University of Rhode Island
DigitalCommons@URI

Senior Honors Projects | Honors Program at the University of Rhode Island

5-2009

Time to Die?

Josh Dunn
University of Rhode Island, dunner897@cox.net

Follow this and additional works at: http://digitalcommons.uri.edu/srhonorsprog

Part of the Social and Behavioral Sciences Commons

Recommended Citation
Dunn, Josh, "Time to Die?" (2009). *Senior Honors Projects.* Paper 131.
http://digitalcommons.uri.edu/srhonorsprog/131

This Article is brought to you for free and open access by the Honors Program at the University of Rhode Island at DigitalCommons@URI. It has been accepted for inclusion in Senior Honors Projects by an authorized administrator of DigitalCommons@URI. For more information, please contact digitalcommons@etal.uri.edu.

Josh Dunn

Political Science and Economics

dunner897@cox.net

Faculty Sponsor: Dr. Art Mead, Economics

Time to Die?

Time to Die?

Josh Dunn
Faculty Sponsor: Dr. Art Mead, Economics

The issue of when life begins has inspired heated debate in this country for nearly half of a century. The importance of this issue cannot be overstated; it has played a pivotal role in elections of public officials and in confirmation hearings of federal judges and justices and has dominated legal, political, economic, religious and ethical discussions. While the issue is far from resolved, it will be joined by another contentious issue in the near future. With our society rapidly getting older, and with the rapidly rising cost of health care, including the extremely high cost of end-of-life care, Americans will soon be confronted with the difficult question of when to die. In fact, the issue of when life ends has the potential to be even more controversial than the abortion issue. Some terminally-ill patients feel that the option of physician assisted suicide (PAS) should be available to them. Two states, Oregon and Washington, have legislation allowing terminally-ill, mentally competent adults to request the medical means to end their lives. Rhode Island currently has legislation making it illegal for anyone to assist another person in the act of committing suicide.

This paper will thoroughly examine all sides of the issue from a variety of disciplines. Relying on both extensive research and several interviews with members of the academic and legal communities, this paper will closely look at PAS in both theory and practice. The implementation of the Oregon and Washington laws will be discussed in detail. It will also discuss the potential implications of physician assisted suicide

legislation on both a national and a state level in an effort to determine the appropriate response to end of life concerns in the state of Rhode Island.

Introduction

The question of when life begins continues to haunt my parents' generation. While many years have passed since abortion was recognized as a fundamental constitutional right in the landmark U.S. Supreme Court case of *Roe v. Wade* in 1973, there is still no widespread consensus on it in this country. Abortion clinics have been subjected to a considerable amount of violence in the last thirty years. From 1977 to 1994, over 1,700 documented acts of violence against abortion providers have occurred.[1] In 1984 eighteen abortion clinics were bombed in the United States and in the year 1994 alone, four people were killed as a result of abortion clinic violence. Furthermore, in 1996 nearly a third of all abortion clinics in the U.S. reported being effected by bombings, threats, and harassment.[2] To this day, the issue of abortion plays a critical role in the appointment of federal judges. Where a particular candidate stands on the issue could make the difference between confirmation and rejection. In the 2005 confirmation hearings for the current Chief Justice John Roberts, several federal legislators indicated that their votes for either confirming or rejecting his appointment would hinge on which side of the abortion spectrum he fell on.[3] The issue is far from being resolved and it

---

[1] "Abortion Clinic Violence," *MSNBC*, 1997, <http://msnbc.com/modules/clinics/>. Hereafter cited as MSNBC Violence.

[2] MSNBC Violence.

[3] Senator John Cornyn, "An Abortion Litmus Test for Judge John Roberts," *The San Diego Union Tribune*, 7 August 2005, <http://www.signonsandiego.com/uniontrib/20050807/news_mz1e7cornyn.html>.

certainly illustrates the delicate nature of the conflict between personal choice and societal values.

Much like the question of when life begins that has dogged preceding generations, the question of when life ends will, I believe, dominate the legal, political, economic, religious, and ethical discussions of future generations. It will become a contentious, important public policy debate for two reasons. First, the high cost of health care, and its rapid rise, in America will put increasing pressure on governments, businesses and individuals. Second, substantial increases in life expectancy due to rapidly improving medical technology will create increasing numbers of individuals who will seek to end their lives because of a lack of "quality." Add in the fact that our society is getting older very quickly and it becomes apparent that, in a short period of time, this issue will erupt onto the national agenda and is likely to be more toxic than the abortion issue. This is especially problematic in the U.S., a society that values the freedom of personal choice. Some patients want to be given a wide array of medical choices when deciding what treatment option is best, while some patients with terminal illnesses for whom the quality of life is far below their personal standards will argue for the right to end their lives. In my opinion, it is time to make a step in the direction of providing people with that choice. I am proposing that the practice of physician assisted suicide (PAS) be legalized in Rhode Island and in this paper I intend to make that case. This paper will look at the problems created by the size and rise of the cost of health care administration in the U.S. as well PAS in practice and the issues that the physician assisted suicide debate brings up. PAS usually entails a physician providing a terminally ill, mentally competent patient with the

medical means to end one's life at the patient's repeated request, followed by the act of ingestion of the medication by the patient. While debate around this practice is relatively new, the time for Americans to discuss the issue will soon be upon us.

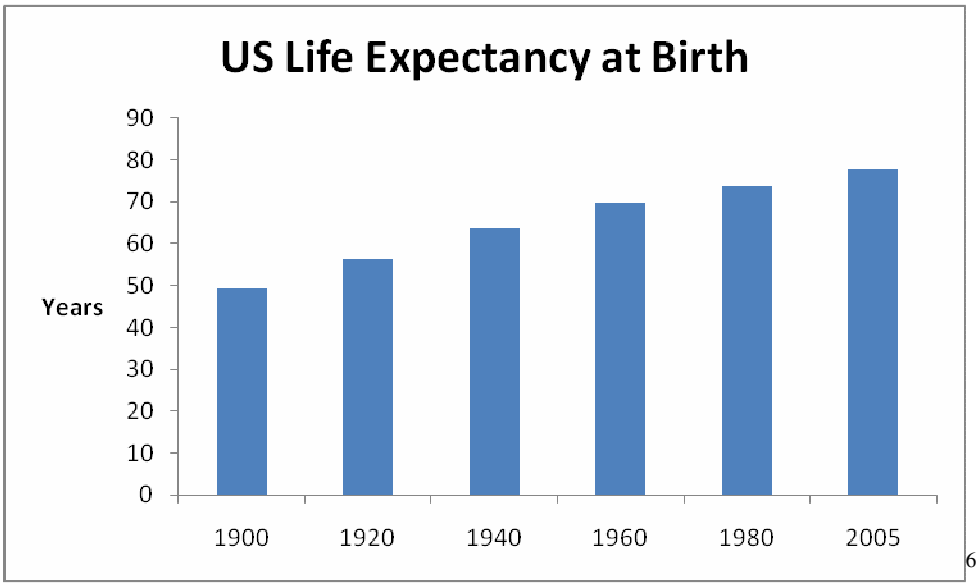
Demographics and Health Care Costs

The cost of health care in America is out of control. Americans spend far more o health care than any other industrialized society and health care costs are rising at unsustainable rates. Additionally, the life expectancy of Americans is among the lowest of the world's 30 wealthiest countries. According to OECD data, life expectancy at birth was 77.8 years in 2005, which placed it 24th on the list of 30 countries – just below Portugal and above the Czech Republic, Mexico and Poland.[4] Life expectancy is, however, rising in the United States. Life expectancy at birth in the U.S. in 2005 was nearly 10 years longer than it was in 1960, nearly fourteen years longer than it was in 1940, and thirty years longer than it was in 1900.[5] This is shown graphically below:

---

[4] "OECD Factbook 2009," *Organization for Economic Co-operation and Development*, <http://oberon .sourceoecd.org/vl=581474/cl=18/nw=1/rpsv/factbook2009/11/01/01/index.htm>.

[5] Elizabeth Arias, "U.S. Life Tables, 2004," *Centers for Disease Control and Prevention*, 28 Dec 2007, < http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_09.pdf>.



