

***A Doctor's Perspective on What
the Law Should Be for End-of-Life Issues* ©**

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Point Blank Range

Gloria was riddled with cancer and was suffocating. Most of her lung tissue was replaced by cancer and she looked to me to ease her suffering. “Doc ... I ... can’t go on. Do something ... please.” She gripped my wrist as hard as she could manage to emphasize the urgency of her aching and I watched her dusky violet lips as she wheezed the words. The days before her death were cruel and I think putting the responsibility on

her to take affirmative action was too much. How clumsy I felt with both of us sitting point blank with death and neither of us knowing exactly what to do.

An anonymous doctor aided his patient and described what he did in *It's Over, Debbie*.¹ "I entered [...] a gallows scene Her only words to me were, 'Let's get this over with.'" The physician aided and set off a firestorm of criticism doing something doctors have done for decades.

Unstable Law, Uneasy Patients, Unsure Physicians

Patients and their physicians swirl in a confusion with the law. In a knee jerk reaction one might conclude that this is a matter which ought to remain inviolable between physician and patient. How dare the state intrude onto the death bed! But physicians typically cure patients, not assist in death. Can death be part of a cure? It is for that reason that the right-to-die controversy requires a legal solution and is not amenable to an wholly medical cure.

To illustrate the legal instability and the reason for change consider that at the trial level, on the same facts, parties, and statutes, *Compassion in Dying v. Washington*,² the federal district court struck down Washington's ban on assisted dying and an appellate panel reversed, *Compassion in Dying v. Washington*.³ Then, in a rare *en banc* opinion the Ninth Circuit reinstated the trial court's decision.⁴ In *Quill v. Vacco*,⁵ the Second Circuit arrived at a similar position by overturning the New York statute which penalized a physician who assisted a mentally competent patient in dying. Most recently, in typical

¹ 259 JAMA 272 (1988).

² 850 F. Supp. 1454 (W.D. Wash. 1994).

³ 49 F.3d 586 (9th Cir. 1995), reh'g granted, 62 F.3d 299 (Aug. 1, 1995).

⁴ *Compassion in Dying v. Washington*, 1996 U.S. App. LEXIS 3944 (9th Cir. 1996).

⁵ 1996 U.S. App. LEXIS 6215 (2d Cir. 1996).

legal meandering, the United States Supreme Court, in *Washington v. Glucksberg*,⁶ failed to settle the question.

The Michigan Supreme Court did not find a right to physician-assisted dying when that state prosecuted Dr. Jack Kevorkian finding that there is no constitutional prohibition on imposing criminal penalties when a physician assists a person to commit suicide. There, politically motivated prosecutors ran up against the will of the people and juries acquitted Dr. Kevorkian twice ... and the frustrated prosecutor dropped charges the third time.⁷

Robert and Peggy Stinson were told that they were “bad parents,” characterized as “intellectually tight,” and that they “had no feelings, only thoughts and words and strategies,” when they sought a compassionate end to the life of their five-month old daughter who was 15 ½ weeks premature, weighed only a pound, and who spiraled downhill from her moment of birth. The hospital collected more than \$102,000 as residents experimented on this child in an inhumane futile effort.⁸

In a study published in the Journal of the American Medical Association of 4,301 terminally ill patients revealed that many suffered painful and prolonged deaths, even when they asked “to avoid aggressive, life-sustaining treatment.” Further, the families of these patients reported that half of the patients who were able to communicate spent “most of their time in moderate or severe pain.”

Interposed between patients and the state is the healing profession where doctors struggle on this ethical knife edge in an attempt to implement patients’ rights to autonomy

⁶ 1997 U.S. LEXIS 4039 (1997).

⁷ *Kevorkian v. Michigan*, 527 N.W.2d 714, 717 (Mich. 1995).

⁸ *On the Death of a Baby*, 244 THE ATLANTIC MONTHLY, July 1979, at 64.

while avoiding a murder charge. Caring doctors worry about official questions into their prescription of controlled substances. What doctor can attend a patient while feeling this legal noose around his own neck? The way the law *is* hamstringing the medical profession by the dilemma of its own tenets: first, do no harm; relieve suffering. And, if physicians are given the authority to actively assist, where will that authority begin and end?

