life.

State Interest

Why should there be laws to govern assisted suicide? According to the Declaration of Independence, one of our nation’s founding documents, there is an “unalienable right” to life and liberty. The Constitution of North Carolina also recognizes this right and says that “no person shall be... deprived of his life.”⁸ An “inalienable right,” by definition, means one that cannot be forfeited, traded, or waived, even with one’s own consent. Therefore, it is incumbent on government to ensure that human life is protected. If for any reason that protection excludes any class of persons, such as the elderly or infirm, then the level of respect for every human is reduced and may lead to the eventual conclusion that certain lives are of lesser value and are therefore expendable.⁹ State government must be proactive in preventing suicide—including suicide assisted by a doctor.

The U.S. Supreme Court discussed several reasons why it is in the state’s best interest to discourage assisted suicide in their *Washington v. Glucksberg* ruling, a landmark decision handed down in July 1997. In their ruling, the Court found that there is no constitutional right to assisted suicide, and noted that there is a distinction between refusal of treatment and physician-assisted suicide.¹⁰ “Refusal of treatment,” the Court concluded, “is about being free of the bodily invasion of unwanted medical treatment, not a right to something.”¹¹ In addition to these conclusions, the Court listed several reasons why the state has a

vested interest in discouraging assisted suicide.

1. Each state is responsible for the preservation of human life and the prohibition on assisted suicide “reflects and advances its commitment to this interest.”¹²
2. The state has a responsibility to prevent suicide, making it a priority to study, identify, and treat its causes.¹³
3. It is the responsibility of the state to protect the integrity and ethics in the medical profession keeping the doctor’s role in society as that of one who provides healing to his or her patients never with the intention to harm.¹⁴
4. The state must uphold its responsibility to prevent the abuse of vulnerable members of society who are already at a disadvantage in society, such as the poor, elderly, and disabled. It must also protect vulnerable individuals from prejudice or inaccurate stereotypes that could indicate their lack of value or give a perception that they have an obligation to die.¹⁵
5. By permitting assisted suicide, a state may fear that this could lead to permitting voluntary or involuntary euthanasia.¹⁶

The Complexities of Regulation

Preserving and defending each citizen’s right to life is a legitimate role of government. As the Supreme Court made clear, the state does have an interest in ensuring that assisted suicide is prevented and that no one be deprived of his or her right to live. Should the state not act to prevent assisted suicide, there is the risk that a “slippery slope” could be created. If permitted, guidelines would have to be established to determine who would be allowed a physician-assisted suicide. However, despite these guidelines, a constant effort would be made to broaden these criteria. If terminally ill patients should be allowed to take their own lives, where is the line drawn? Should people who are deeply depressed also be allowed to do so? If certain citizens are given the option to commit assisted suicide, could it create the possibility for the decision to be based on poor or undesired circumstances in life, rather than one’s physical condition.

In the state of Oregon, where assisted suicide is currently legal, the safeguards currently in place are vague and cannot ensure that patients who intend to be candidates meet the proposed safeguards. For example, one safeguard states that a

candidate must be competent to communicate his medical decision.¹⁷ Competency requires that the patient understand his or her options and the weight of his decision. Depression is commonly found among patients who are terminally ill, and this depression could impair a patient’s understanding of his or her final options and intensify his burdens.

Another part of Oregon’s law that poses difficulty is the lack of clarity surrounding the requirement that a patient must be terminally ill and expected to live less than six months.¹⁸ With the advances in modern medicine enabling patients to live longer than ever before, it is difficult to accurately determine exactly how long a patient with a serious illness may live. Therefore, the definition of “terminal illness” is subjective to one particular doctor’s experience with that illness.

The primary factor influencing a patient’s interest in assisted suicide and euthanasia was not the physical pain he was experiencing, but the depression and hopelessness he was feeling.

The Medical Point-of-View

Physician-assisted suicide is not simply a legal issue, but one that clearly affects the medical community. Because physicians are the people most likely to be involved in carrying out the suicides, their insights on the issue are particularly relevant. According to Dr. Daniel Sulmasy of the American College of Physicians, “Legalization would undermine the patient-physician relationship and the trust necessary to sustain it, alter the medical profession’s role in society, and endanger the value our society places on life, especially the lives of disabled, incompetent and vulnerable individuals.” Therefore, according to Dr. Sulmasy, the underlying question is “should a physician who has sworn to do no harm be allowed, legally, to help a patient kill himself with prescribed lethal doses of barbiturates?”¹⁹ Several polls show that the prevailing argument is “no.” A national Wirthlin Worldwide poll conducted July 6-9, 2001 showed that 67% of those surveyed agreed that federal law should not allow the use of federally controlled narcotics and other dangerous drugs for the purpose of assisted suicide and euthanasia.²⁰ In

addition, the American College of Physicians—American Society of Internal Medicine, a 115,000-member organization, declared its opposition in a position paper that appeared in the August 7, 2001 edition of the *Annals of Internal Medicine*. The unified argument against assisted suicide was that the problems of inadequate care at the end of life must be solved and not avoided through practices such as assisted suicide.²¹

