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The Supreme Court and Physician-Assisted Suicide — The Ultimate Right

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The U.S. Supreme Court will decide later this year whether to let stand decisions by two appeals courts permitting doctors to help terminally ill patients commit suicide.¹ The Ninth and Second Circuit Courts of Appeals last spring held that state laws in Washington and New York that ban assistance in suicide were unconstitutional as applied to doctors and their dying patients.^{2,3} If the Supreme Court lets the decisions stand, physicians in 12 states, which include about half the population of the United States, would be allowed to provide the means for terminally ill patients to take their own lives, and the remaining states would rapidly follow suit. Not since *Roe v. Wade* has a Supreme Court decision been so fateful.

The decision will culminate several years of intense national debate, fueled by a number of highly publicized events. Perhaps most important among them is Dr. Jack Kevorkian's defiant assistance in some 44 suicides since 1990, to the dismay of many in the medical and legal establishments, but with substantial public support, as evidenced by the fact that three juries refused to convict him even in the face of a Michigan statute enacted for that

purpose. Also since 1990, voters in three states have considered ballot initiatives that would legalize some form of physician-assisted dying, and in 1994 Oregon became the first state to approve such a measure.⁴ (The Oregon law was stayed pending a court challenge.) Several surveys indicate that roughly two thirds of the American public now support physician-assisted suicide,^{5,6} as do more than half the doctors in the United States,^{6,7} despite the fact that influential physicians' organizations are opposed. It seems clear that many Americans are now so concerned about the possibility of a lingering, high-technology death that they are receptive to the idea of doctors' being allowed to help them die.

In this editorial I will explain why I believe the appeals courts were right and why I hope the Supreme Court will uphold their decisions. I am aware that this is a highly contentious issue, with good people and strong arguments on both sides. The American Medical Association (AMA) filed an amicus brief opposing the legalization of physician-assisted suicide,⁸ and the Massachusetts Medical Society, which owns the *Journal*, was a signatory to it. But here I speak for myself, not the *Journal* or the Massachusetts Medical Society. The legal aspects of the case have been well discussed elsewhere, to me most compellingly in Ronald Dworkin's essay in the *New York Review of Books*.⁹ I will focus primarily on the medical and ethical aspects.

I begin with the generally accepted premise that one of the most important ethical principles in medicine is respect for each patient's autonomy, and that when this principle conflicts with others, it should almost always take precedence. This premise is incorporated into our laws governing medical practice and research, including the requirement of informed consent to any treatment. In medicine, patients exercise their self-determination most dramatically when they ask that life-sustaining treatment be withdrawn. Although others may sometimes consider the request ill-founded, we are bound to honor it if the patient is mentally competent — that is, if the patient can understand the nature of the decision and its consequences.

A second starting point is the recognition that death is not fair and is often cruel. Some people die quickly, and others die slowly but peacefully. Some find personal or religious meaning in the process, as well as an opportunity for a final reconciliation with loved ones. But others, especially those with cancer, AIDS, or progressive neurologic disorders, may die by inches and in great anguish, despite every effort of their doctors and nurses. Although nearly all pain can be relieved, some cannot, and other symptoms, such as dyspnea, nausea, and weakness, are even more difficult to control. In addition, dying sometimes holds great indignities and existential suffering. Patients who happen to require some treatment to sustain their lives, such as assisted ventilation or dialysis, can hasten death by having the life-sustaining treatment withdrawn, but those who are not receiving life-sustaining treatment may desperately need help they cannot now get.

