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Update - Special Report November 1992

Loma Linda University Center for Christian Bioethics

LOMA LINDA UNIVERSITY
Center for
Christian Bioethics
California Supplement, November 1992

Update

Special Report to Our Contributors
Proposition 161—Death with Dignity Act
Should It Become Law?

Yes

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Law Office of Michael H. White
President, Americans Against Human Suffering

The Proposed Statute

Proposition 161 would allow voluntary physician assisted aid-in-dying for the terminally ill; that is, competent patients would be permitted to ask a willing physician to help them to die.

Proposition 161 also protects physicians who render aid-in-dying from criminal, civil and administrative liability.

Aid-in-dying is defined as a medical procedure that will terminate the life of the qualified patient in a painless, humane and dignified manner whether administered by the physician at the patient's choice or direction or whether the physician provides means to the patient for self-administration.

The proposed statute contains a number of safeguards, among which are the following:

Only physicians are permitted to assist terminally ill persons to die; relatives, friends or others cannot assist in ending a life;

Two physicians must diagnose the terminal condition;

"Terminal condition" is defined as an illness or condition that will result in death within six months or less;

The patient must be competent;

No

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My opposition to Proposition 161 comes in the form of various considerations and judgments that—on balance—weigh against legalizing voluntary active euthanasia. In fact, my opposition to Proposition 161 operates at different levels, which I hope to illustrate in the following three claims and their accompanying explanations.

CLAIM #1: We should not allow ourselves the option of active euthanasia, at least not in this health-care context and social environment.

This claim might strike many as authoritarian or paternalistic. It does sound as if I am suggesting that some of us do not want others to enjoy a certain liberty in their own personal lives. A moment's reflection, however, will reveal that there is nothing "un-American" or inherently suspect about this claim.

There are all sorts of "choices" or "options" that we do not allow ourselves for public policy and public morality reasons. For example, we do not allow ourselves the option of free, discretionary use of addictive drugs, even though there are many among us who would make good and sensible use of such drugs if we had this option. We do not allow ourselves the choice to sell ourselves into servitude or bondage to another (e.g., prostitution), even though for some persons such a choice might be acceptable if not sensible. And we do not allow ourselves the option NOT to provide for our futures

Yes

Two independent persons must witness a written request for aid-in-dying;

If the patient is a resident of a nursing home, one of the witnesses must be a Patient Ombudsman;

The request for aid-in-dying must be enduring one, made on more than one occasion;

If the physician has doubt about the patient's mental competence, a psychological evaluation may be obtained with patient consent;

Insurance policies are not affected;

Notice to relatives is encouraged;

Medical fees are limited to reasonable;

Reporting is required, but patient confidentiality is protected.

Opposition Challenge to Proposition 161

The opposition to Proposition 161 is a narrow one—it is claimed that the initiative does not contain necessary safeguards, that it is fatally flawed and defective. The opposition goes further that this issue is not a moral one, that it is poor draftsmanship. On both grounds the opposition campaign is in error.

Daniel Callahan said in the Hastings Center Report of March/April 1992 the following:

> I see no way, even in principle, to write or enforce a meaningful law that can guarantee effective procedural safeguards. The reason is obvious yet almost always overlooked. The euthanasia transaction will ordinarily take place within the boundaries of the private and confidential doctor-patient relationship. No one can possibly know what takes place in that context unless the doctor chooses to reveal it.

In short, there is no possible way to write a statute with sufficient safeguards unless such safeguards would insure that no patient could have the assistance of a physician in dying. This issue is confirmed in many of the recent debates on this issue by spokespersons for the opposition campaign—they simply cannot accede to the concept of helping a person to die.

The issue is truly a moral one, and that is the debate which should be occurring, rather than whether or not the statute is drafted sufficiently clearly, as it is.

When courts declared the right of patients to refuse medical care, to permit, over the protest of the medical establishment, the shutting off of respirators, the withdrawal or withholding of food and hydration, no safeguards were declared. No statutes have been passed to establish safeguards for the turning off of respirators or withdrawal of food and hydration.

No

(e.g., forced Social Security contributions), even though some among us would make good use of such an option. The mere fact that some persons might make good use of some choice does not in itself decide the issue of what liberties or rights we should allow in our society.

Moreover, Proposition 161 is not a privacy issue. Decriminalizing suicide might be a privacy issue, but this is not what Proposition 161 is about. It is about what we will allow regarding a public institution: health care. Public institutions should be governed by public policy and public morality.

