

Volume 2 | Number 1 (Spring/Summer 2016)
www.jheaonline.org
ISSN 2474-2309
doi:10.22461/jhea.2.7163



CASE STUDY

Physician Assisted Suicide: A Review of Oregon Death with Dignity Act (ODDA)

ALOYSIUS OCHASI, D. BIOETHICS

aochasi@sju.edu

The Institute of Clinical Bioethics, Saint Joseph's University, Philadelphia, Pennsylvania, U.S.A.

*Address correspondence to: The Institute of Clinical Bioethics, Saint Joseph's University, 5600 City Ave, Philadelphia, PA 19131, U.S.A. E-mail: aochasi@sju.edu

Find this and more works at www.jheaonline.org

This work is brought to you for free and open access by the Institute of Clinical Bioethics (ICB) at Saint Joseph's University, Philadelphia, PA, U.S.A. It has been accepted for inclusion in *The Journal of Healthcare Ethics & Administration* by editorial board and an authorized administrator of the *JHEA*. For more information, please contact admin@jheaonline.org

CASE STUDY

Physician Assisted Suicide: A Review of Oregon Death with Dignity Act (ODDA)

ALOYSIUS OCHASI, D. BIOETHICS

aochasi@sju.edu

The Institute of Clinical Bioethics, Saint Joseph's University, Philadelphia, Pennsylvania, U.S.A.

Abstract: *The passage of the Oregon Death with Dignity Act (ODDA) on November 8, 1994, 51 percent to 49 percent, legalized Physician-Assisted Suicide (PAS) in Oregon. This has generated legal, medical, social and ethical controversies. Medically, the lethal drugs (barbiturates) prescribed by physicians for terminally ill patients can kill them within minutes but may not also kill them. Legally, the U.S Supreme Court in 1997 ruled that there is no constitutional 'right to die,' and paved the way for states to legalize PAS. Ethically, PAS goes against the Hippocratic Oath, destroys the trust on which the physician-patient relationship is anchored, and violates the natural law that prohibits killing of self and others. It violates the dignity and sanctity of human life. Guided by a case study, (Helen), autonomy and mercy for the suffering terminally ill (reasons for PAS) is counteracted by viable options of palliative and hospice care, that could give comfort and reduce pain up to 97%. Clinical depression when diagnosed and treated (a safeguard that ODDA does not enforce), most patients abandon their desire for death. When suffering prevails after all is done, Christian faith teaches that there is value in suffering which could be redemptive: redemptive suffering modeled after the suffering of Jesus Christ.*

Keywords: *Oregon Death with Dignity Act, palliative care, hospice care, autonomy, terminal illness.*

INTRODUCTION

Physician Assisted Suicide (PAS) is one of the most sensitive and controversial issues facing the country as a whole, and the healthcare industry in particular. PAS became legal in the state of Oregon in 1994, and this year alone two other states Washington State and Montana have joined Oregon, making PAS legal in three states. Between January 1994 and June 2009, there have been 113 legislative proposals in 24 states (11 states alone in 2009). This is a very troubling trend that is catching fire so fast. The Spring 2009 edition of "The Dignity Report" has identified about 8 states who may likely be considering PAS as a ballot initiative in 2010 or 2012.¹ One could only predict that it is just a matter of time before other states follow these three pacesetters. In Europe, PAS is legal in Netherlands, Belgium and Switzerland. The scope of this paper is limited to the United States and specifically the state of Oregon.

This paper will review legalization of PAS in Oregon under the Oregon "Death with Dignity Act" which became legal in 1994. The intended focus of this paper will be fourfold: following the preliminary consideration, which will incorporate an expose of the Oregon law, the medical issues surrounding PAS will be considered. Secondly, the legal aspects of ODDA will be examined, with a review of the United States Supreme Court's ruling of 1997. Thirdly, the ethical issues involved with PAS will be discussed and analyzed, which will view the arguments from both the proponents and opponents. Finally, with the contemporary natural

¹ Excerpts from a lecture delivered by Ron Hamel, at the Annual McCormick Lecture on "Dying in America: Is the "Fragile Consensus" eroding"? St. Joseph's University, PA. October 7, 2009.

law as my objective norm of morality I will argue (using the case study as a guide), that PAS is against the natural law and a violation of the sanctity of human life. I am contending therefore, that the PAS not only goes against the natural law that forbids suicide and direct killing, but destroys the very fabric of trust on which physician-patient relationship is built. We will conclude with a presentation of palliative and hospice care as alternatives to PAS, and reaffirm the Christian value of suffering: redemptive suffering.

CASE STUDY: HELEN

This case was based on a news conference given by the Compassion in Dying in Oregon. The conference described how a patient in her mid-eighties, who had been diagnosed with metastatic breast cancer and who was then living in a hospice, came to choose assisted suicide. Helen's own physician had refused to assist in her suicide for unspecified reasons. A second physician refused on the grounds that Helen was depressed. Helen's husband then called Compassion in Dying and was referred to a physician who would assist her. The medical director of Compassion in Dying said that he had spoken by phone with Helen at the time of the referral and also spoke by phone to her son and daughter. He described Helen as "rational, determined and steadfast" and questioned the opinion of the physician (with whom the medical director also spoke by phone) who described her as having a depression that was affecting her desire to die. He said Helen was "frustrated and crying because she was feeling powerless." He said she had been doing aerobic exercises up until two weeks before she contacted him but told him she could not do them anymore. She was also unable to continue to garden, which had been one of her favorite activities. The medical director said she was not bedridden, was not in great pain, and was still able to look after her own house. He said the "quality of her life was just disappearing," and he thought it prudent to act quickly before Helen lost the capacity to make decisions for herself. He said she was "going downhill rapidly. . . . She could have had a stroke tomorrow and lost her opportunity to die in the way that she wanted." The physician who agreed to prescribe the medication had met Helen two and a half weeks before she died and described her as having more physical discomfort than Compassion in Dying had indicated. He said that after twenty years the cancer had spread to her lungs, causing some pain and shortness of breath. He followed a protocol that included an anti-nausea medication that Helen had taken before he arrived to be with her and her family when she died. She then took a mixture of barbiturates (nine grams) and syrup followed by a glass of brandy. She is said to have died within thirty minutes.²