[6]

On the issue of health care cost, much is often made about the amount spent on national defense but according to the National Coalition on Health Care, health care spending in the USA is over four times as large as defense spending.[7] Even though almost 46 million Americans are uninsured, the United States pays six times more per capita on the administration of health care than the average Western European country does in the administration of a universal system of health care.[8] In 2008, health care spending in the United States reached $2.4 trillion, which represents 17% of this country's gross domestic product (GDP). This share of GDP is projected to jump to 20% within eight years.[9] According to the Bureau of Labor Statistics, 5.7% of all consumer

---

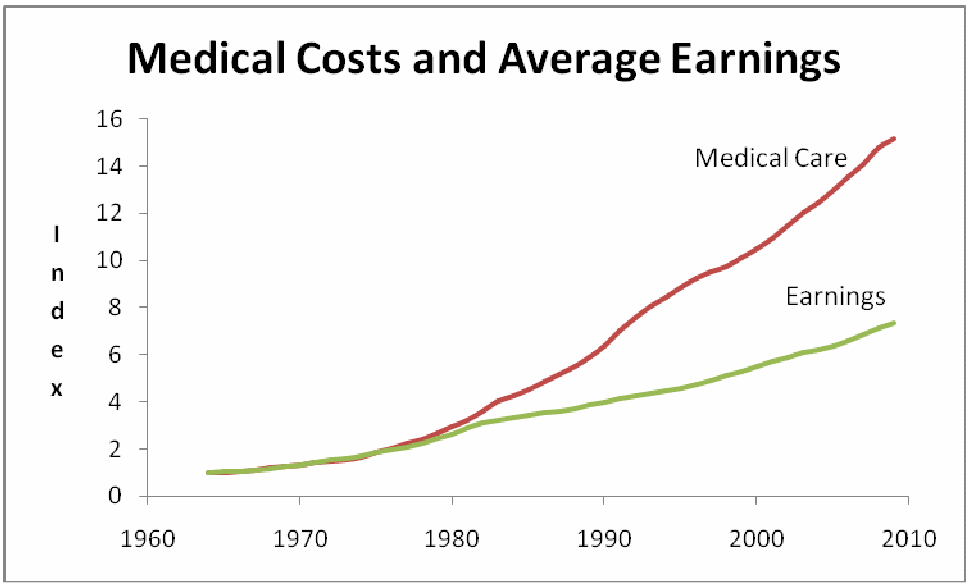
[6] This graph created in Microsoft Excel using data from the footnote above.

[7] "Health Insurance Costs," *National Coalition on Health Care*, 2009, <http://www.nchc.org/facts/cost.shtml>. Hereafter cited as NCHC.

[8] NCHC.

[9] NCHC.

expenditure is on health care. This share increases to 12.7% for those consumers who are 65 years of age and older.[10] In addition, while the overall Consumer Price Index (CPI) for all items declined by 0.4% from March 2008 to March 2009, the CPI for medical care increased by 2.8% over the same period. This increase was fueled by a 6.1% increase in the CPI for hospital and related services.[11] Furthermore, the graph below shows that the growth in medical costs has far outpaced the growth in earnings, especially in the years following 1980:



Of the large amount spent on health care, a substantial amount is spent on end-of-life care. At the close of the millennium, it was estimated that end-of-life care accounts from anywhere from 10-12% of all health care expenditure.[12] Annual expenditure for hospice

---

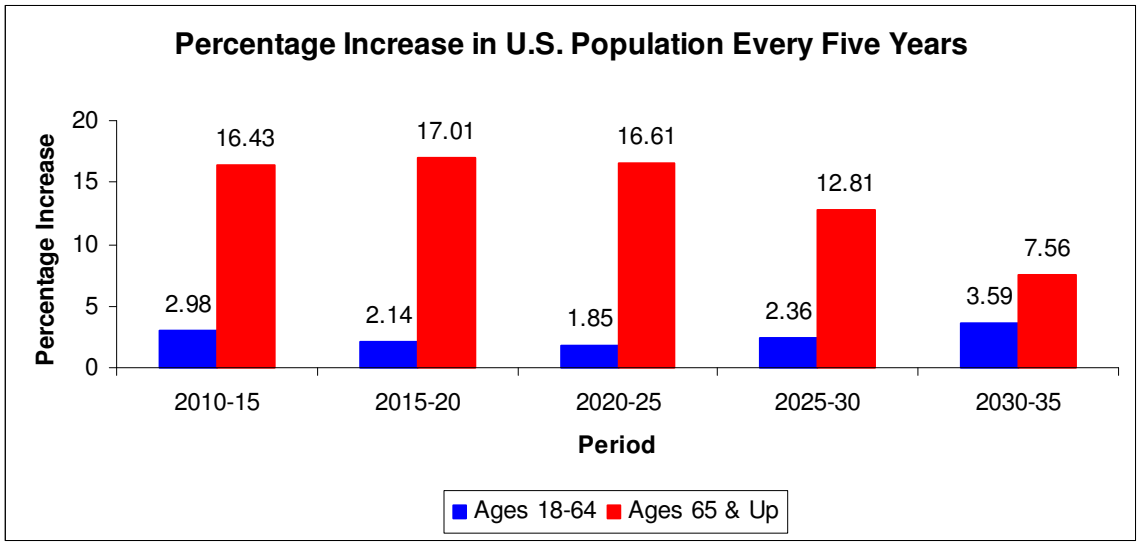
[10] "Table 47. Age of Reference Person: Shares of average annual expenditures and sources of income," Consumer Expenditure Survey, 2007, *Bureau of Labor Statistics*. Hereafter cited as Table 47.

[11] "Table 1. Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category and commodity and service group," *Bureau of Labor Statistics*, March 2009.

[12] Carol Raphael et al., "Financing End-of-life Care in the USA," *Journal of the Royal Society of Medicine* 94 (January 2001): 458-461.

care was $3.5 billion while the expenditure for home care was $29 billion.[13] A quarter of the Medicare budget is estimated to be spent on a beneficiary in the last year of life and 40% of that amount is spent on a person's last 30 days.[14]

In addition to the extremely high cost of health care and end-of-life care, American society is aging rapidly. In the near future, with the retirement of the baby boomer generation, immense pressure will be felt by society to try to care for the growing number of elderly citizens. In the coming years, the number of elderly citizens is projected to grow much faster than the number of working age citizens, as evident in the chart below:



[15]

One can see from this graph that the elderly population is projected to experience to increase rapidly in the fiver year spans from 2010-15 to 2025-2030. While the elderly

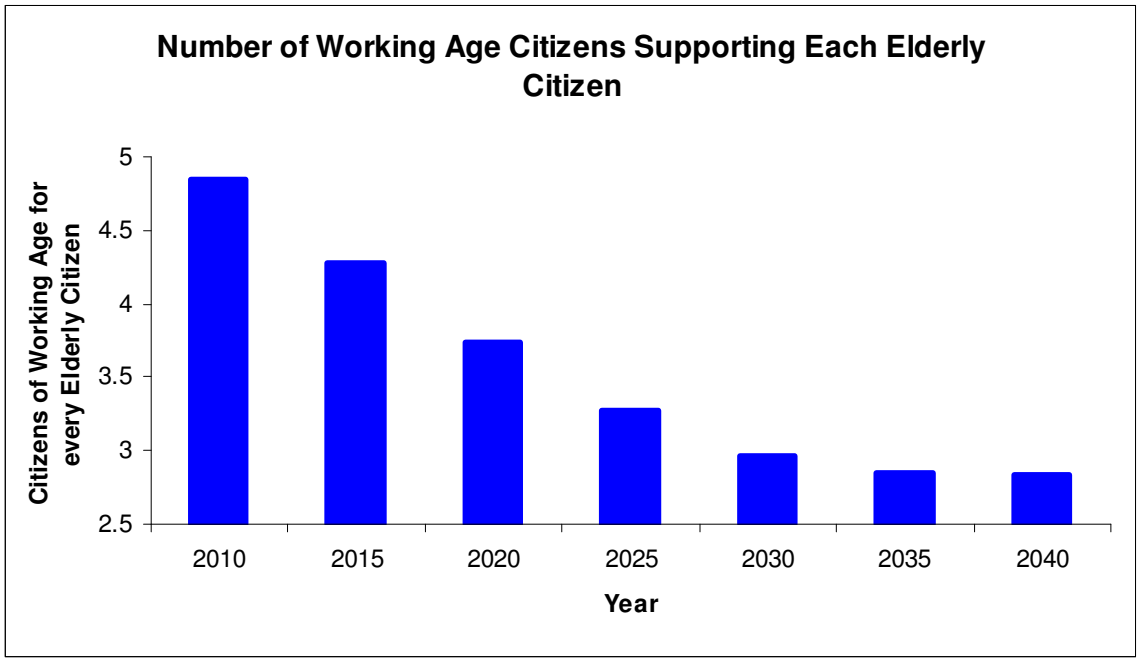
---

[13] Raphael et al., 458-461.

[14] Raphael et al., 458-461.

[15] This graph was created in Microsoft Excel relying on "Table 2. Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050," National Population Projections, 2008, *U.S. Census Bureau*.

population will experience double-digit increase in these time periods, the working age population will experience far more modest growth, at only 2-3% per five year span. The alarming percentage increase in the number of elderly citizens certainly dwarfs the corresponding percentage increase in the number of working age citizens. It is further projected that the total U.S. population will grow by 29.2% from the year 2000 to the year 2030. In this same time period, it is projected that the population of those aged 65 and older will grow by 104.2%![16] What impact will this have on society? Below is a graph depicting the number of working aged citizens for every elderly citizen based on the U.S. Census Bureau's national population projections:



[17]

[16] "Table 4: Interim Projections: Change in Total Population and Population 65 and Older, by State: 2000 to 2030," State Interim Population Projections by Age and Sex: 2004-2030, *U.S. Census Bureau*. Hereafter cited as Table 4, U.S. Census Bureau.