A research paper published in *The Journal of the American Medical Association* (JAMA) sought to “determine the attitudes of terminally ill patients toward euthanasia and assisted suicide, whether they seriously were considering euthanasia and PAS (physician-assisted suicide) for themselves, the stability of their desires, factors associated with their desires, and the proportion of patients who die from these interventions.”²² The research conducted for this study involved a total of 988 patients. According to the authors, this study was the first to use “terminally ill” patients—patients defined by their doctors as having six months or less to live. This is significant because the definition of “terminally ill” has been required as a safeguard for administering assisted suicide/euthanasia in Oregon and most proposals drafted for legalization. The results showed that a total of 10.6% of the terminally ill patients seriously considered euthanasia or assisted suicide. Factors that helped to deter assisted suicide consideration for terminally ill patients were an appreciation by friends and family, a confidence in their care-givers despite their illness, and being 65 years of age or older.²³

Factors associated with consideration for assisted suicide were: “depressive symptoms, substantial caregiving needs, and pain.” Interestingly, the primary factor influencing a patient’s interest in assisted suicide and euthanasia was not the physical pain he was experiencing, but the depression and hopelessness he was feeling. This finding runs contrary to the general perception that most patients who are considering assisted suicide do so in order to relieve physical pain. According to the study, “most of the key determinants or interest in euthanasia and PAS relate not to physical symptoms but to psychological distress and care needs.”²⁴ Another survey conducted in Oregon revealed that this psychological distress experienced by the patients was the decisive factor for choosing assisted suicide. Sixty-eight percent considered assisted suicide because they feared being a burden on their family. This is a significant increase from previous years

when the consideration of being a burden on the family was between 12 and 26 percent.²⁵

This research makes it clear that a patient's state-of-mind is affected by his emotional condition, which may make him more likely to desire assisted suicide. Therefore, more attention should be directed toward evaluating the whole person when a significant contributor such as depression is a treatable condition.

With these concerns in mind, "society should be finding ways of improving palliative care and support for family members during what is a distressing time, rather than pushing for the introduction of a right to die," states David Cotton of the New South Wales Right to Life.²⁶ Dr. Trevor Mudge, a spokesman for the Australian Medical Association, agrees. "If the intent is to improve the quality of life, then that's what doctors do, and that's why they should be about it. If the intent is to take another human life, that's not what the medical profession is about... and we should not be licensing people to do it."²⁷

The Right-to-Die Argument

The right-to-die movement has maintained its support for the legalization of assisted suicide by claiming a fundamental principle of patient autonomy.²⁸ According to the Hemlock Society, the right to die is a basic belief that end-of-life decisions should be an individual choice.²⁹ Supporters also argue that every human being of adult years and sound mind has a right to determine what should be done with his own body.³⁰ This is related to the contemporary trend toward emphasizing patient autonomy in bioethics and law, where it is argued that the decision to end one's own life is intensely personal and private, harms no one else, and should not be prohibited by the government or the medical profession.³¹ Therefore, many advocates for assisted suicide consider the government's interference in the dying process to be unconstitutional.

To date, the U.S. Supreme Court has not found any of these arguments supporting patient autonomy or the right-to-die to be persuasive as illustrated by their rulings in *Washington v. Glucksberg* and *Vacco v. Quill*. These cases were an effort by right-to-die advocates to show the constitutional "right" in choosing one's own death. In *Washington v. Glucksberg*, plaintiffs challenged the State of Washington's ban on assisted suicide claiming that it violated the Due Process Clause of the U.S. Constitution by placing an "undue burden on the exercise of that constitutionally protected liberty interest." However, the court determined that this "right" is not protected

by the Due Process Clause, saying that "this asserted right has no place in our nation's traditions given the country's consistent, almost universal, and continuing rejection of the right, even for the terminally ill, mentally competent adults. To hold for respondents, the Court would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every state."³²

In *Vacco v. Quill*, a ruling handed down around the same time as *Glucksberg*, the Supreme Court found that New York's prohibition on assisted suicide was not a violation of the U.S. Constitution's guarantee of equal protection. In this case, the plaintiffs challenged New York's assisted suicide ban claiming that preferential treatment was given to some terminally ill patients because they were allowed to discontinue life-support systems while others who wanted to accelerate their deaths through assisted suicide were prevented from doing so. However, the court determined that no one has the right to an assisted suicide and pointed out that each patient, regardless of condition, is able to refuse medical treatment.³³

The Supreme Court's decision here is important because it reveals an important distinction that should be made in this debate. There is a significant difference between dying of natural causes or refusing medical treatments and taking proactive steps to end one's life. The former is the prerogative of any terminally ill person. The latter, as the Supreme Court pointed out, is not. Advocates for assisted suicide claim there exists a right to take one's own life, yet such a "right" contradicts the principle that life itself is inalienable. If the right to live cannot be separated from oneself because it is inalienable, then the request to take it is invalid. In essence, a right-to-die cannot exist because it contradicts a pre-existing right to live.