PRELIMINARY CONSIDERATIONS

Etymologically, euthanasia literally means "good death" (eu-good; thanatos-death). The Congregation for the Doctrine of the Faith defines euthanasia as "an action or an omission which or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used."³ It could be active/direct or passive/indirect. Active euthanasia is a deliberate intervention by someone other than the person whose life is at stake, solely intended to end his or her life. This could be voluntary or involuntary. Passive euthanasia is the withholding or withdrawing of life-sustaining medical treatment from a patient with the intent of causing death.⁴ This has to be distinguished from allowing a patient to die (via withholding or withdrawing treatment) which is morally acceptable in Catholic teaching because its intention is not to cause death.

Bioethicist James Rachels makes a distinction between the two types of euthanasia when he noted: "the important difference between active and passive euthanasia is that, in passive euthanasia, the doctor does not do anything to bring about the patient's death. The doctor does nothing, and the patient dies of whatever ills already afflict him. In active euthanasia, however, the doctor intentionally (formal cooperation) does something to bring about the patient's death: he kills him."⁵

Physician-assisted suicide occurs when a physician helps a competent patient take his or her own life by giving advice, writing a prescription for lethal medication, or assisting the individual with some device which allows the patient to take his or her own life. One may say that, the doctor provides the gun, and the patient pulls the trigger (material cooperation). PAS and euthanasia have the same moral goal or intent- the premature death of the patient. This has led ethicists like Richard Gula to say that PAS may not be morally different from euthanasia, and need not be distinguished from euthanasia for purposes of

² This case study was culled from an article on "Physician-Assisted Suicide: A Medical Perspective" Herbert Hendin and Kathleen Foley in *Michigan Law Review*; Vol. 106, June, 2008, 1616-1617.

³ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (Rome:1980), Section II

⁴ Michael Manning, *M.D. Euthanasia and Physician-Assisted Suicide: Killing or Caring* (New York: Paulist Press, 1998), 4

⁵ James Rachels, "Active and Passive Euthanasia," *Critically Thinking About Medical Ethics*, ed. R. Card (NJ: Prentice Hall, 2004), 209

understanding the moral vision, and values at stake in the euthanasia debate.⁶ Many physicians think there is a difference between the two. Elaborating on the difference, Marcia Angell, M.D, a medical ethicist, noted that “both withdrawing treatment and euthanasia do not require the participation of the patient. Either could be done without the patient’s cooperation. In contrast, assisted suicide- the morally “intermediate” act- does require the patient’s participation. To die, the patient must swallow the pills- a voluntary act of a necessarily aware patient.”⁷ Surveys show that some physicians might be willing to assist in suicide than perform active euthanasia for a wide range of reasons. The limited scope of this paper does not permit us to explore these differences more broadly, but suffice it to say that in the course of this paper, PAS and euthanasia may be joined together in presenting or refuting some arguments.

OREGON DEATH WITH DIGNITY ACT (ODDA)

History was made on November 8, 1994 voters through a citizen’s initiative made Oregon the first place in the United States, and the world to legalize PAS. The Oregon Death with Dignity Act passed with 51% in favor to 41% opposed. This was immediately appealed. How did this come to be? Why was this possible? Remotely, the success of this initiative dates back to decades of Oregon’s independence, autonomy and individual freedom. Oregon from its history is known to exhibit rugged individualism and autonomy. She could be said to be very libertarian. The independent spirit of the Oregonian was enshrined in her state motto which reads: “she flies with her own wings.”⁸ Proximately, the “right to die” movement cites the 1976 landmark court case regarding Karen Ann Quinlan as the tonic that engineered and energized the formation of the Hemlock Society.⁹ Karen had a severe brain damage from a drug overdose that left her in an irreversible persistent vegetative state. The New Jersey Supreme Court’s awarding of guardianship to Joseph Quinlan (Karen’s father) and his subsequent order to the physicians to unhook her from the respirator was a major boost for “right to die” movement. It also hyped the fears of many Americans that they could be victims of the irresponsible use of medical technology to keep them alive against their wishes. This case therefore could be said to have acted as the “Socratic gad-fly” that stung people to consciousness leading to the formation of the “right to die” movement behind the passage of PAS.

The immediate factors that led to the passage of ODDA were the “Humane and Dignified Death Act” first published in the Hemlock Quarterly in 1986, and the ballot initiatives of California and Washington state. Washington State in 1991 introduced Initiative 119 described as “aid in dying” authorizing physicians to end the lives of patients in a painless manner. California followed suit in 1992, with Proposition 161 described also as “aid in dying” that would also authorize physicians to end lives of competent patients in a humane way. Both initiatives did not survive.¹⁰ Learning from the failed initiatives in California and Washington State, the Hemlock Society perfected their strategy that led to the passage of the ODDA in Oregon’s ballot initiative known as Measure 16 in 1994, which came into effect in 1997 after three years of legal tussles.

REQUIREMENTS OF DEATH WITH DIGNITY ACT

This law allows terminally ill Oregon residents to obtain and use prescription from their physicians for self-administered, lethal medications. Ending one’s life under this Act is never considered a suicide and the physicians involved will not be prosecuted. The ODDA specifically prohibits euthanasia, where a physician or someone else administers a medication to end another’s life. It is a direct action carried out by the patient alone with the help of his/her physician. To request a prescription for lethal medications, ODDA requires that a patient must be: An adult (18 years of age or older). Patient must be a resident of Oregon. Capable (defined as ability to make and communicate health care decisions), and diagnosed with a terminal illness that will lead to death within six months. Patients meeting these requirements are eligible to request a prescription for lethal medication from a licensed Oregon physician.