If the decisions of the appeals courts are upheld, states will not be able to prohibit doctors from helping such patients to die by prescribing a lethal dose of a drug and advising them on its use for suicide. State laws barring euthanasia (the administration of a lethal drug by a doctor) and assisted suicide for patients who are not terminally ill would not be

affected. Furthermore, doctors would not be *required* to assist in suicide; they would simply have that option. Both appeals courts based their decisions on constitutional questions. This is important, because it shifted the focus of the debate from what the majority would approve through the political process, as exemplified by the Oregon initiative, to a matter of fundamental rights, which are largely immune from the political process. Indeed, the Ninth Circuit Court drew an explicit analogy between suicide and abortion, saying that both were personal choices protected by the Constitution and that forbidding doctors to assist would in effect nullify these rights. Although states could regulate assisted suicide, as they do abortion, they would not be permitted to regulate it out of existence.

It is hard to quarrel with the desire of a greatly suffering, dying patient for a quicker, more humane death or to disagree that it may be merciful to help bring that about. In those circumstances, loved ones are often relieved when death finally comes, as are the attending doctors and nurses. As the Second Circuit Court said, the state has no interest in prolonging such a life. Why, then, do so many people oppose legalizing physician-assisted suicide in these cases? There are a number of arguments against it, some stronger than others, but I believe none of them can offset the overriding duties of doctors to relieve suffering and to respect their patients' autonomy. Below I list several of the more important arguments against physician-assisted suicide and discuss why I believe they are in the last analysis unpersuasive.

Assisted suicide is a form of killing, which is always wrong. In contrast, withdrawing life-sustaining treatment simply allows the disease to take its course. There are three methods of hastening the death of a dying patient: withdrawing life-sustaining treatment, assisting suicide, and euthanasia. The right to stop treatment has been recognized repeatedly since the 1976 case of Karen Ann Quinlan¹⁰ and was affirmed by the U.S. Supreme Court in the 1990 *Cruzan* decision¹¹ and the U.S. Congress in its 1990 Patient Self-Determination Act.¹² Although the legal underpinning is the right to be free of unwanted bodily invasion, the purpose of hastening death was explicitly acknowledged. In contrast, assisted suicide and euthanasia have not been accepted; euthanasia is illegal in all states, and assisted suicide is illegal in most of them.

Why the distinctions? Most would say they turn on the doctor's role: whether it is passive or active. When life-sustaining treatment is withdrawn, the doctor's role is considered passive and the cause of death is the underlying disease, despite the fact that switching off the ventilator of a patient dependent on it looks anything but passive and would be considered homicide if done without the consent of the patient or a proxy. In contrast, euthanasia by the injection of a lethal drug is active and directly causes the patient's death. Assisting suicide by supplying the necessary drugs is considered somewhere in between, more active than switching off a ventilator but less active than injecting drugs, hence morally and legally more ambiguous.

I believe, however, that these distinctions are too doctor-centered and not sufficiently patient-centered. We should ask ourselves not so much whether the doctor's role is passive or active but whether the *patient's* role is passive or active. From that perspective,

the three methods of hastening death line up quite differently. When life-sustaining treatment is withdrawn from an incompetent patient at the request of a proxy or when euthanasia is performed, the patient may be utterly passive. Indeed, either act can be performed even if the patient is unaware of the decision. In sharp contrast, assisted suicide, by definition, cannot occur without the patient's knowledge and participation. Therefore, it must be active — that is to say, voluntary. That is a crucial distinction, because it provides an inherent safeguard against abuse that is not present with the other two methods of hastening death. If the loaded term "kill" is to be used, it is not the doctor who kills, but the patient. Primarily because euthanasia can be performed without the patient's participation, I oppose its legalization in this country.

Assisted suicide is not necessary. All suffering can be relieved if care givers are sufficiently skillful and compassionate, as illustrated by the hospice movement. I have no doubt that if expert palliative care were available to everyone who needed it, there would be few requests for assisted suicide. Even under the best of circumstances, however, there will always be a few patients whose suffering simply cannot be adequately alleviated. And there will be some who would prefer suicide to any other measures available, including the withdrawal of life-sustaining treatment or the use of heavy sedation. Surely, every effort should be made to improve palliative care, as I argued 15 years ago,¹³ but when those efforts are unavailing and suffering patients desperately long to end their lives, physician-assisted suicide should be allowed. The argument that permitting it would divert us from redoubling our commitment to comfort care asks these patients to pay the penalty for our failings. It is also illogical. Good comfort care and the availability of physician-assisted suicide are no more mutually exclusive than good cardiologic care and the availability of heart transplantation.