Legal Status

Currently 38 states have statutes that explicitly criminalize assisted suicide. In addition, North Carolina, Alabama, Idaho, Massachusetts, Ohio, Vermont and West Virginia prohibit assisted suicide by common law or by the interpretation of their homicide statutes.³⁴ The legal status of assisted suicide has yet to be determined in Hawaii, Nevada, Utah, Wyoming and the District of Columbia. Oregon is the only state that legally permits physician-assisted suicide.³⁵

The North Carolina General Assembly has considered legislation to ban this practice, but has not approved any.³⁶

Consideration of such legislation is important as these proposed laws will help guard against the increase in efforts to legalize assisted suicide and prevent legal challenges as end-of-life care questions become increasingly prevalent in the growing aging population.

The need for states such as North Carolina to clarify their laws on this practice is further underscored by the lack of consistency in the federal policy regarding assisted suicide. Shifts in the position held by recent administrations, as well as, continuing litigation have left the federal government's final determination uncertain. During the Clinton administration, former Attorney General Janet Reno, after reviewing the Controlled Substances Act (CSA) and Oregon's "Death with Dignity Act," concluded that the use of controlled substances in congruence with assisted suicide was a medically legitimate purpose and that adverse action against a physician who had assisted in a patient's suicide was not authorized by the CSA. This administrative decision by Attorney General Reno overturned the DEA's first determination that drugs controlled by federal law may not be used for assisted suicide. Subsequently, Attorney General John Ashcroft determined that he was in agreement with the DEA's original interpretation and stated that assisted suicide was not a "legitimate medical purpose" and that prescribing, dispensing, or administering federally controlled substances to assist suicide is a violation of the CSA.³⁷ In addition, Ashcroft wrote "such conduct by a physician registered to dispense controlled substances may render his registration...inconsistent with the public interest and that if this mandate is disregarded by a physician and a controlled substance is used in an assisted suicide, the penalty would be to "revoke the DEA registration of that physician."³⁸

The U.S. District Court for the District of Oregon, however, found Attorney General Ashcroft's interpretation of the CSA to be faulty. The court stated in *Oregon v. Ashcroft* that the determination of what constitutes a legitimate medical practice has traditionally been left to the states, and that the CSA was never intended to allow an Attorney General to determine the legitimacy of a particular medical procedure without a specific congressional grant of authority. "[T]he fact the opposition to assisted suicide may be fully justified, morally, ethically, religiously or otherwise, does not permit a federal statute to be manipulated from its true meaning to satisfy even a worthy goal."³⁹

This ruling, however, does not mean that the federal government cannot restrict assisted suicide nationwide. Congress still has the ability to restrict or ban assisted suicide. Bills were introduced in the House of Representatives in 1998 and 1999 designed to accomplish this. However, only one of the bills passed the House and it did not pass the Senate.⁴⁰ Until decisive action is taken on the federal level, individual states will be left to determine how they will address the issue.

Conclusion

Every citizen, regardless of health or station, possesses an inalienable right to life. With this in mind, it is clear the state has an interest in protecting this valuable and fundamental right. Examining the legal perspective requires us to insist that the government should not sanction the premature ending of life. Instead, it should protect every citizen's rights to "life, liberty, the enjoyment of the fruits of their own labor, and the pursuit of happiness," as granted in the North Carolina Constitution.⁴¹ To do so, the state must reject any claim that a right-to-die exists, just as the U.S. Supreme Court has done. In the same way, the integrity of the medical profession must be upheld so that the traditional role of physicians to offer care to their patients is not undermined.

Although North Carolina's common law addresses physician-assisted suicide, the lack of clarity on the federal level and the advancement of the right-to-die movement may mean that state lawmakers will need to clarify state law. If so, these findings make a clear case for ensuring the protection of our most basic human right—the right to life.