To receive a prescription for lethal medication, the following steps must be fulfilled: The patient must make two oral requests to his or her physician, separated by at least 15 days. The patient must provide a written request to his or her physician, signed and dated in the presence of two witnesses. The prescribing physician and a consulting physician must confirm the

⁶ Richard M. Gula, *Euthanasia: Moral and Pastoral Perspectives* (Mahwah, N.J.: Paulist Press, 1994), 6

⁷ Marcia Angell “Helping Desperately Ill People to Die” in *Regulating How we Die: The Ethical, Medical, and Legal Issues Surrounding Physician- Assisted Suicide*. Linda L. Emanuel, (ed.) (Massachusetts: Harvard Univ. Press, 1998), 6

⁸ Robert Jones, *Liberalism’s Troubled Search for Equality: Religion and Cultural Bias in the Oregon Physician-Assisted Suicide Debates*, (Indiana: University of Notre Dame Press, 2007), pp. 59-60

⁹ Hemlock was a deadly poison used in the classical Greek and Roman periods when death by suicide was ordered by the state or chosen by a rational person. Socrates committed suicide in 329B.C by drinking Hemlock.

¹⁰ Robert Jones, *Liberalism’s Troubled Search for Equality: Religion and Cultural Bias in the Oregon Physician-Assisted Suicide Debates*, 67-70

diagnosis and prognosis. The prescribing physician and a consulting physician must determine whether the patient is capable. If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination. The prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control. The prescribing physician must request, but may not require, the patient to notify his or her next-of-kin of the prescription request.¹¹

Physicians are by law required to report prescriptions for lethal medications to the Department of Human Services (DHS). Reporting is not required if a patient started the process for assisted suicide but changed his mind or never received a prescription. In 1999, the state legislature had an amendment requiring that pharmacists be informed of the prescribed medication's intended use. These are some safeguards put into place to check and monitor abuses, but there are indications that abuses have crept into it as we shall discuss later.

MEDICAL ISSUES

PAS has been a hot and divisive issue for many physicians and the medical profession as a whole. Among other things, the prescription of lethal doses of medication to terminally ill people who want to hasten their own deaths is antithetical to the ideals of the medical profession. Statistics show that between 1998 and 2007, physicians wrote a total of 541 prescriptions for lethal doses of medication, and 341 people died as a result of taking the medication. Thirteen patients who had received prescriptions were alive at the end of 2007, and the rest of those who received prescriptions ultimately died of their underlying disease. The group of patients who died after ingesting a lethal dose of medication had a median age of 69 years, and almost all were white and relatively educated, with the number of men slightly higher than women.¹²

The eight annual report of ODDA gives a yearly breakdown. In 2005, 39 physicians wrote a total of 64 prescriptions for lethal doses of medication. In 1998, 24 prescriptions were written, followed by 33 in 1999, 39 in 2000, 44 in 2001, 58 in 2002, 68 in 2003, and 60 in 2004. Thirty-two of the 2005 prescription recipients died after ingesting the medication. Of the 32 recipients who did not ingest the prescribed medication in 2005, 15 died from their illnesses, and 17 were alive on December 31, 2005. In addition, six patients who received prescriptions during 2004 died in 2005 as a result of ingesting the prescribed medication, giving a total of 38 PAS deaths during 2005.¹³

The lethal drugs used were mainly secobarbital and pentobarbital (used 105 and 137 times respectively between 1998 and 2005) Tuinal and other lethal drugs account for 7 deaths. The International Task Force on Euthanasia and Assisted Suicide reported that there were 12 known cases of regurgitation and 1 case where the patient took the drug but did not die from the lethal dose. Patients who take these drugs become unconscious within five minutes and die in the next 25 to 50 minutes. To buttress how this process could go awry, an Estacada man suffering from lung cancer took a lethal overdose but awakened three later. He died two weeks later of natural causes.¹⁴ We can only imagine how horrible these two weeks were for him.

There are indications that complications are common in assisted suicide, and physicians often have to finish the patient off with a lethal injection. The Royal Dutch Medical Association recommends that a doctor be present when euthanasia is attempted for these reasons: Patients may be unable to take the full medication and may wake from a self-induced coma. Patients with neurological illnesses may have problems with swallowing or using their hands. Barbiturates can cause extreme gasping and muscle spasms can occur. While losing consciousness, a person can vomit and then inhale the vomit. Panic, feelings of terror and assaultive behavior may take place from the drug-induced confusion.¹⁵

LEGAL ISSUES

The passage of ODDA in 1994 raised a plethora of legal battles that made its way to the Supreme Court of the United States. As soon as Measure 16 was passed, it was appealed. On November 23 1994 an injunction was filed at the federal district court by terminally ill clients in Oregon claiming discrimination. This prevented the law from going into effect in what would be the beginning of a three year legal marathon. Meanwhile, in Washington, Compassion in Dying (an affiliate of the Hemlock Society) devised new legal strategies to challenge the constitutionality of existing laws that prohibited PAS. This society filed two law suits

¹¹ *Eight Annual Report on Oregon's Death with Dignity Act*, Richard Leman, M.D et al, (editors) Department of Human Services, March 9, 2006, p.8. <http://www.oregon.gov/DHS/ph/pas/index.shtm>.