Permitting assisted suicide would put us on a moral "slippery slope." Although in itself assisted suicide might be acceptable, it would lead inexorably to involuntary euthanasia. It is impossible to avoid slippery slopes in medicine (or in any aspect of life). The issue is how and where to find a purchase. For example, we accept the right of proxies to terminate life-sustaining treatment, despite the obvious potential for abuse, because the reasons for doing so outweigh the risks. We hope our procedures will safeguard patients. In the case of assisted suicide, its voluntary nature is the best protection against sliding down a slippery slope, but we also need to ensure that the request is thoughtful and freely made. Although it is possible that we may someday decide to legalize voluntary euthanasia under certain circumstances or assisted suicide for patients who are not terminally ill, legalizing assisted suicide for the dying does not in itself make these other decisions inevitable. Interestingly, recent reports from the Netherlands, where both euthanasia and physician-assisted suicide are permitted, indicate that fears about a slippery slope there have not been borne out.^{14,15,16}

Assisted suicide would be a threat to the economically and socially vulnerable. The poor, disabled, and elderly might be coerced to request it. Admittedly, overburdened families or cost-conscious doctors might pressure vulnerable patients to request suicide, but similar wrongdoing is at least as likely in the case of withdrawing life-sustaining treatment, since that decision can be made by proxy. Yet, there is no evidence of

widespread abuse. The Ninth Circuit Court recalled that it was feared *Roe v. Wade* would lead to coercion of poor and uneducated women to request abortions, but that did not happen. The concern that coercion is more likely in this era of managed care, although understandable, would hold suffering patients hostage to the deficiencies of our health care system. Unfortunately, no human endeavor is immune to abuses. The question is not whether a perfect system can be devised, but whether abuses are likely to be sufficiently rare to be offset by the benefits to patients who otherwise would be condemned to face the end of their lives in protracted agony.

Depressed patients would seek physician-assisted suicide rather than help for their depression. Even in the terminally ill, a request for assisted suicide might signify treatable depression, not irreversible suffering. Patients suffering greatly at the end of life may also be depressed, but the depression does not necessarily explain their decision to commit suicide or make it irrational. Nor is it simple to diagnose depression in terminally ill patients. Sadness is to be expected, and some of the vegetative symptoms of depression are similar to the symptoms of terminal illness. The success of antidepressant treatment in these circumstances is also not ensured. Although there are anecdotes about patients who changed their minds about suicide after treatment,¹⁷ we do not have good studies of how often that happens or the relation to antidepressant treatment. Dying patients who request assisted suicide and seem depressed should certainly be strongly encouraged to accept psychiatric treatment, but I do not believe that competent patients should be *required* to accept it as a condition of receiving assistance with suicide. On the other hand, doctors would not be required to comply with all requests; they would be expected to use their judgment, just as they do in so many other types of life-and-death decisions in medical practice.

Doctors should never participate in taking life. If there is to be assisted suicide, doctors must not be involved. Although most doctors favor permitting assisted suicide under certain circumstances, many who favor it believe that doctors should not provide the assistance.^{6,7} To them, doctors should be unambiguously committed to life (although most doctors who hold this view would readily honor a patient's decision to have life-sustaining treatment withdrawn). The AMA, too, seems to object to physician-assisted suicide primarily because it violates the profession's mission. Like others, I find that position too abstract.¹⁸ The highest ethical imperative of doctors should be to provide care in whatever way best serves patients' interests, in accord with each patient's wishes, not with a theoretical commitment to preserve life no matter what the cost in suffering.¹⁹ If a patient requests help with suicide and the doctor believes the request is appropriate, requiring someone else to provide the assistance would be a form of abandonment. Doctors who are opposed in principle need not assist, but they should make their patients aware of their position early in the relationship so that a patient who chooses to select another doctor can do so. The greatest harm we can do is to consign a desperate patient to unbearable suffering — or force the patient to seek out a stranger like Dr. Kevorkian. Contrary to the frequent assertion that permitting physician-assisted suicide would lead patients to distrust their doctors, I believe distrust is more likely to arise from uncertainty about whether a doctor will honor a patient's wishes.

