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Hastening Death

The Seven Deadly Sins of the Status Quo

Charles H. Baron, A.B., LL.B., Ph.D.

The law regarding end-of-life treatment is at an awkward and dangerous stage. In response to modern medicine's capacity to prolong life beyond the point some patients can bear, U.S. courts, beginning with *Quinlan*,¹ have effected a series of compromises in the law of homicide and assisted suicide. The compromises have left us feeling fairly secure as to the handling of the most common and pressing end-of-life dilemmas. However, they rely on a complicated, fictional conceptual framework that will not bear close scrutiny. Under current law, positive acts, like switching off a ventilator, are treated as mere "omissions to act." (At least when physicians take such action for consenting, terminally ill patients. Turning off a ventilator would clearly be treated as an "action" if you and I went into an ICU and did it on a drunken spree.) Physicians' acts in hastening death with pain medication are considered not to be acts of homicide if, and only if, the physician who prescribes the medication is thinking (while prescribing) that he or she is primarily trying to suppress pain and only incidentally shortening life. (That such acts are homicide, however, if the secret intention at the moment of prescription is to shorten the life of the suffering patient is reminiscent of the regime of birth control before *Griswold v. Connecticut*.² In those days, packs of condoms bore the legend, "For prevention of disease only." Whether someone using a condom was committing a crime or not depended upon whether he or she secretly harbored a forbidden intention to avoid pregnancy at the time of use.)

The present conceptual framework finds defenders in those who seek "bright line" distinctions between what is to be forbidden and what is to be permitted in ending the lives of terminally ill patients. Kamisar and Coleman, for example,

argue that we must cling to current boundary concepts to avoid sliding down a slippery slope to invidiously discriminatory involuntary euthanasia.³ However, there is little evidence that current concepts mark clear boundaries for those in practice. Foley, among others, has pointed out the difficulty physicians have in understanding and applying current criteria for deciding what is lawful and what is not;⁴ and experience over the years since *Quinlan* shows that grabbing at bright-line distinctions doesn't keep us from sliding down slippery slopes. *Quinlan's* recognition of the right of a patient in a persistent vegetative state to refuse (by proxy) an indefinite existence on a ventilator, for example, seems to have become today's right of any competent patient to hasten death by refusing to eat or to drink.⁵ Advocates of a bright-line distinction are continually forced to look for new stopping points. Kamisar, who used to argue that respect for human life would be unalterably undermined if laws regarding homicide and assisted suicide were interpreted to allow patients to refuse life-prolonging treatment, now takes only a rearguard position opposing exceptions for physician-assisted suicide and active euthanasia.⁶

Attempting to cling to bright-line distinctions does not seem to offer us much protection, and it comes at significant cost. In the case of the line purportedly drawn against physician-assisted suicide, we have created at least the following seven costly and dangerous problems that I shall call the "seven deadly sins of the status quo":

- inhumanity
- paternalism
- utilitarianism
- hypocrisy
- lawlessness
- injustice
- deadly risk of error and abuse

Inhumanity

Denying physician-assisted suicide as an option to terminally ill patients means enforced suffering for many patients. If hastening of death is available only to those who can obtain it through refusal of life-prolonging treatment, such as cardiopulmonary resuscitation or artificial ventilation, then patients who do not need such treatment are required to soldier on. (Ironically, the opposite may be true for terminally ill patients who require temporary life support or

an intervention to correct a life-threatening complication. They may feel forced into refusing treatment prematurely for fear that an option to refuse may not come later, at a time when they might dearly want it.) Of course, recent years have seen efforts to expand the concept of “refusal of treatment” to include refusal to drink or eat—an option that is available to any patient at any time. Even assuming that the law recognizes such a right to dehydrate or starve oneself to death, it hardly provides the humane option (for the patient or the patient’s loved ones) afforded by a system of physician-assisted suicide that might provide a swift, painless, and dignified death at a time of the patient’s choosing and in the company of his or her friends and family.