¹² *The New England Journal of Medicine*, December 11, 2008. www.nejm.org.org

¹³ *Ibid.*

¹⁴ William McCall "Assisted Suicide Declines in Oregon in 2004, report says". Associated Press, March 10, 2005

¹⁵ *New England Journal of Medicine*, Volume 342:551-556 February 24, 2000; Number 8

challenging laws against PAS under the 14th Amendment .They held that prohibiting assistance in suicide violated the equal protection clause of the Fourteenth Amendment (1868) which states “...No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.”¹⁶

The first was on the West Coast (originally filed as: *Compassion in Dying v Washington*, Jan.24, 1994) in which after several rulings and appeals, the 9th Federal Circuit Court in March, 1996 found in the 14th Amendment the right to assisted suicide of a competent terminally ill person. In the suit on the East Coast, New York (originally filed as: *Quill v. Koppell*, 1994) the 2nd Federal Circuit Court of Appeal in April, 1996 felt it was unconstitutional for a state to discriminate, in the sense that it allows some patients to cut- off of life saving medical treatment, while forbidding others to die with a physician’s assistance. They invoked the “Equal Protection Clause” of the 14th Amendment which “requires a state to treat similarly situated individuals in a similar manner” The legal conundrums arising from these rulings finally drew the attention of the U.S Supreme court who agreed to hear the cases.

U.S Supreme Court and PAS

The United States Supreme Court heard the appeals of both cases in January 1997. On June 26, 1997 the U.S Supreme Court ruled on what paved the way for PAS. In two opinions, the Supreme Court ruled that the Constitution recognizes no right to physician assistance in committing suicide; thus states may prohibit it. In both cases, *Washington et al. v. Glucksberg et al.*, and *Vacco v. Timothy E. Quill et al.* there was a unanimous agreement with no dissenting voice (9-0 decision). Kurt Darr commented that: “what is reassuring about the opinion in both cases is that the justices are clearly aware of the legal and ethical distinctions between physician-assisted suicide and passive euthanasia and that they have a good grasp of the issue.”¹⁷ In *Glucksberg* the Court in making their decision examined the legal traditions and practice and found that the Anglo-American common law has punished and disapproved of assisted suicide for over 700 years, rendering assistance in suicide is a crime in almost all states. She held also that Due Process Clause does not include a right and assistance to suicide.

In *Quill*, the Court examined the constitutionality of the distinction between person refusing life-sustaining treatment and persons requesting aid from a physician in committing suicide. In applying the Fourteenth Amendment to the States, the Court interpreted the Equal Protection Clause as representing an Aristotelian concept of justice, like cases must be treated alike, but unlike cases may be treated differently. She made a distinction between letting a patient die and making a patient die.¹⁸ Basically, the court was trying to make clear this simple fact: the ban on assisted suicide, as well as the law permitting patients to refuse medical treatment is even handed and fair to all groups.

The Court went on to list legitimate governmental interests which justifies the ban in *Washington* and *New York*. They are: 1. Preservation of human life, 2. Preventing suicide, 3. Protecting the integrity and ethics of the medical profession, 4. Protecting vulnerable groups from abuse, neglect and mistakes, 5. Preventing a downward path to voluntary and perhaps involuntary euthanasia. She also cited instances of abuse from a 1991 study in Netherlands.¹⁹ The summary from the ruling of the U.S Supreme Court shows there is no constitutionally protected right to die, as was claimed by the *Compassion in Dying* in *Washington* and *New York*, however they held that states are free to make their own laws regarding PAS, and openly encouraged this debate to go on. It is important to note that the Court challenged the medical profession to adequately assess and control pain or they would re-open the case.²⁰ With the three year legal battle apparently ended, the injunction against ODDA was vacated and the law came into effect in 1997. It was passed by a 60% to 40% margin and has been in effect till date.

ETHICAL ISSUES

The moral arguments supporting or opposing PAS are numerous. In some situation one finds both camps arguing from the same moral principle. The major moral arguments put forward by the proponents of PAS are based on the respect for autonomy, compassion, mercy and relief of pain among others. Based on these factors which we will elaborate on, they opine that the

¹⁶ Floyd G. Cullop, *The Declaration of Independence and the Constitution of the United States*; First Signet Classic Printing, July 2009. p. 141.

¹⁷ Darr, Kurt., “Physician-Assisted Suicide and the Supreme Court: Implications for Health Service Delivery”, *Nexus Ethics, Law and Management*, 4-6 (June 26, 1997) p.4

¹⁸ *Ibid.*

¹⁹ George Annas, “The Bell Tolls for a Right to Suicide” *Regulating How we Die*, Linda Emanuel (ed.), 119-22.

²⁰ *Ibid.*, 224

physician is ethically obligated to assist the suffering person to die. It has to be the physician because he is “the most plausible party for providing such assistance... it is the physician who has access to drugs, who has specialized knowledge of appropriate dosage, and who knows how to prevent side effects such as nausea and vomiting.”²¹ For these proponents of PAS it is the right of the suffering patient to get this kind of assistance from his physician.

Proponents of PAS generally invoke autonomy as the primary justification for medical cooperation in suicide. It is the moral right to live one’s life as one sees fit, subject only to the constraint that this does not involve harm to others. The freedom to live as one chooses must include the ability to decide how one ends his/her life. Choosing how to die is an integral part of choosing how to live. If this right is denied them they can never be said to have lived a happy life. Arguing in the light of eudaimonia (the ancient Greek conception of happiness across one’s whole life) D.M Shaw opines that one cannot be said to have fully flourished or had a truly happy life if one’s death is preceded by a period of unbearable pain or suffering that one cannot avoid without assistance in ending one’s life.²² The ability to choose, they argue, gives patients the choice to write the last chapter of their lives the way they want it.