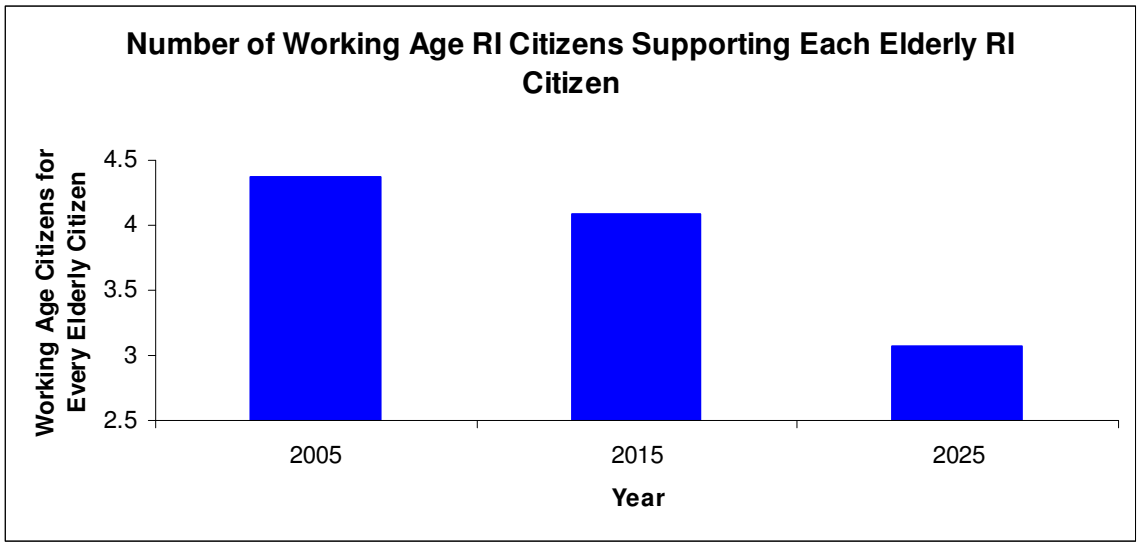
[17] This graph was created in Microsoft Excel relying on the table cited above in Footnote 12.

As one can see from the graph, the number of workers supporting the elderly is projected to decline sharply in the next 30 years. Today there are nearly five working aged citizens who, at least in theory, can be working to provide the funds to support one elderly citizen, but this is projected to decline sharply in the coming years as the baby boomers begin to retire. By 2030, that proportion is expected to fall to nearly three. If society has difficulties dealing with the high cost of health care and end-of-life care now, imagine how great those difficulties will be thirty years from now when the amount of workers supporting the elderly is almost cut in half!

The situation in Rhode Island looks even worse. While the total Rhode Island population is projected to increase by 10% from 2000 to 2030, the population of those aged 65 and older is projected to increase by 61.7%.[18] How about the number of workers supporting each elderly RI citizen? That ratio is depicted graphically below:

---

[18] Table 4, U.S. Census Bureau.



[19]

The graph above makes it clear that Rhode Island is projected to suffer a similar fate as the United States in the years ahead. With just fewer than four and a half working aged citizens for every elderly citizen, RI can expect to see this ratio decrease significantly to just over three working aged citizens for every elderly citizen. While the projected drop-off in RI is not as pronounced as the projected national drop-off, it seems clear that, with an extremely high cost of health care and a rapidly aging society, America will be forced to address some tough questions in the years ahead. One step in answering these tough questions is the legalization of physician assisted suicide.

History of Physician Assisted Suicide (PAS)

The PAS legislation being proposed for RI is based on the experiences others have had with the issue. In this paper I will discuss five important examples of the practice of physician assisted suicide; physician assisted suicide in the Netherlands, the

[19] This graph was created in Microsoft Excel relying on, "Projections of the Populations, by Age and Sex, of States: 1995 to 2005," State Population Projections, 1996, *U.S. Census Bureau*.

exploits of Dr. Kevorkian, physician assisted suicide in Oregon and Washington, the U.S. Supreme Court's rulings on physician assisted suicide legislation, and Rhode Island's stance on physician assisted suicide.

PAS in the Netherlands

Officially, physician assisted suicide and euthanasia became legal in the Netherlands in April of 2002.[20] However, the practice of both physician assisted suicide and euthanasia has been condoned by the courts of the Netherlands since 1981.[21] In the Oregon and Washington laws, an important distinction exists between physician assisted suicide and euthanasia. Physician assisted suicide involves a physician writing a prescription for medication that will end life and the patient's act of ingesting that medication. Euthanasia, on the other hand, involves a physician actively killing a suffering patient in a painless way, usually through lethal injection.[22] As will be discussed shortly, a big distinction is drawn in both the Washington and Oregon laws between physician assisted suicide and euthanasia. This distinction is not an important one in the Netherlands and both physician assisted suicide and voluntary euthanasia (euthanasia at the patient's request) are legal there.[23] In 1981, the Rotterdam Court of the Netherlands set forth the guidelines for physicians in assisting terminally ill patients in ending their lives. These guidelines include the following requirements: the patient must

---

[20] Derek Humphry, "Tread Carefully When You Help to Die: Assisted Suicide Laws Around the World," *Euthanasia Research and Guidance Organization*, 1 March 2005, <http://www.assistedsuicide.org/ suicide_laws.html>.

[21] "Euthanasia in the Netherlands," *International Task Force*, no date of publication given, <http://www. internationaltaskforce.org/fctholl.htm>. Hereafter cited as International Task Force.

[22] Oxford American Dictionary, 2006, s.v. "euthanasia."

[23] Humphry.

be experiencing unbearable pain and be conscious, the death request must be voluntary, the patient must be informed of alternatives to death and must be given time to consider these alternatives, there must be no other reasonable solutions than ending the patient's life, the patient's death must not inflict unreasonable suffering on others, more than one person must be involved in the decision to end the patient's life, only a doctor can euthanize the patient, and great care must be taken in making the death decision.[24] In addition to these requirements, physicians were expected to report each assisted suicide/euthanasia death to the local prosecutor.[25] The guidelines set forth by the Rotterdam Court in 1981 are similar to those guidelines set up by physician assisted suicide legislation in the United States. For this reason, many opponents of physician assisted suicide fear that any legalization of the practice will suffer the same fate as the Netherlands practice has suffered.

Physician assisted suicide and euthanasia in the Netherlands proved difficult to contain, even with the requirements set up by the Rotterdam Court. Small expansions of the practice seemed logical at the time. In 1986, for example, The Hague Court of Appeals ruled that the unbearable pain requirement was not limited to physical pain. The court recognized that "physic suffering" or "the potential disfigurement of personality" could also be grounds for granting a request for physician assisted suicide or euthanasia.[26] Also in 1986, a Dutch court found that a physician acted within the law when he gave a lethal injection to a young quadriplegic woman because "paralyzed patients have

---

[24] International Task Force.
[25] International Task Force.
[26] International Task Force.

difficulty swallowing and could die from aspirating their food at any time."[27] Similarly, a court decision made in 1993 in the Netherlands upheld the legality of a physician's assistance in ending the life of a physically healthy fifty year old woman who wanted to die because of the death of her two children and the breakup of her marriage.[28]

In addition to the expansion problems, the Netherlands practice of physician assisted suicide and euthanasia demonstrated widespread abuse. In September of 1991, the first official government report of the practice was issued. Popularly called the Remmelink Report, the report chronicled the practice in the year of 1990.[29] The results were very disturbing. The report found that an extremely large number of patients were euthanized without their consent. In 1990 alone, 1,040 patients, almost three per day, were euthanized without their express consent. Of these cases, 72% never gave any indication that they wished to end their lives and, in 8% of the cases, the doctors admitted that there were other alternatives available but that they thought that euthanasia was the best course.[30] The most frequently cited reasons given by doctors who put patients to death without their consent were "low quality of life," "no prospect for improvement," and "family couldn't take it anymore."[31] Additionally, 4, 941 patients were given intentional overdoses of pain medication without their knowledge or consent in 1990.

---

[27] Richard Doerflinger, "Assisted Suicide: Pro-Choice or Anti-Life?," in *The Right Thing to Do: Basic Readings in Moral Philosophy, 5th ed.,* ed. James Rachels and Stuart Rachels (Boston: McGraw Hill, 2007), 317.

[28] International Task Force.

[29] International Task Force.

[30] International Task Force.

[31] International Task Force.

This led the report to conclude that the majority of euthanasia deaths in the Netherlands are involuntary.[32]

The practice of physician assisted suicide and euthanasia in the Netherlands also has expanded to disabled newborn children. The Remmelink Report made no mention of the euthanasia of disabled newborn children but several documented cases existed.[33] In 1992, a year after the report was issued; the Dutch Pediatric Association issued formal guidelines for the euthanasia of severely handicapped children. The rationale behind this was explained by the chairman of the associations Working Group on Neonatal Ethics when he said, "Both for the parents and the children, an early death is better than life."[34] Understandably, many critics of physician assisted suicide view the events that have transpired in the Netherlands with horror. Seemingly small expansions that seemed rational at the time have provided the basis for further expansions. The end result is a system that seems to be far from the one set up by the Rotterdam Court in 1981. Many opponents of physician assisted suicide legislation feel that any legislation enacted in the United States will follow the path of physician assisted suicide in the Netherlands.