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Endnotes

1. Bender, David. *Euthanasia: Opposing Viewpoints*. San Diego, California. Greenhaven Press. 1995.
2. Snyder, Lois and Daniel P. Sulmasy. "Physician-Assisted Suicide." *Annals of Internal Medicine*. July-Aug. 2001.
3. *Ibid.*
4. *Physician-Assisted Suicide and Euthanasia*. Focus on the Family. CitizenLink. Available at: www.family.org/cforum/. See also: Schemmer, Kenneth, M.D. Interview for NCFPC broadcast of "Family Policy Matters" radio program. Jan.12-18, 2002
5. Snyder, Lois and Daniel P. Sulmasy. "Physician-Assisted Suicide." *Annals of Internal Medicine*. July-Aug. 2001.
6. *Euthanasia & Assisted Suicide: Frequently Asked Questions*. International Task Force on Euthanasia and Assisted Suicide. Available online at: www.iaetf.org/faq.htm.
7. Rice, Charles E. Amicus brief filed in support of petitioners in *Vacco v. Quill*. American Life League. 1996. See also: Wattenberg, Ben. "Is There a Right to Die?" Think Tank Radio Transcript. PBS radio. Available online at: <http://www.pbs.org/thinktank/index.html>.
8. North Carolina State Constitution. Article 1, Section 19.
9. "Physician-Assisted Suicide." *Legislation and Policy Guide*. Americans United for Life. August 2001.
10. *Washington v. Glucksberg*, 521 U.S. 702, 117 S. Ct. 2258 (1997).
11. Snyder, Lois and Daniel P. Sulmasy. "Physician-Assisted Suicide." *Annals of Internal Medicine*. July-Aug. 2001.
12. *Washington v. Glucksberg*, 521 U.S. 702, 117 S. Ct. 2258 (1997).
13. *Ibid.*
14. *Ibid.*
15. *Ibid.*
16. *Ibid.*
17. Department of Human Services, Oregon Health Division, Center for Disease Prevention and Epidemiology. "Oregon's Death with Dignity Act: Three years of legalized physician-assisted suicide." February 22, 2001.
18. Oregon Revised Statute. 127.800 s.1.01. Definitions. (12).
19. Andrusko, David. Another Major Medical Voice Against Physician-Assisted Suicide. *National Right to Life News*. Sept. 2001.
20. National Right to Life. "Attorney General acts to bar use of controlled substances for assisted suicide. NRTL news. November 2001.
21. Snyder, Lois and Daniel P. Sulmasy. "Physician-Assisted Suicide." *Annals of Internal Medicine*. July-Aug. 2001.
22. Emanuel, Ezekiel J., Diane L. Fairclough and Linda L. Emanuel. "Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers." *Journal of the American Medical Association*. November 15, 2000.
23. *Ibid.*
24. *Ibid.*
25. Balch, Burke and Randall K. O'Bannon. "Why We Shouldn't Legalize Assisting Suicide, Part I." Department of Medical Ethics, National Right to Life Committee.
26. Goodenough, Patrick. "Hastening death in Australia: Doctors survey sparks debate." *CNS News*. November 19, 2001.
27. *Ibid.*
28. Rogatz, Peter. "The Positive Virtues of Physician-Assisted Suicide." *The Humanist*. November-December 2001. See also: Humphry, Derek. *Freedom to Die*. St. Martin's Press. New York, New York. 1998.
29. The Hemlock Society. *What Hemlock Believes*. Available online at <http://www.hemlock.org/about/beliefs.asp>.
30. Bender, David. *Euthanasia: Opposing Viewpoints*. Greenhaven Press. San Diego, California. 1995.
31. Snyder, Lois and Daniel P. Sulmasy. "Physician-Assisted Suicide." *Annals of Internal Medicine*. July-Aug. 2001.
32. *Washington v. Glucksberg*, 521 U.S. 702, 117 S. Ct. 2258 (1997).
33. *Vacco v. Quill*, 521 U.S. 793, 117 S. Ct. 2293 (1997).
34. "Physician-Assisted Suicide." *Legislation and Policy Guide*. Americans United for Life. August 2001.
35. Oregon Revised Statute. 127.800-127.995. Available online at <http://www.ohd.hr.state.or.us/chs/pas/ors.htm>.
36. N.C. General Assembly. HB 1012. *Physician-Assisted Suicide Unlawful*. See also SB 389. *Physician-Assisted Suicide Unlawful*.
37. "Dispensing of Controlled Substances to Assist Suicide." Memorandum to Asa Hutchinson Administrator of the Drug Enforcement Administration from Attorney General John Ashcroft. November 6, 2001.
38. *Ibid.*
39. *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1092, 1088 (D. Or. 2002).
40. *Ibid.* See also: H.R. 2260—Pain Relief Promotion Act of 1999 and H.R. 4006—Lethal Drug Abuse Prevention Act of 1998. Available online at www.congress.gov.
41. North Carolina State Constitution. Article 1, Section 1.

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