The second argument of the proponents of PAS is grounded in the joint obligation to avoid doing harm and to do good (what bioethicists refer to as nonmaleficence and mercy). Some in medical ethics call this the principle of patient interest or patient welfare, M. Battin prefers to call it the ‘principle of mercy.’²³ What this principle states is that one ought to refrain from causing pain or suffering in any shape or form and act to relieve it. In addition to doing no harm, physicians have a duty to ease human suffering.²⁴ In some situations, helping patients end their lives is a more humane option than forcing them to continue to live in agony and being over treated at the end of life. The rationale therefore for PAS, is the inherent right to die that one exercises when life is no longer satisfactory. The argument is: if I would die anyways from this painful and devastating illness, then I have to choose how best to die.

The *New England Journal of Medicine* chronicles the reasons given by 143 patients in Oregon for requesting for PAS. Loss of independence 57%, Poor quality of life 55%, Ready to die 54%, Wanted to control circumstances of death 53%, saw continued existence as pointless 47%, Physical pain 43%, Loss of dignity 42%, Viewed self as a burden 38%, Fatigue 31%, Unable to perform personal care 31%, Unable to pursue pleasurable activities 30%, Wanted to die at home 28%, Dyspnea 27%, Confusion or unconsciousness 22%, Incontinence 19%, Life tasks completed 18%, Financial burden 11%, Nausea 8%, Lack of social support 6%.²⁵ Thus PAS may be a rational and compassionate response to unbearable suffering.

The opponents of PAS argue that it is unethical for a variety of reasons. First, PAS is a violation of the Hippocratic Oath and destroys the nature of the medical profession whose goal is to cure the patient and to help alleviate suffering when cure is not possible. PAS erodes the patient–physician relationship built on trust. Edmund Pellegrino captures this idea in these words, “How can patients trust that the doctor will pursue every effective and beneficent measure when she can relieve herself of a difficult challenge by influencing the patient to choose death.”²⁶ To underscore the foundational importance of trust in the physician – relationship William F. May discusses the essential elements of the biblical notion of covenant: gift: God is the giver of life and only God can take it away; exchange of promises that shape all subsequent activity. PAS in his view goes against the covenantal professional ethics of medicine.²⁷ PAS leads to role reversal; it reverses the role of a physician from that of a healer to

²¹ Gerrit K. Kimsma, “Euthanasia and Euthanizing Drugs in the Netherlands,” *Journal of Pharmaceutical Care in Pain and Symptom Control* 3, nos. 3/4, 1995.

²² D.M Shaw “Euthanasia and eudaimonia” *Journal of Medical Ethics- Journal of the Institute of Medical Ethics*, Sept. 2009, vol.35, Issue 9, p.530.

²³ Margaret P. Battin “Is a Physician Ever Obligated to Help a Patient Die? Regulating How we Die,” 22.

²⁴ Loewy, E.H. “Healing and killing, harming and not harming: physician participation in euthanasia and capital punishment”. *Journal of Clinical Ethics* 1992; 3:1:29-34.

²⁵ Linda Ganzini et al “Physicians’ Experiences with The Oregon Death with Dignity Act” *The New England Journal of Medicine*, Feb. 24, 2000; vol. 342, number 8, 560.

²⁶ Pellegrino, E.D., “Doctors must not kill, 1”. *Journal of Clinical Ethics*, Vol. 3, 1992, 95-102.

²⁷ William F. May, *Active Euthanasia and Health Care Reform: Testing the Medical Covenant* (Grand Rapids, Michigan: William B. Eerdmans, 1996) pp 6-9

that of a killer. Singer succinctly puts it: “it will subvert the role of physician as healer and erode patients trust in their physician.”²⁸

The principle of autonomy which the proponents of PAS have made their ‘Holy Grail’ cannot be seen in isolation because it is inextricably linked to the theory of the good, in this case the good of the society and protection of human life. Autonomy could be misguided if it ignores the bases of the theory of the good. John Safranek elucidates this when he said that assisted suicide committed in the name of autonomy annihilate the very basis of individual autonomy.²⁹ The autonomy argument for PAS is a self refuting argument. The hype about self-determination trumping over all other principles has gone astray. Fr. Michael Manning, M.D, a Fellow of the American College of Physicians, commented thus: “‘Choice’ has been made an inviolable transcendental, Catholic moral theologian Richard McCormick calls this the “absolutization of autonomy”; Dan Callahan calls it “self-determination run amok.”³⁰ Critics argue that the incidents involving Jack Kevorkian’s “Mercy killings” is an example of this self determination absolutized. The moral claim to autonomy for some ethicists including Pellegrino has impediments that make such claim coercion in requesting for PAS. Dan Callahan argues that PAS and euthanasia should not be tolerated because they go against the common good.³¹

Modern medicine can reduce pain up to 97%, and with an integrated relief of pain and suffering, patients do not ask for assistance in suicide. Hospice programs and palliative care are viable options for managing pain and providing comfort of the suffering patient instead of helping them kill themselves. Pellegrino who has written extensively on this said that the request for PAS or euthanasia is a plea for help in dealing with suffering as much as pain. The wish for death may be a desperate move to gain the caretaker’s attention to the patient’s experience of illness and suffering.³² In the same line of reasoning, Bioethicist McCormick insists that “assisted suicide is a flight from compassion, not an expression of it. It should be suspect not because it is too hard, but because it is too easy.”³³ Studies have shown that depressed patients who request suicide frequently change their minds after their depression is treated, even though their physical condition is not improved. Yet physicians fail to recognize treatable depression in about 50 percent of cases. The recently published study by Ganzini et al proves that 26% of people in Oregon who requested assisted suicide were experiencing depressive disorders. Though their conclusion “suggests that most patients who request aid in dying do not have a depressive disorder.”³⁴ I think that physicians owe these terminally ill patients the duty of recommending that their depression be treated rather than aiding them to kill themselves.