I can think of at least three reasons that would counsel against a right to voluntary active euthanasia, even though I admit that some people might make good use of such a right. First, it is a dangerous right—one that lends itself to serious abuse—in the context of a health-care culture that poorly manages pain and that tends to overtreat patients because of an ad hoc approach to patient care (treating symptoms or complications as they arise with little thought to the overall treatment goals for this patient). Moreover, it is a dangerous right in a racially and ethnically divided society in which millions are without adequate access to health care. These conditions in health care and society put great pressure on individuals to make all the wrong assessments about the quality of their lives and their worth as individuals. If you introduce into this context a right to voluntary active euthanasia, then you introduce an irreversible way for people to act out these wrong assessments.

Second, there is the danger of a slippery slope between a very limited right to active euthanasia and its abuse in cases where patients are terminated on the initiative of others. The logic operating here would be the following. If a competent, terminally ill patient is allowed the right to voluntary active euthanasia, it is because we consider it reasonable for someone in this situation to want this "service." But if it is reasonable for the competent patient, why not the incompetent patient? And if it is reasonable for the terminally ill patient, why not the chronically ill patient in an equally painful condition? Would not all the reasons offered in support of Proposition 161 apply equally well to these other categories of patients?

Third, I think that voluntary active euthanasia is wrong in itself, because it violates the fact that we as individuals have only a stewardship and not an absolute ownership over our own lives. This is not an appeal to some sectarian religious notion. The idea of stewardship is central to most, if not all, Christian moral traditions. It is also central to most, if not all, Jewish moral traditions and Islamic moral traditions. It is even central to John Locke's argument for natural rights and limited government! In other words, the stewardship of life is a defining idea of our religious and political traditions, and should not be ignored in determining the public propriety of Proposition 161.

CLAIM #2: Even it we were to agree to give ourselves the option of voluntary active euthanasia, Proposition 161 is the wrong way to legalize this practice.

Yes

Rather, guidelines have developed along with the case law and statutory law, and such guidelines are the rules by which the medical community renders services.

Opponents examine Proposition 161 as if no other rules exist to guide society or medical practice. Rather, the statute is dissected in a vacuum, and if it cannot stand on its own, in the opposition view, it is defective, fatally flawed.

A recent critic, a physician said that he examined patient files in preparing for the debate of this issue and found that in each of six cases where life support systems were turned off to permit patients to die, there were at least three consultations reflected in the medical records of each patient. And he pointed out that nothing in Proposition 161 required consultation, nor the use of qualified medical specialists, nor did it require the involvement of family members in the dying process, etc., etc., etc.

My response was simple. Where is the statute which requires the consultations, the specialists, the family, and the other issues he raised regarding the treatment of patients in his facility, whether such patients are dying or having a simple appendectomy? I got a blank stare, because there are none. There is only the ever growing, ever changing body of good medical practice which goes on, and will go on with Proposition 161 as law.

Nothing in the statute prohibits specialists to be involved, for consultation to be obtained, for family to be involved, for witnesses to be present at the time of death. Because a medical procedure is at the heart of the statute, informed consent of the patient will be required in every case. Institutions will determine the appropriate guidelines, protocols, rules of practice that should guide good medical practice in dealing with the dying process, which will include assisting those who are dying.

Impact

For those physicians who are ethically, morally or religiously opposed to aid-in-dying, there will be no impact on their medical practice, as they will not participate in the process.

For those physicians who will participate, it will permit them to determine with their patients the time and manner of death, should the physician be unable to relieve the pain and suffering which terminally ill patients fear. It will not be necessary for the physician to choose between abandoning a patient by saying there is no more that he or she can do, or breaking the law.

The practice of assisting person to die which presently occurs in violation of law, in secret, without documentation, control or regulation, will with Proposition 161 be brought into the open, permitting the treatment of dying patients in a caring way with full documentation, participation of family and friends as the patient may choose, and with the support of necessary and appropriate medical staff.

No

This claim involves two points. The first is that a ballot initiative is a clumsy way to enact a law of such far-reaching implications. The ballot initiative process does not allow for or encourage the kind of reflective deliberation available in the processes of legislative enactments. How many people really understood Proposition 161 and its implications before signing the petition getting it on the ballot? And how many people will educate themselves on the issues and problems of Proposition 161 before voting for or against it? Yet if passed, Proposition 161 could be altered or changed only upon a 2/3 vote of the California Legislature.