Dr. Kevorkian

In physician assisted suicide literature, few names are mentioned more than Dr. Jack Kevorkian. Dr. Kevorkian was a media magnet in Michigan in the 1990s and he certainly generated a substantial amount of attention for the physician assisted suicide

---

[32] International Task Force.
[33] International Task Force.
[34] International Task Force.

cause. Both proponents and opponents of the practice were critical of the pathologist's practices, however.

In 1956, Kevorkian published a journal article discussing his efforts to photograph the eyes of dying patients. That publication earned him the nickname "Dr. Death."[35] The nickname seems appropriate for Kevorkian, as he would dedicate his career to the study of death and to helping dying patients end their lives. Kevorkian advertised in several Detroit area newspapers as a "physician consultant for death counseling" in 1987 and, a year later, he published an article outlining a proposal for suicide clinics that would provide planned death services.[36] The following year Kevorkian crossed the line between theory and practice when, using thirty dollars worth of spare parts, he built his so-called "suicide machine."[37] He called this machine the "Thanatron," which is Greek for "death machine." This machine was designed for the patients to use themselves; by pushing a button, the IV saline solution, that the patient would already be hooked up on, would stop and a drug of thiopental would be released on a sixty second timer. The patient would go into a deep sleep and, at the timer's click, a lethal dose of potassium chloride would be released that would stop the heart in minutes. The patient would essentially die of a heart attack in their sleep.[38]

On June 4, 1990, Janet Adkins became the first of Kevorkian's patients to use the Thanatron to end her life. This was done in the back of Kevorkian's 1968 VW van while

---

[35] "Chronology of Dr. Jack Kevorkian's Life and the Assisted Suicide Campaign," *Frontline: The Kevorkian Verdict*, PBS, < http://www.pbs.org/wgbh/pages/frontline/kevorkian/chronology.html>. Hereafter cited as PBS.

[36] PBS.

[37] PBS.

[38] "The Thanatron," *Frontline: The Kevorkian Verdict*, PBS, < http://www.pbs.org/wgbh/pages/frontline/ kevorkian/aboutk/thanatronblurb.html>.

it was parked in a public park.[39] He continued to allow his patients who wished to end their lives to use the Thanatron until, in November of 1991, his license to practice medicine in Michigan was revoked by the state medical board. With no license to practice medicine, Kevorkian could no longer obtain the potassium chloride needed for his Thanatron.[40] Kevorkian resorted to much cruder means of helping patients end their lives; he used a tank of carbon monoxide hooked up to a facemask. The tank was turned on and a clip was placed on the air hose going from the tank to the facemask. In order for some one in this situation to end their life they needed to simply remove the clip from the hose to allow the carbon monoxide to flow freely.[41] Kevorkian continued this practice throughout the 1990s. Despite several criminal actions brought against Kevorkian, Michigan had no law on the books expressly outlawing physician assisted suicide. In 1993, the governor of Michigan signed legislation banning physician assisted suicide but it was held up for many years in the court system.[42] All of the actions against Kevorkian during this time were unsuccessful.

In 1998 Kevorkian allowed the CBS program "60 Minutes" to do a segment on him. The segment showed Kevorkian administering a lethal injection to Thomas Youk, who was suffering from ALS.[43] This act was different from all of Kevorkian's previous assisted suicides. By administering the lethal injection to Youk, Kevorkian was not merely assisting in Youk's suicide; he was actively killing Youk at Youk's request. In

---

[39] PBS.
[40] PBS.
[41] PBS.
[42] PBS.
[43] "Kevorkian Released From Prison After 8 Years," *MSNBC*, 1 Feb. 2009, < http://www.msnbc.msn.com/ id/18974940/>. Hereafter cited as MSNBC.

Michigan, this act constituted murder and, in 1999, Kevorkian was tried and found guilty. He was sentenced to 10-25 years, but was released in 2007 for good behavior. The conditions of his parole are that he is not to help in another suicide, care for anyone over the age of 62 or for anyone who is disabled, or to show anyone how to build his suicide machine.[44]

Proponents of physician assisted suicide have mixed feelings about what Kevorkian did. While they admire him for his courage, determination and compassion, they are critical of his methods.[45] A significant number of Kevorkian's patients were not Michigan residents. As a result, many had to end their lives in public cabins, at the home of Kevorkian's assistants or even in the back of Kevorkian's van.[46] Additionally, Kevorkian made little effort to examine the patients' causes of suffering. Contrary to the systems of Oregon and Washington, discussed below, that provide for an examination of the patient to see if they are of sound mind and not depressed, Kevorkian made no effort to screen out depressed patients. Marjorie Wantz, for example, came to Kevorkian with severe pelvic pain. After she ended her life using the Thanatron, her autopsy revealed that she had no physical cause for her pain. Furthermore, her medical record showed that she had been hospitalized for mental problems.[47] Another of Kevorkian's patients, Rebecca Badger, claimed to have multiple sclerosis. After her suicide, her autopsy revealed that she had no disease and it was later reported that she suffered depression and was addicted

---

[44] MSNBC.

[45] Donald Humphry, "Evaluating Dr. Kevorkian's Contribution to the Right-to-Die Movement in America," 1 June 2007, *Euthanasia Research & Guidance Organization*, < http://www.assistedsuicide.org/Kevorkian _contribution_to_the_right_to_die_movement_in_America.html>.

[46] PBS.

[47] Wesley J. Smith, "Death on Demand: The Assisted-Suicide Movement Sheds Its Fig Leaf," *The Daily Standard*, 5 July 2007, < http://www.discovery.org/a/4121>.

to pain killers.[48] Kevorkian claims to have helped over 130 of his patients end their lives.[49] How many more of those 130 patients decided to end their lives primarily because of depression? We'll never know, but it is clear that any system of physician assisted suicide needs to identify those patients who are depressed and have them treated for it.

PAS in Oregon and Washington

In November of 1994 Oregon made history by becoming the first state in the United States to legalize the practice of physician assisted suicide. The Oregon Death with Dignity Act (DWDA) was a citizen's initiative that passed by the narrowest margin possible, 51% in favor.[50] The law did not take effect in 1994, however. It was delayed by legal injunction until the Ninth Circuit Court of Appeals lifted the injunction on October 27, 1997.[51] An appeal to the United States Supreme Court was subsequently denied. Once the Ninth Circuit Court of Appeals lifted the legal injunction, the Oregon DWDA came into effect. In November of the same year a measure was placed on the general election ballot asking voters to repeal the DWDA. This measure, Measure 51, failed by a margin of 60% to 40%.[52] Four years later, U.S. Attorney General John Ashcroft pronounced a new interpretation of the Controlled Substances Act (CSA). All of the medications

---

48 Smith.
49 MSNBC.
50 "Death with Dignity Act History," Oregon Department of Human Services, March 2006, < http://www. oregon.gov /DHS /ph/pas/docs/History.pdf>. Hereafter cited as DWDA History.
51 DWDA History.
52 DWDA History.

prescribed under the Oregon DWDA have been barbiturates. Under the Controlled Substances Act, a barbiturate is a controlled substance; therefore, Attorney General Ashcroft interpreted the CSA in such a way that would make it illegal for physicians to prescribe any barbiturate to a patient for use under the DWDA.[53] Essentially, Ashcroft hoped to eliminate physician assisted suicide as a legal option available to terminally ill, mentally competent Oregon residents. Ashcroft's interpretation was, of course, met with another round of litigation. The State of Oregon filed suit in U.S. District Court and the court issued a temporary restraining order against Ashcroft's interpretation of the CSA. In April of 2002, the district court upheld the DWDA and basically nullified Ashcroft's interpretation. Ashcroft appealed to the Ninth Circuit Court of Appeals and his appeal was subsequently denied.[54] Normally, a circuit court of appeals will hear a case with a three judge panel, however, if a petitioner appeals for the court to hear the case *en banc*, all of the judges on that circuit court of appeals will sit in on the hearing of a case. Following the rejection of his appeal, Ashcroft appealed to the Ninth Circuit Court of Appeals to hear the case *en banc* and the eleven judge panel rejected his appeal. Ashcroft then appealed to the U.S. Supreme Court and the Court agreed to hear the case. In January of 2006, the Court announced its decision affirming the district court's decision.[55] The DWDA remained in effect during this entire legal battle.