The slippery slope effect of PAS could lead to ‘medical holocaust’. PAS will spell doom for the sick and the society at large. Many ethicists worry that allowing even sympathetic cases of physician assistance in suicide would lead down the “slippery slope,” as overworked doctors, burdened or resentful family members, and callous institutions eager to save money (especially with the idea of rationing in healthcare today) would manipulate or force vulnerable patients into choices of suicide that were not really their own. William F. May is among the many ethicists who believe the shortcoming of the present health care system may lead vulnerable patients to PAS or euthanasia.³⁵ Pressures would be particularly severe for patients with disabilities, even those who were not terminally ill. Pellegrino warns that the abuses in the Netherlands should serve as a deterrent: “The Dutch experience shows that even when euthanasia is not legal but is tolerated, expansion of its boundaries - from voluntary to involuntary, from adults to children, from terminally ill to chronically ill, from intolerable suffering to dissatisfaction with the quality of life, from consent to contrived consent - is inevitable.”³⁶ This is real. Even though the State of Oregon has denied instances of this, there are indications that abuse and negligence of the safeguards have crept in which may finally dovetail into a slippery slope effect. There

²⁸ Peter Singer and Mark Siegler, “Euthanasia: A Critique,” in *Mercy or Murder*, ed. Overberg, 136.

²⁹ John Safranek, “Autonomy and Assisted Suicide: The Execution of Freedom” *Hastings Center Report*, July-August 1998. pp. 32-35

³⁰ Michael Manning, *Euthanasia and Physician Assisted Suicide*, 30

³¹ Dan Callahan, “When Self-Determination Runs Amok” *Hastings Center Report* 22, (March/April, 1992), 52

³² Edmund Pellegrino, “The False Promise of Beneficent Killing” *Regulating How we Die*, 75

³³ McCormick, R.A., “Physician-assisted suicide: Flight from compassion,” *The Christian Century*, Dec. 4, 1991, 1132-1134.

³⁴ Linda Ganzini, Elizabeth R. Goy, and Steven K Dobscha – *British Medical Journal*, 337(2008); a1682

³⁵ William F. May, *Active Euthanasia and Health Care Reform: Testing the Medical Covenant*, 26

³⁶ Pellegrino, E.D., “Doctors must not kill, 1”. *Journal of Clinical Ethics*, Vol. 3, 1992, 95

is also the argument against PAS rooted in the sanctity and dignity of human which I will treat in the next section under natural law.

OBJECTIVE NORMS OF MORALITY

My objective norm of morality is the Contemporary Natural Law. Simply put: Natural Law is reason reflecting on human experience discovering moral value. The force of “law” in natural law theory is the force of reason in the Thomistic sense of *recta ratio* (right reason) – the inclination to grasp the whole of reality and come to moral truth. Aristotle and Thomas Aquinas are considered the founders of this theory. Natural Law has four basic convictions; a) It claims the existence of an objective moral order, b) It is accessible to all persons with right reason independently of one’s religious commitment, c) The knowledge of moral law can be universalized, d) Human persons do not always actualize their fundamental ability to know the objective moral order.³⁷

There are two types of natural Law: traditional and contemporary. The traditional natural law is based on human nature that uses an act- centered approach in its application of laws (Physicalism), while the contemporary natural law (CNL) is person centered via deliberation of reason (Personalism). Contemporary natural law unlike the physicalism of the traditional natural law is real, experiential, consequential, historical, proportional and personal.³⁸ This change in perspective came into play after the Second Vatican Council. In considering morality of actions, CNL looks at the Intention, Act and Circumstances (Peter Clark, SJ, adds a fourth dimension, Consequences which could be foreseen or unforeseen).

In Natural law the primary precept which is reason (Do Good and Avoid Evil) perceives natural inclinations and reflects on them (a. Self Preservation, b. Procreation and education of offspring and c. Seek truth and live in society), forms moral imperatives from which laws are derived. This principle when applied to the case study, Helen, reveals PAS as not only against natural law, but unveils the inherent abuses that the Oregon State government denies.

The facts of the case on Helen (pp.2-3) reveal how a depressed woman was assisted to commit suicide under ODDA when no effort at all was made to treat her depression which the law has as a safeguard. The opinion of two doctors who considered her depressed were ignored and she received lethal drugs from the hands of a physician who barely knew her. The truth is safeguards in Oregon are ignored, grossly overlooked or completely ineffective. Ganzini et al in the study cited above acknowledged that “In a study of 321 psychiatrists in Oregon only 6% were very confident that in a single evaluation they could adequately determine whether a psychiatric disorder was impairing the judgment of a patient requesting assisted suicide. In a study of 290 US forensic psychiatrists, 58% indicated that the presence of major depressive disorder should result in an automatic finding of incompetence for the purpose of obtaining assisted suicide.”³⁹

The physician who wrote lethal prescription for Helen claims to act out of beneficence. The actions of all involved in this incident go contrary to natural law and the integrity of the medical profession. Human life is sacred because life is a gift from God. No one is morally permitted to destroy his/ her life or that of another human being. The tendency to preserve in being is natural to human beings, and therefore to preserve and protect life is a basic value, that belongs to the natural law. All forms of suicide and killing except in self defense violate this law. God has absolute sovereignty and dominion over all human life; humans do not freedom to kill others or be killed by others except in certain conditions such as capital punishment, war etc. We are not free to take our lives when we decide or to exercise control over how we will die. Richard Gula supports this view.

Having said this, I contend that Helen should never have been allowed to have PAS. All who assisted her to die ‘played God’ by deciding who dies and who lives when other viable options should have been explored. A metastatic breast cancer (stage 4 cancer) could cause pain and suffering which may induce fear in the patient. Medically, with hormonal therapy, chemotherapy and targeted therapy a woman’s life could be extended while maintaining the best quality of life possible.⁴⁰ If these treatment options do nothing to help Helen, the successes of the medical profession in pain management can manage her pain up to 97% and the remaining 3% if necessary she may need to be sedated to the point of unconsciousness. Terminal sedation could be considered as a last option. The palliative care alternative to PAS for terminally ill patients has been very effective in Oregon where Helen lives. It is an injustice to offer patients like Helen assisted suicide or euthanasia as options when so much more can be offered in sophisticated treatment via palliative care and hospice.