Paternalism

In denying legality to physician-assisted suicide, we are currently granting society the power to tell dying patients, “You must continue to suffer because it is good for you.” Some members of our society believe, as Callahan does, that suffering at the end of life may serve some important goal for the dying person. “Our duty,” he says, “is to enhance one another’s good and welfare, and the relief of suffering will ordinarily be an important way to accomplish that. But not always. What we need to know is whether the suffering exists because without it some other human good cannot be attained; and that is exactly the case with the suffering caused by living out one’s moral duties or ideals for a life.”⁷ Adherents of such a view may base their paternalism on avowedly religious grounds. In some religious systems, suicide is forbidden under all circumstances—even if it is to avoid unbearable suffering while facing imminent death from a terminal disease. Certainly, those who wish to follow such religious precepts by bravely bearing a long and painful dying process should have the right to do so—whether or not society believes it is good for them. On the other hand, why shouldn’t those who are not so committed have the same right to decide what is best for themselves? Imagine a legislature dominated by Jehovah’s Witnesses: Would we tolerate its members’ forbidding those of us who are not adherents of their religion the right to a life-saving blood transfusion because they believed it to be proscribed in the Bible?

Of course, Jehovah’s Witnesses have typically been victims, rather than practitioners, of medical paternalism. In the 1960s and early 1970s, blood transfusions were often forced on them “for their own good.” Doctors who believed that rejecting life-saving treatment on such religious grounds was irrational got the legal system to support them in that judgment.⁸ American physicians were

at the peak of their power to decide what was best for their patients. In a 1961 article in the *Journal of the American Medical Association*, Oken reports that oncologists regularly refused to tell patients the truth about their condition. “Most people do not want to know,” was a typical reason given for not being honest. “Knowledge of cancer is ‘a death sentence,’ ‘a Buchenwald,’ and ‘torture.’ Telling is ‘the cruelest thing in the world,’ ‘awful,’ and ‘hitting the patient with a baseball bat.’” However, study after study had demonstrated that the vast majority of cancer patients actually wanted to be told the truth. How to explain the discrepancy? Oken concludes,

Avoidance of telling reflects the psychological problems of the doctor. If any group is constantly bombarded with the awful fact of death it is doctors—the same group which has such strong needs to conquer it. . . . Situations of this kind, associated with intense charges of unpleasant emotions, call forth a variety of psychological defenses which reduce the intensity of feelings to manageable proportions. Among such defenses are those which involve the avoidance, negation, or denial of the existence of some unpleasant fact, and acting as if it were not real.⁹

Similarly, those physicians who today oppose legalization of physician-assisted suicide may be concerned more with their own feelings than with their patients’ welfare. Solomon has documented the fact that physicians tend to avoid methods of hastening death that leave them feeling directly responsible for “killing” the patient.¹⁰ They prefer ending life-prolonging treatment over assisting suicide and, still more, favor not starting such treatment over stopping it once it’s begun. “Among the motivations for entering medicine,” Oken observes, “the wish to conquer suffering and death stands high on the list. Practicing physicians are not the kind of persons who can sit quietly by while nature pursues its course.”¹¹ The law no longer allows the physician’s needs to outweigh those of the patient when it comes to sitting quietly by “while nature pursues its course.” The law should not allow them to trump those of the patient as regards legalization of the practice of physician-assisted suicide.

Utilitarianism

The most common form of argument made in support of the status quo essentially tells dying patients, “You must continue to suffer because it is good for *us*.” Dying patients’ interests, it is said, must be sacrificed for the public good. One variant is the claim that keeping physician-assisted suicide illegal helps mo-

tivate the health care system to improve delivery of palliative care. Reducing patient suffering by allowing physicians to hasten death makes it too easy, this argument contends, for society to escape its obligation to render dying more comfortable. Foley and Hendin, for example, endorse “the World Health Organization recommendation that governments not consider the legalization of physician-assisted suicide and euthanasia until they have demonstrated the full availability and practice of palliative care for all citizens.”¹² It is hard not to sympathize with any strategy for improving the delivery of palliative care; but what evidence is there that forcing individual patients to undergo unnecessarily prolonged lives will succeed in doing that? Indeed, empirical evidence from the Oregon experiment would seem to demonstrate just the opposite—that delivery of palliative care improves when physician-assisted suicide is an option.¹³

Most troubling, this strategy conscripts suffering patients as cannon fodder—and for what is likely to be a very long campaign. (“I’m sorry, Mr. Smith. Letting you end your life early to avoid your personal suffering is too easy an out for the health care delivery system. We can’t let anyone do that until the system has demonstrated to our satisfaction that there is ‘full availability and practice of palliative care for all citizens.’”) If winning the palliative care battle in this way really makes sense and has moral validity, why aren’t we denying patients the right to refuse life-prolonging treatment in situations in which better palliative care might have prevented them from throwing in the towel? This would put at stake the suffering of many thousands more patients each year and would presumably apply that much more pressure on “the system.”