Under the Oregon DWDA, any adult resident of Oregon who is deemed to be suffering from a terminal illness and who is considered capable may make a written request for medication for the purpose of ending his or her life in a dignified and humane

---

[53] DWDA History.
[54] DWDA History.
[55] DWDA History.

manner.[56] The act defines "terminal illness" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months."[57] The term "capable" means that the patient is, in the opinion of physicians, psychiatrists or psychologists, able to make and communicate important health care decisions.[58] The act expressly states that only Oregon residents can request the medical means to end their lives. The act lays forth several qualifications for Oregon residency: the possession of an Oregon driver's license, registration to vote in Oregon, evidence of property ownership in Oregon or evidence that property is being leased in Oregon, or the filing of an Oregon tax return for the most recent year.[59]

Pursuant to the Oregon DWDA, a patient who wishes to end his or her life through medical means must follow a certain procedure. A patient must first make a written request that follows a certain form. This written statement must be signed and dated and this signing must be witnessed by two individuals. At least one of the individuals must not be a person who is a relative of the patient, is entitled to any portion of the patient's estate after the patient's death, is an owner or employee of a health care facility where the patient is receiving care, or is the patient's own doctor. The witnesses must attest to their belief that the patient is "capable, acting voluntarily, and is not being coerced to sign the request."[60] The patient's physician, upon receiving the request, is required to inform the patient of alternatives to ending his or her life and to refer the patient to a consulting physician. The act also stipulates that the physician should

---

56 ORS 127.805 c. 1 s. 2.01.
57 ORS 127.800 c.12 s.1.01.
58 ORS 127.800 c.3 s.101.
59 ORS 127.860 s.3.10.
60 ORS 127.810 s.2.02.

determine that the patient is capable, acting voluntarily, and is making an informed decision and that the physician request, but not compel, the patient to inform the patient's next of kin about the decision.[61] The consulting physician is required to confirm the initial physician's diagnosis and prognosis in writing.[62] If, at any time, either physician feels that the patient's judgment is in any way impaired, they are required to refer the patient for psychological and/or psychiatric counseling.[63] In addition to the written request, a patient needs to make an oral request to the physician as well. After a waiting period of at least fifteen days, this oral request must be repeated to the physician.[64] The physician is required to inform the patient that he or she has the right to rescind the request at any time. Additionally, all aspects of the process need to be recorded in the patient's medical file.

Once the patient has received the prescription from the physician, the patient is not allowed to ingest the medication in a public place. Upon ingesting the medication, the patient's life, health, or accident insurance policy will be unaffected. The act further expressly prohibits the ending of a patient's life through lethal injection, mercy killing or euthanasia.[65] Additionally, any person who is found to coerce or exert undue influence on a patient to request medication to end life is subject to a Class A Felony charge.[66]

The Oregon DWDA also stipulates that the Oregon Department of Human Services is responsible for compiling data about the patients who end their lives through

---

61 ORS 127.815 s.3.01.
62 ORS 127.820 s.302.
63 ORS 127.825 s.303.
64 ORS 127.840 s.306 and ORS 127.850 s.308.
65 ORS 127.880 s.3.14.
66 ORS 127.890 c.1 s.4.02.

this practice. So far, from the beginning of 1998 to the end of 2008, a total of 401 terminally ill Oregonians have ended their lives in accordance with the law.[67] Of the 401 patients, slightly more have been male (53.1%), most have had at least some college education (66.8%), and an overwhelming majority have been Caucasian (97.5%).[68] A majority of the patients have private health insurance (66.8%). With the exception of five patients who had no health insurance and four patients for whom health insurance information was unknown, the remaining patients were insured by either Medicare or Medicaid.[69] In their data compilation, the Oregon Department of Human Services also assembles the patient's reasons for making the choice to end their lives with medical means. Of the 401 DWDA patients who ended their lives, 89.9% cited "loss of autonomy" as an end-of-life concern, 83.8% cited "loss of dignity," and 38.3% cited "burden on family, friends/caregivers" as a one of the reasons for requesting medical means to end their lives. Surprisingly, given the high cost of health care and end-of-life care, only 11 patients (2.8%) cited "financial implications of treatment" as an end-of-life concern.[70] Additionally, 95% of the deaths that have occurred in accordance with this act have been complication free and the median duration between the patient's first request and the patient's death is 43 days.[71]

Since the practice has only been legal for just a little over ten years, proponents and opponents alike are generally unsure whether this practice has adequate safeguards to

---

[67] "Characteristics and end-of-life care of 401 DWDA patients who died after ingesting a lethal dose of medication, by year, Oregon, 1998-2008," Oregon Department of Human Services, <http://www.oregon.gov /DHS /ph/pas/docs/yr11-tbl-1.pdf>. Hereafter cited as Oregon DWDA Characteristics.

[68] Oregon DWDA Characteristics.

[69] Oregon DWDA Characteristics.

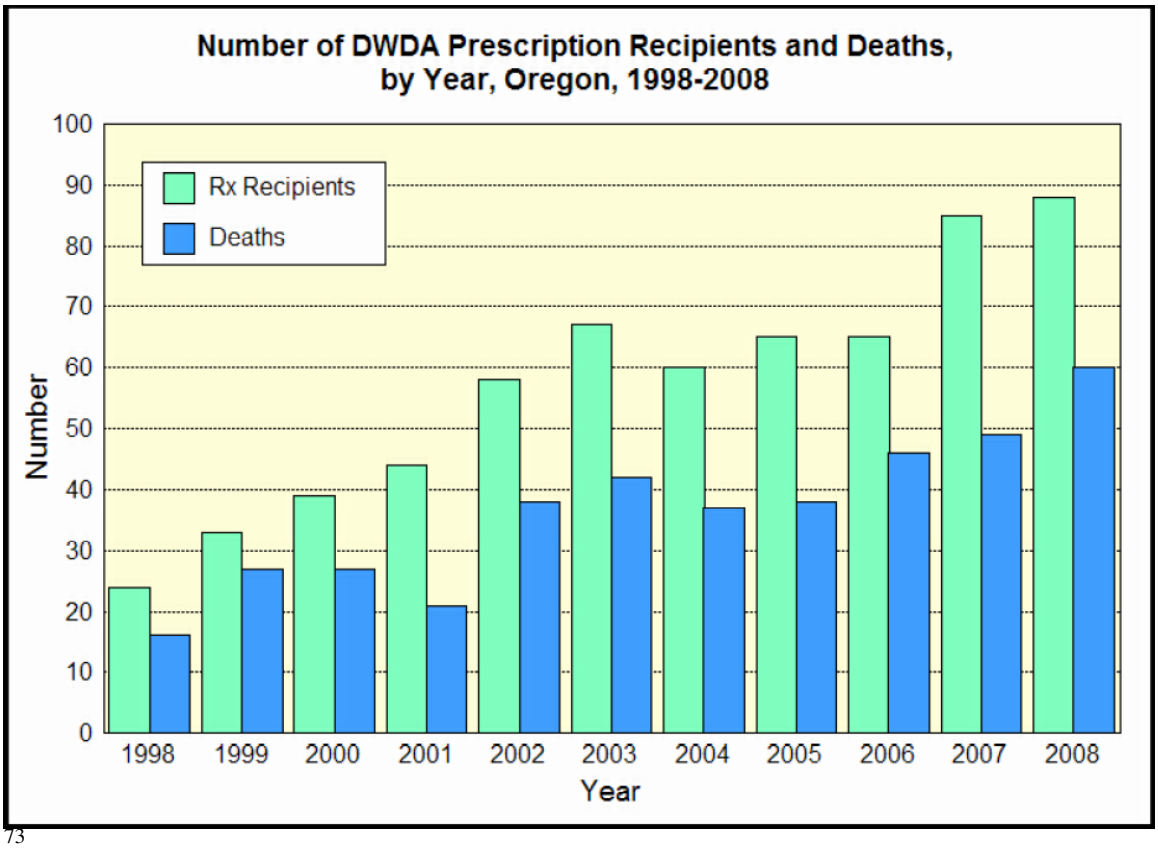
[70] Oregon DWDA Characteristics.

[71] Oregon DWDA Characteristics.

prevent the expansion experienced in the Netherlands. Proponents, as will be discussed further in the following pages, point to the fact that not every patient whose request for the medication is granted, ends up using the medication to end his or her life. From the time that the legislation has been in full effect to the end of 2008, 628 prescriptions have been written.[72] As mentioned above, 401 patients have ended their lives pursuant to the act. This means that 36% of those who receive a prescription for the medication to end their lives choose not to use it. The chart on the following page, provided by the Oregon Department of Human Services, illustrates graphically the number of prescriptions written since 1998 and the number of deaths from ingestion of the medication:

---

[72] Oregon DWDA Characteristics.



[73]

It seems as though, for a substantial portion of patients, just knowing that ending their lives through medical means was an option was comfort enough.[74] However, opponents of the practice argue that the program is dangerous because it gets its information almost exclusively from self-reporting doctors. Also, opponents of the Oregon DWDA point to the fact that a cancer patient who had been hospitalized for mental illness received a prescription for the medical means to end his life despite the fact that his doctor told a court that the patient could be "susceptible to periods of

---

[73] "2008 Summary of Oregon's Death with Dignity Act," *Oregon Department of Human Services*, March 2009, <http://egov.oregon.gov/DHS/ph/pas/docs/year11.pdf>.

[74] Howard Wineberg, "Physician-assisted Suicide in Oregon: Why So Few Occurrences?," *Medical Journal of Australia* 174 (2001): 353-354.

confusion and impaired judgment."[75] Some opponents of physician assisted suicide are not persuaded that Oregon's safeguards are sufficient enough to contain the practice.