Many terminally ill patients like Helen have had ‘good’ experiences in hospice care, where they spent the last days of their lives and died naturally with their loved ones surrounding them without PAS. One of the greatest fears of dying patients is the fear of suffering and dying alone. The presences of family and support groups around the bedside of dying patients go a long way

³⁷ Richard Gula, *Reason Informed by Faith* (New York: Paulist Press, 1989), 242-243.

³⁸ *Ibid.*, 242-246.

³⁹ *BMJ* 337 (2008): a1682, http://www.bmj.com/cgi/content/abstract/337/oct07_2/a1682

⁴⁰ Dr. William Gradishar, “Metastatic Breast Cancer - Statistics, Diagnosis, Treatment Options”, www.breastcancer.com. Accessed 11-21-09.

to reassure the dying that they are still loved and cherished. Their intrinsic human dignity is not in any way diminished by the devastating and painful illness. I have ministered to many dying patients in hospice care and can testify that most of them die nobly, courageously and peacefully. "In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued. Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional setting, intrusive medical technology is kept to a minimum."⁴¹

Clinical depression if untreated could be the reason why most patients seek exit by suicide or euthanasia. They are dogged with despair, anxiety, guilt and a sense of unworthiness. If they are adequately treated the feelings of dying disappear. Helen was never given this option. However, among patients who requested PAS but availed themselves of a substantive intervention by a physician, including treatment of depression, forty-six percent changed their minds about having PAS.⁴² Pellegrino also concurred with this view "if pain and depression are treated, most patients abandon their desire for death."⁴³ Helen's case among others suggest strongly that these safeguards which ODDA claimed are 'inviolable' are circumvented in ways that are harmful to patients. This without doubt will degenerate to the Netherland saga, and may spiral downward into the slippery slope it claims to avoid.

No one told Helen of the rights she had under the Health Care Decision Act that was passed in Oregon in November, 1993 (HCDA) less than a year before PAS. This raises a red flag about informed consent. The new law allowed patients or their designated proxies to forgo all forms of life-prolonging medical treatment, including nutrition and hydration "under any of the following circumstances: imminent death, permanent unconsciousness, advanced progressive illness and extraordinary suffering". The act also guarantees that patients have access to "all necessary and sufficient" comfort care and pain control.⁴⁴ Why did the citizens not know about the right they have to control their dying and death? Why was no reference made about this act in the ODDA? Why should the terminally ill like Helen think that the only choice is between kept alive by a machine and assisted suicide?

The American Medical Association has reaffirmed that PAS is unethical and therefore contrary to what the medical profession stands for. They agreed that: (1) PAS is fundamentally inconsistent with the physician's professional role (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. (3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. (4) Requests PAS should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary.⁴⁵

CONCLUSION

This paper has been an appraisal of PAS as is practiced in Oregon under the ODDA. The act has been in effect since 1997 but the controversy is far from over. Its medical, legal and ethical dimensions confront and challenge us every day. I unequivocally reaffirm that PAS cannot be justified under any circumstance because the direct killing of another human being in the name of mercy, not only goes contrary to natural law but violates the very foundation and integrity of the medical profession. It violates the Hippocratic Oath and repudiates the ethical principles of beneficence and respect for person. PAS could backfire on people with debilitating conditions leading not to more autonomy but less. It goes against the principles of justice and the common good because its slippery slope effects will destroy society especially the weak and vulnerable.

We should all realize that medical technology may not cure all diseases and treat all pains. There may still be suffering after all is said and done. When physicians with all the sophistication of medical technology have done their best, and sufferings still persist, one could offer it up, uniting it to the suffering of Jesus Christ. The Christian faith teaches that there is value in suffering which could be redemptive: redemptive suffering modeled after the suffering of Jesus Christ who suffered on the cross to free humanity from the slavery of sin and death.

Pope John Paul II of blessed memory who has reflected much on the meaning of human suffering, noted that all the afflicted are contributors to salvation: "The Lord has assigned you (sick) a singular mission: to remind each of us that suffering has

⁴¹ Miller RJ. "Hospice Care as an alternative to Euthanasia". *Law Medicine Health Care*. 1992; 20: 127-132

⁴² Linda Ganzini et al., "Physicians' Experiences with the Oregon Death with Dignity Act", *342 New England Journal of Medicine*. 557, (2000).

⁴³ Edmund Pellegrino, "The False Promise of Beneficent Killing" *Regulating the Way we Die*, p.82.

⁴⁴ Robert Jones, *Liberalism's Troubled Search for Equality*, p.76

⁴⁵ www.ama-assn.org September 28, 2007

mysterious value.”⁴⁶ Walking the same path as his predecessor, Benedict XVI says: “Pain is part of being human. Anyone who really wanted to get rid of suffering would have to get rid of love before anything else, because there can be no love without suffering, because it always demands an element of self sacrifice...”⁴⁷ This is by no means an endorsement of suffering by the Church but to a pointer to the immeasurable value we could get if we endure suffering with the proper Christian attitude.

In conclusion, euthanasia and PAS are not the solution to ending pain and suffering in the terminally ill. Sickness does not rob us of our intrinsic human dignity. Even if our mortal bodies have been devastated and disfigured by illness, we are still beloved children of God who were created in His own image and likeness. Its claims of autonomy and mercy as the reasons for its justification denigrate the human being who is a reflection of God. It is part of the “culture of death” of our contemporary world that has total disregard for the sanctity of human life. We are challenged every day to help restore the “culture of life” that is under serious assault by our society. PAS is part of this ‘fighting battalion’ that has to be disarmed.