The second objection contained in this claim has to do with the issue of adequate safeguards, and whether Proposition 161 contains sufficient safeguards to minimize possible abuses in the practice of active euthanasia. Since this issue of safeguards is the one usually debated and may be most familiar to the reader, I will focus on only two problem areas. There is no requirement that the active euthanasia be administered solely or even principally for the elimination of pain and suffering. Thus, a clinically depressed patient who is not in pain could be assisted in his or her suicide, even though the motivating force for the suicide is clinical depression. Second, any physician can certify terminal illness and perform active euthanasia, regardless of that physician's lack of training or expertise in the illness or lack of extended, meaningful relationship with the patient. Along with other safeguard problems, these two suggest that Proposition 161

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Yes

Defining a New Area of Approved Behavior of Physicians

We do not help the argument or advance understanding by saying that the Initiative provides for assisted suicide or euthanasia. It does both, but in a qualified way: it relates solely to the competent, terminally ill patient.

The question is whether we believe that what is permitted by the Initiative is conduct which we wish to condone. That conduct is voluntary physician assisted aid-in-dying for the terminally ill, as I have defined it: to administer a medical procedure which is painless, human and dignified or provide the means for patient self-administration to end a life. The question is not if what the Initiative would permit is suicide or euthanasia; it is, should such behavior be permissible, lawful behavior.

The real issues that motivate interest in aid-in-dying are the patient's desire to maintain control during the dying process, the fear of pain and the fear of prolonged suffering and indignity. As physicians gain more confidence in the use of pain-relieving drugs for the terminally ill and the public perceives a willingness to use such measure, terminally ill person will have less actual need for aid-in-dying. However, there will be some, at least under present technology, whose suffering will not be relieved, and Proposition 161 will permit a physician to lawfully help such a patient to die.

Conclusion

Voluntary physician assisted aid-in-dying for the terminally ill is not mutually exclusive of adequate pain management and control nor more and better hospice care. I believe it is complementary, and the passage of Proposition 161 will encourage physicians to do better in pain management and to make better use of hospice alternatives.

The moral issue is not whether or not it is moral to take affirmative steps to end a life, even if the patient requests such help and is dying with pain and suffering. The moral issue, in my view, has become whether or not it is immoral to withhold from dying, suffering patients who request help in dying the technology which will end life painlessly, humanely and with dignity.

I have come to the conclusion that a compassionate society will provide the benefits of its technology to end suffering for those competent, terminally ill persons who request such help, and that Proposition 161 in providing aid-in-dying for the competent, terminally ill person is a step toward a more compassionate society. ❐

No

could turn California into a suicide haven for clinically depressed patients and for unscrupulous physicians eager to resurrect their failing practices.

CLAIM #3: Even if Proposition 161 were to pass on November 3, it would be wrong for health-care professions to embrace the "ethic" implied in this measure as their professional ethic.

If Proposition 161 does pass on November 3 it may be because it is based upon the "legal ethic" that dominates our attitudes if not conduct towards one another. This is the "ethic" of maximum forbearance and maximum autonomy. It is the idea that as fellow citizens of this civil society we are obliged to give to one another the greatest leeway possible and thereby insure that each of us as individuals is granted as much autonomy as possible. Given the origins of our political culture and the current composition of this society, this ethic might make perfect sense, but not necessarily in every context. This legal ethic is, after all, an ethic of strangers, and it is not every context in which we should relate to one another as strangers.

Health care is not civil society. Accordingly, an ethic that might make sense in the context of the relations of civil society would not make sense in the context of the relations of health care: the physician and patient are not simply "fellow citizens" and thereby should not be strangers.

This means that while the physicians as fellow citizens might have to recognize and forebear the patient's legal right to voluntary active euthanasia, the physicain as health-care professional must resist this practice for the good of the profession.

Proposition 161 asserts that performing voluntary active euthanasia "shall [not] be...unprofessional conduct" (Sec. 2525.9). This assumes, of course, that the law can dictate by caveat what is or is not professional conduct in the healthcare professions. I prefer to believe that the inherent ethical integrity of health care derives from its nature, and that this nature dictates the pursuit of three equally important and compelling goods: sustaining life, eliminating suffering, and restoring physicial autonomy (meaning that the patient becomes as little dependent as possible on medical assistance itself). When any one of these goods is pursued in a way that excludes or ignores the others, then health care loses its ethical integrity—not withstanding pronouncements in case law or statutes or ballot initiates. This is, I believe, precisely what would happen if healthcare professionals began to practice voluntary active euthanasia under the authority of Proposition 161. ❐