Physician-assisted suicide may occasionally be warranted, but it should remain illegal. If doctors risk prosecution, they will think twice before assisting with suicide. This argument wrongly shifts the focus from the patient to the doctor. Instead of reflecting the condition and wishes of patients, assisted suicide would reflect the courage and compassion of their doctors. Thus, patients with doctors like Timothy Quill, who described in a 1991 *Journal* article how he helped a patient take her life,²⁰ would get the help they need and want, but similar patients with less steadfast doctors would not. That makes no sense.

People do not need assistance to commit suicide. With enough determination, they can do it themselves. This is perhaps the cruelest of the arguments against physician-assisted suicide. Many patients at the end of life are, in fact, physically unable to commit suicide on their own. Others lack the resources to do so. It has sometimes been suggested that they can simply stop eating and drinking and kill themselves that way. Although this method has been described as peaceful under certain conditions,²¹ no one should count on that. The fact is that this argument leaves most patients to their suffering. Some, usually men, manage to commit suicide using violent methods. Percy Bridgman, a Nobel laureate in physics who in 1961 shot himself rather than die of metastatic cancer, said in his suicide note, "It is not decent for Society to make a man do this to himself."²²

My father, who knew nothing of Percy Bridgman, committed suicide under similar circumstances. He was 81 and had metastatic prostate cancer. The night before he was scheduled to be admitted to the hospital, he shot himself. Like Bridgman, he thought it might be his last chance. At the time, he was not in extreme pain, nor was he close to death (his life expectancy was probably longer than six months). But he was suffering nonetheless — from nausea and the side effects of antiemetic agents, weakness, incontinence, and hopelessness. Was he depressed? He would probably have freely admitted that he was, but he would have thought it beside the point. In any case, he was an intensely private man who would have refused psychiatric care. Was he overly concerned with maintaining control of the circumstances of his life and death? Many people would say so, but that was the way he was. It is the job of medicine to deal with patients as they are, not as we would like them to be.

I tell my father's story here because it makes an abstract issue very concrete. If physician-assisted suicide had been available, I have no doubt my father would have chosen it. He was protective of his family, and if he had felt he had the choice, he would have spared my mother the shock of finding his body. He did not tell her what he planned to do, because he knew she would stop him. I also believe my father would have waited if physician-assisted suicide had been available. If patients have access to drugs they can take when they choose, they will not feel they must commit suicide early, while they are still able to do it on their own. They would probably live longer and certainly more peacefully, and they might not even use the drugs.

Long before my father's death, I believed that physician-assisted suicide ought to be permissible under some circumstances, but his death strengthened my conviction that it is simply a part of good medical care — something to be done reluctantly and sadly, as a

last resort, but done nonetheless. There should be safeguards to ensure that the decision is well considered and consistent, but they should not be so daunting or violative of privacy that they become obstacles instead of protections. In particular, they should be directed not toward reviewing the reasons for an autonomous decision, but only toward ensuring that the decision is indeed autonomous. If the Supreme Court upholds the decisions of the appeals courts, assisted suicide will not be forced on either patients or doctors, but it will be a choice for those patients who need it and those doctors willing to help. If, on the other hand, the Supreme Court overturns the lower courts' decisions, the issue will continue to be grappled with state by state, through the political process. But sooner or later, given the need and the widespread public support, physician-assisted suicide will be demanded of a compassionate profession.

Marcia Angell, M.D.

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