REFERENCES

- Congregation for the Doctrine of the Faith, Declaration on Euthanasia. Rome: 1980.
- Dan Callahan, “When Self-Determination Runs Amok” Hastings Center Report 22, March/April, 1992.
- Darr, Kurt. “Physician-Assisted Suicide and the Supreme Court: Implications for Health Service Delivery”, Nexus Ethics, Law and Management, 4-6, June 26, 1997.
- D.M Shaw “Euthanasia and Eudaimonia” Journal of Medical Ethics- Journal of the Institute of Medical Ethics, vol.35, Issue 9, Sept. 2009.
- Declaration of the American Medical Association on Physician- Assisted Suicide; www.ama-assn.org; September 28, 2007
- Edmund Pellegrino, “The False Promise of Beneficent Killing” Regulating How we Die: The Ethical, Medical, and Legal Issues Surrounding Physician- Assisted Suicide. Linda L. Emanuel, (ed.), Massachusetts: Harvard Univ. Press, 1998.
- , “Doctors must not kill, 1”. Journal of Clinical Ethics, Vol. 3, 1992.
- Floyd G Cullop, The Declaration of Independence and The Constitution of the United States. First Signet Classic Printing, July 2009.
- George Annas, “The Bell Tolls for a Right to Suicide” Regulating How we Die: The Ethical, Medical, and Legal Issues Surrounding Physician- Assisted Suicide. Linda L. Emanuel,(ed.), Massachusetts: Harvard Univ. Press, 1998.
- Gerrit K. Kimsma, “Euthanasia and Euthanizing Drugs in the Netherlands,” Journal of Pharmaceutical Care in Pain and Symptom Control 3, nos. 3/4, 1995.
- Herbert Hendin and Kathleen Foley “Physician-Assisted Suicide: A Medical Perspective” in Michigan Law Review; Vol. 106, June, 2008.
- James Rachels, “Active and Passive Euthanasia,” Critically Thinking About Medical Ethics, R. Card (ed.), New Jersey: Prentice Hall, 2004.
- John Safranek, “Autonomy and Assisted Suicide: The Execution of Freedom” Hastings Center Report, July-August 1998.
- J.L.A Garcia “Sin and Suffering in a Catholic Understanding of Medical Ethics” Christian Bioethics: Non –Ecumenical Studies in Medical Morality; Corinna D. Hayes et al (eds.)vol. 12, number 2, August, 2006,
- Linda Ganzini et al., “Physicians’ Experiences with the Oregon Death with Dignity Act”, 342 New England Journal of Medicine. 557, 2000.
- Loewy, E.H. “Healing and killing, harming and not harming: physician participation in euthanasia and capital punishment”. Journal of Clinical Ethics; 3:1:29-34, 1992.
- Marcia Angell “Helping Desperately Ill People to Die” in Regulating How we Die: The Ethical, Medical, and Legal Issues Surrounding Physician- Assisted Suicide. Linda L. Emanuel, (ed.), Massachusetts: Harvard Univ. Press, 1998.
- Margaret P. Battin “Is a Physician Ever Obligated to Help a Patient Die? Regulating How we Die: The Ethical, Medical, and Legal Issues Surrounding Physician- Assisted Suicide. Linda L. Emanuel,(ed.), Massachusetts: Harvard Univ. Press, 1998.

⁴⁶ John Paul II, 2004 p. 102 in J.L.A Garcia “Sin and Suffering in a Catholic Understanding of Medical Ethics” Christian Bioethics: Non – Ecumenical Studies in Medical Morality; Corinna D. Hayes et al (eds.)vol. 12, number 2, August, 2006, 176-177.

⁴⁷ Benedict XVI, 2005, p. 150, in J.L.A Garcia, Christian Bioethics; p.180

McCormick, R.A. "Physician-assisted suicide: Flight from compassion," *The Christian Century*, Dec. 4, 1991.

Michael Manning, M.D *Euthanasia and Physician- Assisted Suicide: Killing or Caring*; New York: Paulist Press, 1998.

Miller RJ. "Hospice Care as an alternative to Euthanasia". *Law Medicine Health Care*. 20: 127-132, 1992.

New England Journal of Medicine, Volume 342:551-556 Number 8, February 24, 2000.

The New England Journal of Medicine, December 11, 2008. www.nejm.org.org

Peter Singer and Mark Siegler, "Euthanasia: A Critique," in *Mercy or Murder*, ed. Overberg, 136.

Richard M. Gula, *Euthanasia: Moral and Pastoral Perspectives*; Mahwah, New Jersey: Paulist Press, 1994

-----, *Reason Informed by Faith*; New York: Paulist Press, 1989.

Richard Leman, M.D et al, (editors) *Eight Annual Report on Oregon's Death with Dignity Act*, Department of Human Services, March 9, 2006, <http://www.oregon.gov/DHS/ph/pas/index.shtm>.

Robert Jones, *Liberalism's Troubled Search for Equality: Religion and Cultural Bias in the Oregon Physician-Assisted Debates*; Indiana: University of Notre Dame Press, 2007.

Ron Hamel, "Dying in America: Is the "Fragile Consensus" eroding"? Annual McCormick Lecture on St Joseph's University, PA. October 7, 2009.

William Gradishar, Dr., "Metastatic Breast Cancer - Statistics, Diagnosis, Treatment Options", www.breastcancer.com. Accessed 11-21-09.

William F. May, *Active Euthanasia and Health Care Reform: Testing the Medical Covenant*; Grand Rapids, Michigan: William B. Eerdmans, 1996.

William McCall "Assisted Suicide declines in Oregon in 2004, report says". Associated Press, March 10, 2005.