Health care providers who ignore final wishes will be liable for the results. Recently, Brenda Young won a \$16.5 million judgment after her doctors ignored her wishes to permit her to end her life in Michigan where she suffered from devastating seizures. Against her will, this patient now spends her days thrashing and screaming in her bed “trapped in a body that is alive but not functioning.”⁹

Managed care interjects another factor into the mix. What bioethical principles will be applied in the face of economic realities?¹⁰ Managed care will exacerbate many ambiguities in the roles of physicians and patients. Is it possible that economic incentives could ultimately determine who lives and who dies under managed care?

Finally, technology has surpassed the imaginations of Jefferson, Hancock, and Franklin and we need cohesive approaches drawn from the Constitution to this problem which will affect potentially every citizen in every state. The “planned, unplanned, positive, and negative consequences of science and technology” now requires something

⁹ Stephen Cohen, *Medical Community Must Listen To The Needs Of Dying Patients*, SEATTLE POST-INTELLIGENCER, November 13, 1996, at page A11.

¹⁰ E. Haavi Morreim, *BALANCING ACT: THE NEW MEDICAL ETHICS OF MEDICINE'S NEW ECONOMICS* (1995).

beyond what the Constitution anticipated but it is neither necessary nor right to rewrite the Constitution.¹¹

Quinlan, Cruzan and the Constitutional Right To Assisted Dying

There already is a right to die and many find a constitutional right to assisted dying which can be applied to all members of society.¹² Advocates posit that the right should be limited to the terminally ill and a narrowly tailored statute must permit the state to exert its compelling government interest in the preservation of life. Kline points out that the state's interest recedes the sicker the patient becomes, so that as the patient nears death, his autonomy asymptotically rises. But can there exist a point at which there is a complete defeasance of state interest, where personal interest touches the abscissa?

The landmark case where one may have argued that the state had no further interest was *In re Quinlan*.¹³ Karen Quinlan, at twenty-one lapsed into coma. The family sought to remove their daughter from futile medical treatment ... except that she lived an additional nine years after the favorable ruling.

The *Quinlan* decision sanctioned the right to die with dignity, the right to avoid futile treatment for the terminally ill as a constitutional principle. As a consequence of the *Quinlan* decision, the New Jersey Supreme Court broadened its "right to die" standard ruling that it was permissible to withdraw all life-sustaining medical treatment, including intravenous line and feeding tubes from the terminally ill patient.

¹¹ Sandra Anderson Garcia, *Sociocultural and Legal Implications of Creating and Sustaining Life through Biomedical Technology*, 17 J. LEGAL MED. 469 (1996).

¹² Robert L. Kline, *The Right To Assisted Suicide In Washington And Oregon: The Courts Won't Allow a Northwest Passage*, 5 B.U. PUB. INT. L.J. 213, 214 (1996).

¹³ 355 A.2d 647 (1976), cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

The next step was *Cruzan v. Director, Missouri Department of Public Health*,¹⁴ where the Court stated “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”¹⁵

The fact that the Supreme Court did not find a due process right in *Glucksberg* within American jurisprudence does not mean that it isn't there. The justices just didn't find it.¹⁶ Advocates would allow patients and their families to decide at some point that the patient's quality of life was so severely diminished as to justify the withholding or termination of medical life support. The right to die is similar to the right to abortion, based on privacy and self determination: choice is choice.

Supporters feel that physicians and families must wrestle with the incurably ill and the suffering patient and that medicine should serve only to increase the conditions of the span of life, not uselessly prolong human suffering. One should be permitted to die in dignity and relative comfort.

Slippery Slope and Opponents

Opponents see physician-assisted dying as murder. In all instances, quantity of life supersedes quality of life. Traditional values permit killing as self-defense or to save an innocent person from a murderer. Then, opponents point to the slide down the slippery slope, that active euthanasia will include some who want to live. Constitutional scholar and Loyola University Chicago, School of Law Professor Alan Schoenberger noted that,

¹⁴ 497 U.S. 261 (1990).

¹⁵ Id. at 278.

¹⁶ Linda Greenhouse, *Whose Life is This?*, NEW YORK TIMES, January 5, 1997, at §4, page 1.