A willingness to sacrifice the interests of individual dying patients for those of society as a whole is also at the heart of every form of “slippery-slope” argument made in support of the status quo. Opponents of physician-assisted suicide warn us that the price of too much compassion for a particular suffering, terminally ill patient may be abuse of other patients and a general undermining of respect for human life. These seem to be empirical claims—appeals to laws of cause and effect. However, it is sometimes hard to know exactly what is being predicted. That doctors or relatives will not fully understand how to use the criteria for determining when it is all right, and when not, to assist a suffering patient to end his life? That they will make mistakes in determining the relevant facts? That they will cheat (out of self-interest, on the basis of prejudice, and the like)? Or is it a more global claim that the bonds of civilization will be generally cast aside once our society no longer enshrines as an absolute principle the sanctity of human life?

Whatever the precise import of the claims, they are serious and deserve to be taken seriously. They were, of course, taken seriously by the U.S. courts that

gradually fashioned what has become the right to refuse life-prolonging treatment. At each stage, the courts recognized that respect for the rights of individual suffering patients required more than merely giving in to fear of the unknown. Taking tentative steps, the courts promulgated substantive standards and procedural protections that were designed to mitigate the risk of slippery-slope problems while freeing palliative care practitioners to act with greater respect for patient autonomy and increased compassion for the plight of the terminally ill.¹⁴

Would legalizing physician-assisted suicide make the risks any greater or more intractable? The patient who is considering a hastened death by refusal of life support is no less vulnerable to depression, coercion, prejudice, financial pressure, ineffective communication, mental incompetence, failure of adequate palliative care, impatience of medical personnel, or mistaken prognosis or diagnosis than the patient who is considering a hastened death by physician-assisted suicide. Indeed, as to some of these risks, legalization of refusal of treatment would seem more dangerous than legalization of physician-assisted suicide. Is a vulnerable patient more likely to succumb to a request that she commit suicide or to the statement, "You know, Mrs. Jones, maybe we've put you through enough. Maybe it's time to think of giving up?" Are impatient or prejudiced medical personnel more likely to be tempted to cut financial and emotional costs by means of physician-assisted suicide or by terminating life-prolonging treatment that they can claim has become "medically inappropriate?" Ironically, there may be less slippery-slope basis for denying patients the option of physician-assisted suicide than for denying them the right to refuse treatment. At the very least, there is no more.

Hypocrisy

A major vice of the current regime is its corrupting influence on the health care professions. An air of hypocrisy currently surrounds the practice of palliative care. Despite the illegality of physician-assisted suicide and euthanasia, many health care professionals admit to engaging in one or the other practice when they feel circumstances require it. "Don't worry," they will say in private (almost with a wink), "such steps are being taken when they need to be. Everyone knows that they are. The law doesn't need to get involved here. Better to leave all this to the individual physician's clinical judgment." Although the American Medical Association takes a public stand against physician-assisted suicide,¹⁵ it seems opposed only to its legalization, not to its practice. Despite a number of articles

reporting fairly widespread practice of physician-assisted suicide—some of them published in the pages of its own journal¹⁶—the association has not taken steps to find out who these physicians are in order to have them disciplined. Indeed, it has not even expressed shock to find that the practice is going on. Rather than being concerned with protecting society and patients from the evils of assisted suicide, the American Medical Association appears concerned to protect its members from the evils of legalization—the bad public relations or increased legal oversight that might result from an admission that doctors sometimes take positive steps to terminate the lives of suffering patients.¹⁷