From 1975 up through the new millennium, the state of Washington had a statute making the practice of physician assisted suicide illegal. That statute was the subject of a long legal battle that eventually made its way to the U.S. Supreme Court, discussed in the following pages. In November of 2008, however, the citizens of Washington passed the Washington Death with Dignity Act by a margin of 57.8% to 42.2%.[76] Washington's legislation is identical to the legislation of Oregon with respect to each of the elements of the Oregon DWDA cited above.[77] The act went into full effect on March 5th 2009.[78] As the act has just taken effect, data about its participants has yet to be reported.

PAS and the Supreme Court

The Due Process Clause of the Fourteenth Amendment to the United States Constitution states that no state shall "deprive any person of life, liberty, or property, without due process of law."[79] The cases that were brought to the U.S. Supreme Court regarding physician assisted suicide legislation involved interpretation of this clause. The Fourteenth Amendment applies some, but not all, of the Bill of Rights to the state governments. Additionally, the idea behind substantive due process is that there are certain rights that are not expressly protected in the Constitution but are nevertheless

---

75 Smith.

76 "Physician Aid-in Dying," *Ethics in Medicine*, University of Washington School of Medicine, April 2009, <http://depts.washington.edu/bioethx/topics/pad.html>.

77 RCW 70.245 Sec. 1 to RCW 70.245 Sec. 31.

78 "Physician Aid-in-Dying."

79 The Founding Fathers and Justiceleaning.org, *The United States Constitution: What it Says, What it Means*, (New York: Oxford University Press, 2005), 55.

fundamental.[80] In *Cruzan v. Director, Missouri Department of Health*, decided in 1990, the U.S. Supreme Court held that, "it cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining treatment."[81] While the Court in *Cruzan* upheld a Missouri statute that required clear and convincing proof of a patient's wishes to withhold or withdraw life-sustaining treatment when that patient was unable to communicate those wishes, the Court held that a fundamental right of a patient to choose to withdraw or withhold life-sustaining treatment existed in the Constitution.

In 1997 the Court heard arguments in it first ever case dealing with physician assisted suicide. In *Washington v. Glucksberg* the Court upheld the constitutionality of a Washington statute that made it a crime to assist another in an act of suicide. Physician Harold Glucksberg, three other physicians, and three terminally ill patients in Washington brought suit against the State, arguing that the right of a mentally competent, terminally ill patient to choose to end his or her life through a physician assisted suicide is protected by the Due Process Clause of the Fourteenth Amendment.[82] The Supreme Court rejected this argument and held that there is no fundamental right to assisted suicide in the U.S. Constitution. In writing the opinion of the Court, Chief Justice William Rehnquist explained the centuries-long tradition of the rejection of suicide. Rehnquist explained that if the Court were to find a fundamental right of an individual to end his or her life through the practice of physician assisted suicide, the Court would

---

[80] Thomas R. Bender, Esq., interview by author, Providence, Rhode Island, 17 April 2009.

[81] *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 at 281, 110 S.Ct. 2841 at 2853; (1990).

[82] *Washington v. Glucksberg*, 521 U.S. 702 at 708, 117 S.Ct. 2258 at 2262; (1997).

"have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."[83]

In the Court's opinion in *Glucksberg*, Rehnquist explained the rights of individuals that the Court has recognized as fundamental, and therefore protected by the Due Process Clause, in their previous cases. These liberties include the rights to marry, to have children, to direct the education and upbringing of one's children, to marital privacy, to the use of contraception, to bodily integrity, to abortion, and to refuse unwanted lifesaving medical treatment.[84] Rehnquist further explained that in order for a right to be recognized by the Court as being fundamental it must be "deeply rooted in the Nation's history and tradition" and be "implicit in the concept of ordered liberty."[85] In the case of physician assisted suicide, it was clear to the Court that the practice is neither "deeply rooted in the Nation's history and tradition" nor "implicit in the concept of ordered liberty." Even if legislation does not infringe upon the exercise of a fundamental right, it still must be rationally related to a legitimate governmental interest. In this case, the Court found the Washington legislation to have a relation to six state interests: the preservation of life, the prevention of suicide, the avoidance of the possibility of undue influence on the patient from third parties, the protection of family members of the patient, the protection of the integrity of the medical profession and the avoidance of a future movement toward euthanasia.[86] The Washington ban on PAS was therefore upheld.

---

[83] *Washington v. Glucksberg*, 521 U.S. at 723, 117 S.Ct. at 2269; (1997).
[84] *Washington v. Glucksberg*, 521 U.S. at 720, 117 S.Ct. at 2267; (1997).
[85] *Washington v. Glucksberg*, 521 U.S. at 721, 117 S.Ct. at 2268; (1997).
[86] *Washington v. Glucksberg*, 521 U.S. at 727, 117 S.Ct. at 2272; (1997).

Will there never be a right to PAS in the U.S. Constitution? It is of course possible that the Court will overturn itself. This is a rare occurrence but it does happen from time to time. Most law professionals and scholars agree that trying to determine how any court will rule in the future is risky and inaccurate because, in large part, the way a court will decide an issue or case depends on the composition of the court.[87] It seems doubtful that the Court will reverse itself anytime soon because, as Rehnquist explained in his opinion, there is no sense in society of an emerging recognition of a right to PAS.[88] However, if an awareness of such a right did begin to emerge, the Court may have to reconsider its position one day. The Court seems to be indicating that any change of their position on PAS needs to be initiated by a change in society's attitudes towards the practice.[89] Additionally, just because the U.S. Supreme Court declines to find a fundamental right in the U.S. Constitution, that does not mean that the state supreme courts must also decline to find the same fundamental right in their state constitutions. After the Supreme Court's decision in *Glucksberg*, any state supreme court is still free to find a fundamental right to physician assisted suicide in their state constitution.[90]

In the same term as *Glucksberg*, the Court also heard a case involving a physician assisted suicide ban in New York. A New York law, which allows a patient to refuse life saving medical treatment, makes assistance in an act of suicide a crime. In *Vacco v. Quill*, three physicians and three terminally ill patients brought suit against various public

---

[87] Bruce Wolpert, Esq., interview by author, Providence, Rhode Island, 17 April 2009. Also, Bender, interview by author.

[88] Yale Kamisar, "Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy," *Issues in Law and Medicine*, Fall 2008: 110.

[89] Bender, interview by author.

[90] Bender, interview by author.

officials, arguing that because the New York statute allows a mentally competent person to refuse life-sustaining or lifesaving medical treatment, which is "essentially the same thing" as PAS, but denies the choice of physician assisted suicide, it violates the Equal Protection Clause."[91] The Equal Protection Clause of the Fourteenth Amendment prohibits a State from denying "to any person within its jurisdiction the equal protection of the laws."[92] In this case, the Court rejected the physicians' arguments and upheld the constitutionality of the New York statute. Writing the opinion of the Court was again Chief Justice Rehnquist who explained that if the right in question is not a fundamental one, the Court will generally uphold the legislation as long as it doesn't target a suspect class and it has a rational relation to a legitimate governmental interest.[93] In this case, the Court decided that the New York statute did not target a suspect class and that it had a rational relation to the same governmental interests highlighted in the *Glucksberg* case.

Furthermore, the Court rejected the physicians' argument that PAS and the refusal of life-sustaining treatment is essentially the same thing. Rehnquist explained that the "distinction between assisting suicide and withdrawing life-sustaining treatment…is both important and logical."[94] Rehnquist then discussed how a physician who withdraws life-sustaining treatment from a patient is simply honoring the patient's wishes. Similarly, he argues, when a doctor provides a patient with aggressive palliative care that may hasten death, the "physician's purpose and intent is, or may be only to ease his patient's pain. A doctor who assists a suicide, however, 'must necessarily and indubitably, intend primarily

---

91 *Vacco v. Quill*, 521 U.S. 793 at 797-798, 117 S.Ct. 2293 at 2296; (1997).
92 Founding Fathers, 55.
93 *Vacco v. Quill*, 521 U.S. at 799, 117 S.Ct. at 2297; (1997).
94 *Vacco v. Quill*, 521 U.S. at 800-801, 117 S.Ct. at 2298; (1997).

that the patient be made dead.'"[95] The importance of a physician's intent in a given act is discussed in more detail later in this paper.