“The problem with Dr. Kevorkian is that he advocates the affirmative act. The potential for abuse is too great to permit the affirmative act.”

Opposition to assisted dying mainly comes from three directions: the Catholic Church, organized medicine, and political opposition. The Catholic view is that there is no absolute ownership right to one’s body and life is so precious that the fact of life overshadows the circumstances of life.

When Cardinal Joseph Bernardin realized that he had a short time to live,¹⁷ he wrote to the Justices of the United States Supreme Court and asked them to reject arguments that the dying have a right to physician assistance. “As one who is dying,” he wrote, “I ... appreciate the gift of life,”¹⁸ and he was concerned that there would be a false message given to society, that a less than perfect life is not worth living. The Catholic Church does not require continuation of medical care when it is futile, permits withdrawal of care and administration of medicines to make the patient comfortable, but draws a line at dying with help.¹⁹

Political voices are loud. Senator Orin Hatch, Chairman of the Senate Judiciary Committee, Representative Henry J. Hyde, Chairman of the House Judiciary Committee, and Representative Charles T. Canady, Chairman of the House subcommittee on the Constitution foresee a danger in creating the right to assisted dying that neither Congress nor the states will be able to explore contrary policies” and if that policy proves to be “misguided, great injury will have been done to thousands of vulnerable persons.”²⁰

¹⁷ Kenneth L. Woodward and John McCormick, *The Art of Dying Well*, TIME, November 25, 1996, at page 61.

¹⁸ *Id.* at 62.

¹⁹ GREENHOUSE at page 4.

²⁰ GREENHOUSE at page 5.

Organized medicine opposes physician-assisted dying as unethical but the profession is split. The American Medical Association and forty-five medical societies find that the power to take a life is “antithetical to the central mission of healing that guides both medicine and nursing.” The real danger, however, is the slippery slope argument: where will it stop? The right to physician assisted dying would create a profound danger for many ill patients who would choose dying rather than consider the alternative of “good palliative care.” Clearly, if physicians permit active euthanasia, then medical care will have turned a corner contrary to traditional teachings.

Linda Emanuel, AMA vice-president for ethics standards, said that the assisted-dying issue is a call “to the profession to re-examine medical care for the dying” and she recommends a compassion infusion in the form of additional education for providers in pain management, depression treatment, and in arriving at life plans.²¹

Geoffrey Fieger, who represents Kevorkian, says, “We don’t need more laws!” He continued, “Doctors should act according to professional standards according to existing criminal, licensure and civil laws. Let doctors implement the standard of care.” But this broad call to action ignores a real impediment to compassionate dying: doctors undermedicate patients since the physicians fear prosecution for violating controlled substance laws.

In an Harvard study, 79% of those aged 18 to 34 believe a physician should be allowed to give lethal injections to the terminally ill, but only 5.3% of older Americans agree. Other nations have regulated physician-assisted dying but not without controversy. According to the International Anti-Euthanasia Task Force there were 8100 deaths, not

reported as euthanasia, where doctors deliberately gave overdoses of drugs in order to bring about death. Nearly 5000 occurred without the patient's consent. Holland permits "involuntary euthanasia if the doctor can argue that this is what the patient would have wanted." Under American law, such latitude is excessive and what constitutes any standard of care is unknown.

Karen Quinlan's doctor, Dr. Joseph Fennelly, said he "would like to see dying as a rehabilitative state."²² The AMA concludes that the knowledgeable patient who receives compassionate care will not "seek the services of ... Jack Kevorkian" and claims that those who do seek dying, often change their minds when "their pain is alleviated or their depression cured." Of 45 provider groups which joined the AMA in asking the Supreme Court to ban euthanasia; only twenty-three were state medical societies.

Directives, Permission, the MODEL ACT

The law should reflect these goals: Patients need medical care and doctors need to be able to practice medicine without fear of criminal prosecutions and licensure revocations; society needs guidance.

Three changes in current law will meet the goals: (1) Advanced directives emphasis; (2) Official agencies must recognize that large amounts of opiates are needed to treat dying; (3) States should adopt statutes along the line of the Harvard Model Act which permits physicians to aid the dying but which prohibit active physician participation. 283

²¹ Julie Johnson, *Re-Examining Care For The Dying*, AMA December 23/30 1996, at page 3.