Lawlessness

Physicians are not the only ones taking the law into their own hands. Mercy killings by family members are regularly reported in the press; many more most likely go unreported and undetected. Prosecutions are often dropped, grand juries do not indict, and trial juries acquit. When there are convictions, they are usually followed by light sentences. As a particularly striking example, consider the case of Vernal “Bob” Ohlrich of Nebraska. In October 1998, when Mr. Ohlrich was seventy-six, he responded to his seventy-four-year-old wife’s pleas for relief from the pain she suffered while being treated for colon cancer by entering her hospital room with a gun and killing her with one shot to the head. Mr. Ohlrich then turned the gun on himself, but it misfired. He was charged with first-degree murder but avoided trial by agreeing to plead to manslaughter. In a bizarre twist, the state pathologist who autopsied Mrs. Ohlrich reported her to have been free of cancer at the time of her death. The prosecutor accepted the results of the autopsy but, noting that Mrs. Ohlrich had once been diagnosed with cancer and was in pain at the time of her death, recommended that Mr. Ohlrich serve only a short term in prison.¹⁸ In July 1999 Mr. Ohlrich was sentenced to two years in a correctional facility. (The maximum penalty for manslaughter in Nebraska is twenty years in prison and a \$25,000 fine.) A year later, he was paroled.¹⁹

Mr. Ohlrich fared better than sixty-six-year-old Dietrich “Whitey” Brandt of Pennsylvania, who was sentenced to life imprisonment for beating his sixty-five-year-old wife to death with a two-foot-long oxygen tank in answer to her prayers for death to end her suffering from asthma, congestive heart failure, and diabetes.²⁰ Mr. Ohlrich did not do as well, however, as forty-two-year-old Susan Scheufler of New York. She smothered her fifty-five-year-old terminally ill husband with a pillow on his deathbed. The Rensselaer County district

attorney refused to prosecute.²¹ Overall, mercy killings receive increasingly lenient treatment. Back in 1985, when seventy-five-year-old Roswell Gilbert shot to death his seventy-three-year-old wife to end her suffering from Alzheimer's disease and osteoporosis, the State of Florida convicted him of first-degree murder and sent him to prison for life. In 1990 the governor pardoned him.²² By 1998 a Florida court felt it could acquit seventy-two-year-old Justina Rivero of attempted murder (on grounds of insanity) for having laced her Alzheimer's-afflicted husband's food with rat poison.²³ In that same year, a Florida prosecutor refused even to bring charges against seventy-one-year-old Elaine McIlroy after she confessed three times to three different police departments that she had assisted the suicide of her seventy-five-year-old, leukemia-suffering husband by sprinkling the contents of Seconal tablets over his chocolate ice cream. Florida judges and prosecutors expressed decreased willingness to pursue such cases because they viewed them more compassionately than they previously had and because of "lack of evidence, uncooperative family members, and juries' reluctance to convict defendants."²⁴

Injustice

Manifestly, those who break the law to end the suffering of patients and loved ones cannot expect equal treatment under law. Whether they will be sentenced to life in prison or left completely alone will depend on the luck of their draw of police officers, emergency medical personnel, public prosecutors, grand juries, trial juries, and judges—each of whom will have the chance to exercise his or her discretion for or against leniency. Similarly, terminally ill patients cannot expect just treatment under such a system. Although physician-assisted suicide is technically illegal in almost all American jurisdictions, it most likely takes place in all of them. Whether it will be available, however, to any given patient will depend (everywhere but Oregon) less on the merit of that patient's case than on his or her ability to find an empathetic and courageous physician who feels safe with the patient, the patient's family, and the patient's attending medical personnel. In this respect, the present regime regarding physician-assisted suicide is much like that regarding abortion before *Roe v. Wade*. In the 1960s and the early 1970s, women with the right connections found physicians to provide them with professional help; those without were abandoned to the often grotesque ministrations of amateurs. Today, it is the terminally ill patient—unable to obtain physician assistance in suicide—who may be forced to resort to a gunshot to the head or rat poison sprinkled on dessert.