PAS in Rhode Island

In his opinion in *Glucksberg*, Chief Justice Rehnquist discussed the long legal tradition of the rejection of suicide. To further his argument, Rehnquist referenced the legislators of Providence Plantations declaration in 1647 that "'self-murder is by all agreed to be the most unnatural.'"[96] Three hundred forty-nine years later, the Rhode Island General Assembly made physician assisted illegal. In 1996 the General Assembly passed this legislation based on the reasoning that the "state requires that vulnerable persons be protected from suicide."[97] This law makes any individual who knowingly either provides the physical means by which another commits or attempts to commit suicide or participates in the act of suicide or attempted suicide of another guilty of a felony. Upon conviction, the guilty party may be punished by up to ten years imprisonment, by a fine of up to $10,000 or both.[98] Additionally, the statute expressly exempts any health care professional who either dispenses pain medication, in order to relieve pain, that may hasten death, or withholds or withdraws a life sustaining procedure from a patient at the patient's requests, from any liability.[99]

While the RI General Assembly may prohibit the practice of physician assisted suicide, the legislature does acknowledge that the terminally ill have certain fundamental

---

95 *Vacco v. Quill*, 521 U.S. at 801-802, 117 S.Ct. at 2298-2292; (1997).
96 *Washington v. Glucksberg*, 521 U.S. at 712-713, 117 S.Ct. at 2264; (1997).
97 RI Gen.Laws, 1956, § 11-60-1.
98 RI Gen.Laws, 1956, § 11-60-3.
99 RI Gen.Laws, 1956, § 11-60-4.

rights. Chief among these rights is the fundamental right to have life-sustaining procedures withheld or withdrawn at the terminal patient's request.[100] In certain cases, communication of a patient's wishes becomes impossible. Under a scenario of this type, a patient may create a durable power of attorney for health care.[101] In accordance with this statute, a person may sign a document, in the presence of two witnesses who attest to the patient's mental and emotional state, which expresses the patient's desires regarding medical treatment if the patient becomes unable to communicate them. The patient further authorizes a person of the patient's choosing to make health care decisions for the patient in accordance with the document if the patient becomes unable to do so.[102] Furthermore, the Health Care Power of Attorney statute stipulates that the fundamental right to withhold or withdraw medical care is not impaired in any way and that all decisions made in accordance with the patient's durable power of attorney for health care will be respected.[103]

Despite Rhode Island's law against the practice of physician assisted suicide, some lawmakers in the General Assembly have made efforts to legalize PAS. In 1996, before the statute making PAS illegal was in effect, the RI Senate Judiciary Committee held hearings on bills to legalize and criminalize physician assisted suicide. After the hearings, the Committee voted by a margin of 12-0 to criminalize the practice and that version of the bill went on to the full Senate.[104] In both 1998 and 2007 legislators in the

---

[100] RI Gen.Laws, 1956, § 23-4.11-1.
[101] RI Gen.Laws, 1956, § 23-4.10-3.
[102] RI Gen.Laws, 1956, § 23-4.10.3.
[103] RI Gen.Laws, 1956, § 23-4.10.9.
[104] Felice J. Freyer, "A Time to Die," *The Providence Journal*, 16 February 1997, Special Report: Section 1, p. 5, p. 12.

House proposed bills that were nearly identical to the Oregon DWDA. The measures proved to be unsuccessful.[105] At the time of this writing, the practice of physician assisted suicide is still illegal in the state of Rhode Island and if we are to move forward with the legalization of the practice, we will have to examine the ethical dimensions of the issue.

Issues

Personal Choice

Perhaps the strongest argument for legalizing physician assisted suicide is that it enhances the options available to a patient suffering from a terminal illness. In America great weight and importance is given to an individual's right to make critical life choices. Several examples of this freedom of individual choice abound in our society. It is widely accepted in American culture that individuals have the right to choose a career, whom to marry, where to live, and several other aspects of their personal life.

Proponents of physician assisted suicide feel that this individual freedom of choice should naturally extend to the questions of how and when to die. Even opponents of PAS recognize that this is a strong argument in favor of this practice. According to Dr. Stephen D. Schwarz, a philosophy and ethics professor at the University of Rhode Island, the principle of autonomy as applied to the case of physician assisted suicide consists of

---

[105] "An Act Authorizing and Regulating Physician Assisted Suicide," H 7918, RI General Assembly, January 1998 Session, <http://www.rilin.state.ri.us/billtext98/housetext98/h7918.htm>. This bill was referred to the House Judiciary Committee on February 3, 1998. After that, I was unable to find any information on this bill and have therefore concluded that it must have not made it out of the Committee. And also, "The Rhode Island Death with Dignity Act," H 6080, RI General Assembly, January 2007 Session, <http://www.rilin.state.ri.us/billtext07/housetext07/h6080.htm>. This bill was referred to the House Judiciary Committee on March 1, 2007. Like the bill mentioned in the previous footnote, I was unable to find any record of this bill after that date and have therefore concluded that it must have not made it out of the Committee.

the argument that a person's life is their own and not that of the community or of the government.[106] This argument is furthered rather effectively by Paul Chamberlain in his book *Final Wishes: A Cautionary Tale on Death, Dignity, & Physician-Assisted Suicide*. In this book, Chamberlain uses a fictional story to highlight the several issues of the physician assisted suicide debate. Chamberlain explains the individual choice argument through one of his characters who says, "People want information, options and choices so they can participate in the decision-making process with their physicians. After all, whose life is it?"[107] This question raises a very valid point. If so much respect and deference is given to individual choice in the area of important life decisions, it follows naturally to those advocating PAS that this freedom of choice should extend to decisions surrounding the end of one's life. Indeed, as Dr. Alfred G. Killilea, a Political Science professor at the University of Rhode Island, put it, "if a person doesn't have control over the ending of their life, what kind of freedom do they have?"[108] Furthermore, argue the proponents of physician assisted suicide, refusing to legalize physician assisted suicide is too paternalistic. Proponents argue that patients do not want to simply be told what is best for them; they want to be active participants in their medical care process and they want to have a wide assortment of choices available to them.[109] Physician assisted suicide should be one of these options, according its supporters.

While proponents lay out strong arguments for legalization of physician assisted suicide on individual choice grounds, opponents of this practice do see some problems

---

[106] Dr. Stephen D. Schwarz, interview by author, Kingston, Rhode Island, 27 March 2009.

[107] Paul Chamberlain, *Final Wishes: A Cautionary Tale on Death, Dignity and Physician-Assisted Suicide*, (Illinois: Intervarsity Press, 2000), 39.

[108] Dr. Alfred G. Killilea, interviewed by author, Kingston, Rhode Island, 2 April 2009.

[109] Chamberlain, 52-53.

with this line of reasoning. Those against physician assisted suicide are quick to point out that the right of individual choice is not unlimited. Schwarz offers several examples where personal autonomy must be restricted for the good of society. Far from being a "blanket right," he argues that an individual freedom is constantly being curtailed by things like traffic laws and laws against the possession or use of drugs.[110] In Schwarz's opinion, laws against prostitution offer a perfect example of society's limiting of personal autonomy for the common good. If someone is consistently pro-choice for a woman's right over her body, he argues, prostitution should be viewed as a purely individual act.[111] Chamberlain extends this rationale and argues that "PAS is not a purely private act," and that any legislation dealing with physician assisted suicide will have to take into account potential effects on society.[112]

Certainly Chamberlain and Schwarz are correct in their analysis, as several rights that may at first seem private do have considerable effects on society. Opponents of physician assisted suicide have additional criticisms of the personal choice arguments of the supporters of PAS. In his book, Chamberlain puts forth the argument that in the situation of physician assisted suicide, the individual does not really make the decision of when to end their life. He believes that the final decision rests with the government.[113] In a dialogue that he sets up between two characters, Chamberlain compares the approval process of applying for physician assisted suicide assistance to that of getting a driver's license. In both situations, the government must approve the individual's request for

---

110 Schwarz, interview by author.
111 Schwarz, interview by author.
112 Chamberlain, 134-135.
113 Chamberlain, 141.

certification. Then, he argues, the analogy breaks down. According to Chamberlain, once a person receives a driver's license, the decision of when to use that freedom is up to the individual. In PAS, he reasons, that final decision rests with others and "all the suffering person can do is put in his request and wait to have his fate decided by someone else."[114]

Chamberlain's analysis, if true, would be severely damaging to the individual choice arguments for the legalization of physician assisted suicide. I believe, however, that Chamberlain's analogy actually would be workable if it was slightly revised. I think that Chamberlain fails to recognize that the final choice rests with the patient, not with others. One can reason that the acceptance of one's request for physician aid in dying is similar to the issuance of a driver's license. If a terminally-ill patient's request for physician assisted suicide is approved, there is no condition that he or she must go through with it. Like the decision by a licensed motor vehicle operator to go out for a drive, the ultimate decision of whether to go through with a PAS procedure is the individual's. In the case of PAS, of course, the "drive" can be taken only once and will not be returned from. The fact remains, in a significant number of Oregonians approved for PAS procedures, the patients declined to exercise this option. In this situation it appears as though people just want to know that they have the option and the choice to end their lives with the help of a physician should they need it. Killilea believes that this "represents an opportunity to assert control over your life and once people get that, their decision sometimes is not to use it."[115] It seems as though Chamberlain was mistaken in his analysis of with whom the final decision rests.

---

[114] Chamberlain, 139-141.

[115] Killilea, interviewed by author.