²² *Id.* at 37.

First, in terms of the ideal, at each stage of medical care, patients should be asked their wishes and should be encouraged to complete an appropriate directive. A directive requirement could be codified in Medicare and this modality has no opposition.

Second, clinicians need peace of mind and need state and federal legislation to permit the legitimate administration of opiates and other controlled substances without fear of prosecutions.

And finally, third, states should adopt the Harvard Model Act,²³ which is consistent with the *Compassion in Dying* decision where the court reasoned that Due Process is violated by any categorical ban on assisted dying which does not make exceptions for physician-assistance for terminally ill patients who competently request relief. This Act is similar to the Oregon Statute.²⁴

The Model Act endorses physician-assisted dying and draws the line between physician-assistance and voluntary active euthanasia. This makes sense since the nucleus of the end-of-life controversy is autonomy and consent. When the patient's motion reflects his volition this most clearly removes the ambiguity over consent. In the incompetent patient whose wishes are known, family members may implement those wishes under the Act.²⁵ To permit physicians more authority than to provide means, though, would go too far.

Under any Supreme Court decision states must remain free to control medical care within their boundaries and a federal constitutional amendment is inappropriate. To use

²³ Charles H. Baron, *et al.*, *A Model State Act To Authorize And Regulate Physician-Assisted Dying*, 33 HARV. J. ON LEGIS. 1 (1996); see <http://www.efn.org/%7ergo/mdlact.shtml>.

²⁴ *Oregon Statute on Doctor Assisted Dying*, (Measure 16, voted on and passed at the General Election, November 8, 1994).

²⁵ BARON at 10.

the Constitution by constitutional amendment to implement a particular political end is dangerous precedent. The problem is *intrastate* and seeking a federal constitutional amendment would trample states' rights. There is legitimate concern about judicial legislation, however, but this concern would be mollified by the action of individual state legislatures when each would custom tailor the Act to each state's needs.

Finally, in a subsequent test the Supreme Court should recognize the right to physician-assisted dying by upholding statutes such as those in Washington statute permit a physician to prescribe the means of death but it should draw the line in prohibiting anything further. This plan leaves states free to engage in legislation consistent with the principles of federalism and comity.

Conclusion

A group of physicians in Salem, Oregon has created a set of written guidelines to help the terminally ill patients die under the Oregon statute.²⁶ One thousand Oregon doctors oppose these guidelines and have called them "chilling." Since physicians most often accompany patients in end-of-life matters, it will be physicians who will require the support of the courts. In this regard, Justice Ruth Bader Ginsburg told *Compassion in Dying* lawyer Kathryn Tucker when she argued the case at the Supreme Court in January of 1997 that the solution belongs in the "legislative chamber." The Justice is legally correct but that path of analysis will prolong suffering.²⁷ Ultimately state legislatures must undertake this task but the ideal situation would be something different at this time.

²⁶ The Associated Press, *Doctor's Give Guidelines to Assist Suicide*, SEATTLE POST-INTELLIGENCER, August 15, 1997 at C8.

²⁷ Linda Greenhouse, *High Court Hears 2 Cases Involving Assisted Dying*, THE NEW YORK TIMES, January 9, 1997, at page 1.

The critical point with respect to the law in end-of-life issues is that procedures must never foreclose patient choice and must preclude abuse and the only way to do that requires the patient, or his surrogate, to act. All other considerations are secondary and no other solution will permit ethical physician participation: the patient is first. To permit anyone else to perform the act is unethical; unthinkable.

Dr. Tom Preston, Seattle cardiologist and a plaintiff in *Compassion in Dying*, heard the Supreme Court arguments and inferred from the Justices' questions that they need more medical facts about the abuse potential. "Safeguards must be developed and that is the main barrier at this time," he concluded. When the Justices hear the next case perhaps the statistics will be available with respect to safeguards and they will find the right. Then, after each state adopts a form of the Model Act, in conjunction with advanced directives and controlled substance policy changes, when challenges to those acts reach the Supreme Court, it will produce a result with which physicians, their patients, and all of us can live ... or die.