The Deadly Risk of Error and Abuse

Maintaining the present legal regime unduly heightens the risk of deadly mistakes and abuse in the treatment of terminally ill patients. In the face of increasing sympathy for the plight of suffering patients, the legal system largely looks the other way when physicians—and even family members—assist in suicide. Of course, persons providing assistance have to keep in mind that there is always the chance that they could be caught and punished, and some argue that the threat of punishment provides a check against abuse sufficient to ensure that assistance in suicide and euthanasia will be employed in only the most compelling and meritorious cases.²⁵ In the 1970s some commentators similarly argued that the threat of criminal punishment was enough to regulate decisions to withdraw life-prolonging treatment from terminally ill patients.²⁶ However, we have wisely abandoned the “slow codes” and secret do-not-resuscitate orders of days gone by in favor of open procedures for permitting patients to die without undergoing last-ditch efforts at resuscitation. Post hoc criminal review is a very rough tool for regulating such sensitive decisions—especially when both the life of the patient and the freedom and reputation of the actor are at stake. Criminal review comes too late to rectify any errors, such as the apparent error involved in diagnosing colon cancer as the source of Mrs. Ohlrich’s pain, and at a time when patients can no longer be interviewed as to whether steps were taken on the basis of their competent, informed, and voluntary consent.

Leaving regulation to the possibility of post hoc criminal review also discourages honest communication among health care professionals and between professionals and their patients.²⁷ It inhibits helpful professional consultations and the development of medical protocols. Fear of open discussion creates the possibility that physician’s orders or patient’s wishes will be misread.²⁸ Making matters worse, the chilling effect of post hoc criminal review extends beyond the realm of technically illegal practices such as physician-assisted suicide. Among other things, physicians’ fear of appearing after the fact to have intentionally hastened a patient’s death with morphine, as Foley points out, is a leading cause of undertreatment of pain in terminally ill patients.²⁹

The risk of deadly mistakes and abuse in the treatment of terminally ill patients is exacerbated in yet another way by the current regime. In attempting to maintain a bright-line distinction between physician-assisted suicide and refusal of life-prolonging treatment, the regime does not treat decisions opting for the latter as seriously as it should. Today, we recognize not only the right of

Jehovah's Witnesses and others to refuse treatment on the ground that the treatment itself is offensive to them and the right of patients or their proxies to decide that, on balance, the patient would prefer to die relatively comfortably without chemotherapy than live a somewhat extended uncomfortable life with chemotherapy, but also the right of a patient who has decided that life no longer has any meaning for him or her to end that life by refusing life-prolonging treatment. In *Brophy v. New England Sinai Hospital, Inc.*, for example, Brophy's exercise of his right to refuse life support was not based on any objection to artificial nutrition or hydration; it was based on his frequently expressed preference to have his life terminated by any means if he were ever to end up in a persistent vegetative state. It just happened that ending artificial nutrition and hydration was a convenient, if not the most merciful, way to accomplish that end.³⁰

Such decisions to die raise the same issues of patient autonomy and compassion toward suffering patients that are raised by physician-assisted suicide, and they face all the same risks of abuse and mistake. Yet the present regime categorizes them as mere determinations to "let nature take its course." Coleman, for one, sees the danger in this and calls on us to work with the organization Not Dead Yet "to minimize the damage resulting from professional, cultural, and economic factors in the context of refusal of treatment." (Indeed, all of the cases of abuse of the disabled that she points to are cases involving refusal of treatment.) She herself, however, is so caught up in the effort to retain "the *relatively* 'bright line' distinction between passive measures that cause death and active measures that cause death" that she treats the problem of abuse of passive euthanasia as a lesser priority.³¹

Moving Forward

In 1691 the Virginia Colony passed a law forbidding freed slaves from continuing to reside within its boundaries.³² The society could not abide the presence of living counterexamples to its racist theories of the black man's inability to become civilized and to live with whites in anything but a state of servitude. Today, in similar fashion, U.S. Attorney General John Ashcroft and other foes of legalization of physician-assisted suicide feel they must do all they can to terminate the Oregon experiment. It is a living contradiction of their claims that progressing beyond the current regime will inevitably lead to unchecked abuse and invidious discrimination. As legal experiments go, the Oregon law has been extraordinarily successful. Over time, problems will doubtless surface,

and changes will have to be made to correct them. Nevertheless, the five-year Oregon experience demonstrates that there is no longer need to fear the unknown. Whether through common-law development in the courts or by legislative action, it is time to move on to the next stage in making laws that show greater respect for patient autonomy and increased compassion for the plight of the terminally ill.

Notes

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