Several terminally ill patients cite concerns about loss of autonomy and loss of dignity as reasons for making requests for physician assisted suicide. According to Dr. Ira Byock, former President of the American Academy of Hospice and Palliative Medicine, the phrase, "'I feel so undignified,' is a constant refrain among terminally ill people whose personhood is being assaulted from all directions."[116] Terminally ill patients have trouble adjusting to being dependent on others for daily care. In the data released by the Oregon Department of Human Services, these concerns are all too apparent. Of the 401 people who have died from 1998-2008 from a lethal injection pursuant to the Oregon DWDA, 89.9% cited "loss of autonomy" as a concern and 83.8% cited "loss of dignity" as a concern for seeking to end their lives through physician assisted suicide.[117] How can these concerns be adequately addressed? In the minds of proponents of PAS, the answer to this question is again one of personal choice. Many terminally ill patients want all of the issues to be on the table in combating their main aspects of suffering.[118]

Opponents of physician assisted suicide also see these feelings among the terminally ill as problematic, but they do not see the legalization of physician assisted suicide as the appropriate way to address these concerns. Many of those who oppose PAS blame society for fostering this notion that equates the loss of one's autonomy to the loss of one's dignity. Byock points out that, "society reinforces the belief that the loss of normal capability and independence renders a person undignified."[119] Byock and others suggest that the notion of dignity as physical independence needs to be shed by

---

[116] Ira Byock, *Dying Well: The Prospect for Growth at the End of Life*, (New York: Riverhead Books, 1997), 85.
[117] Oregon DWDA Characteristics.
[118] Chamberlain, 53.
[119] Byock, 86.

society.[120] Agreeing with Byock, Schwarz suggests that there are different levels of dignity. He argues that most people's idea of what dignity is actually is what he calls "secondary dignity." As an example of this kind of dignity, Schwarz put forth the scenario in which a person was attending a fancy dinner in a beautiful mansion wearing dapper attire. According to Schwarz, the real or primary dignity is retained by an individual no matter what physical state that individual is in. In Schwarz's mind, even if a person is on the operating table or is losing control of bodily functions, the primary dignity is still retained.[121] It seems that Chamberlain agrees with both Schwarz and Byock on this point, concluding that, "You don't lose your dignity just because you lose control of your body."[122] Most opponents of physician assisted suicide are in agreement that changing society's notions of dignity is the proper response to address these concerns of the terminally ill.

Being a Burden on Others and the Danger of Coercion

Similar to the feelings about loss of autonomy and loss of control, feelings about being a burden on others often lead terminally ill patients to request for the medical means to end their lives. Though not as prevalent as the concerns mentioned above, feeling like a burden on others is a relatively common thing for those with terminal illnesses. According to the Oregon Department of Human Services, 38.3% of those who died in accordance with the Oregon DWDA cited "burden on family, friends/caregivers"

---

120 Byock, 98.
121 Schwarz, interview by author.
122 Chamberlain, 196.

as an end-of-life concern.[123] A study done by Northwestern University yielded strikingly similar results; 46% of those who made a request for some assistance in suicide cited being a burden on others as one of several factors for making that request.[124] Proponents believe that PAS should be one of many legal options available to those suffering from a terminal illness.

Opponents of physician assisted suicide see a more practical and less dangerous way of adequately addressing the feelings of being a burden on others that many with terminal illnesses have. Many of those against this practice believe that, like society's notions of dignity, society's negative notion of the sick and elderly as "burdens" needs to change. Kiki Latimer, a teaching assistant to Dr. Schwarz, explains that, "This concept that we shouldn't be a burden to other people is a false concept."[125] She explains that by caring for the sick and elderly, people learn to care for each other in a very real way. Being a burden on others is part of the human package and is simply sometimes the reality of our relationship with others.[126] Relying on his experience in the field of hospice and palliative care, Byock explains that in many cases caregivers come to appreciate their time spent with the dying as precious.[127] Byock agrees that the terminally ill need to change their negative views about becoming burdens and realize that sometimes,

---

[123] Characteristics and end-of-life care of 401 DWDA patients who died after ingesting a lethal dose of medication, by year, Oregon, 1998-2008," Oregon Department of Human Services, <http://www.oregon.gov /DHS /ph/pas/docs/yr11-tbl-1.pdf>.

[124] "Important Questions About Physician Assisted Suicide," EndLink, Northwestern University, <http://endlink.lurie.northwestern.edu/index.cfm>.

[125] Kiki Latimer, interview by author, Kingston, Rhode Island, 27 March 2009.

[126] Latimer, interview by author.

[127] Byock, 159.

accepting care can be the most important and meaningful thing that a terminally ill patient can do for their loved ones.[128]

Due to the burden that several terminally ill patients feel they are imposing on their friends and families, opponents of physician assisted suicide see legalization of the practice as extremely dangerous. Depending on the study used, Northwestern University estimates that anywhere from 25-77% of the patients suffering from serious illnesses have persistent depression symptoms. Even more disturbing is the university's findings that depression is undiagnosed and untreated in roughly two out of three such cases.[129] Given the vulnerable state of the elderly and the terminally ill, many opponents of PAS legislation argue that several terminally ill patients will be coerced to choose PAS in order to not be a burden on friends and families. Several of those who oppose the practice are worried about the terminally ill developing what some call a "duty to die."[130] While opponents of physician assisted suicide acknowledge the proponents' claim that in theory PAS would be strictly voluntary, many fear that in practice coercion presents a big problem. Sometimes a simple suggestion or a look of stress on the face of a caregiver could indirectly influence a terminally ill patient's decision to end their life through legal, medical means.[131] Other opponents of PAS see patients having to justify their own existence to themselves. With all of the issues that terminally ill patients must deal with, such as the feeling that they are burdens to their caregivers coupled with the legality of

---

[128] Byock, 167.

[129] "Anxiety, Delirium, and Depression," EndLink, Northwestern University, <http://endlink.lurie.northwestern.edu/index.cfm>.

[130] Paula Nelson-Marten, "'Duty to Die?' – An Ethical Dilemma," in *Death: Completion and Discovery*, ed. Charles A. Corr and Richard A. Pacholski (Ohio: Association for Death Education and Counseling, 1987), 211.

[131] Schwarz, interview by author. Also, Chamberlain, 86.

PAS, some patients may decide that they have a duty to die, not because they really want to but because they are unable to justify their own existence.[132] For those who oppose physician assisted suicide, the danger of subtle coercion is too great to risk legalizing the practice.

While this point is certainly a valid and frightening one, in the eyes of some proponents of PAS, this train of thought is too paternalistic. Although it is important to acknowledge the vulnerability of the elderly and the terminally ill, it is equally important to acknowledge that we are not talking about children. The elderly and the terminally ill in question are adults nonetheless and they can be expected to know the difference between a right and a duty, argue those in favor of legalizing physician assisted suicide.[133] A conflict exists here between individual choice and society attempting to promote the common good. The argument of government knowing what is best for the people is not one that sits particularly well with some members of American society. For proponents of physician assisted suicide, intense vigilance over the process is the appropriate way to address this concern.[134]

While the two sides may debate about the appropriate response to the feelings of being a burden on others felt by terminally ill patients, there is no ignoring the fact that, financially speaking, end-of-life care is extremely costly. In a study cited by Northwestern University, 31% of families lost "most of their savings caring for a loved one." In a second study, "40% of families caring for a person cancer became

---

132 Chamberlain, 78.
133 Killilea, interview by author.
134 Killilea, interview by author.

impoverished" as a result of the treatment.[135] These stark financial figures lead many who oppose physician assisted suicide to conclude that patients will be pushed to choose death as a cost-cutting measure. Richard Doerflinger explains that if PAS becomes accepted and, "life-extending care of the terminally ill is increasingly seen as strictly elective, society may become less willing to appropriate funds for such care, and economic pressures to choose death will grow accordingly."[136] Doerflinger is certainly not alone in this fear. Indeed, this position also finds support from the U.S. Supreme Court. In the *Glucksberg* case, discussed above, Chief Justice Rehnquist argued that "if physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs."[137]

This danger of coercion is very real and, with the high cost of end-of-life care, opponents of PAS are correct to be wary. If physician assisted suicide were legalized in several states in America under the current system of health care, an ominous trend may develop – poorer patients overwhelmingly choosing to end their lives through physician assisted suicide with more affluent patients choosing to spend money to trying to alleviate their pain. This is a legitimate concern but it does not necessarily suggest that physician assisted suicide legislation is entirely unworkable. Some proponents of PAS answer their critics' problems with physician assisted suicide by arguing that a system of universal health care needs to be set up.[138] Even today, Killilea argues, one can see the

---

[135] "Important Questions About Physician Assisted Suicide," EndLink, Northwestern University, <http://endlink.lurie.northwestern.edu/index.cfm>.

[136] Doerflinger, 316. Similar arguments can be found in Chamberlain, 114. Also Schwarz, interview by author.

[137] *Washington v. Glucksberg*, 521 U.S. at 732, 117 S.Ct. at 2273; (1997).

[138] Killilea, interview by author.

problem that personal wealth poses under our current system of health care. Medical problems that are solvable to the more affluent members of society are nearly impossible ones to solve for the poorer members of our society. As a result, they must accept a speedy death as a result of their inability to afford expensive treatment and the end result of our current system is that, "people with more resources or with better luck, better circumstances, can live longer."[139]

The Danger of Expansion

Perhaps the strongest argument made by the opponents of physician assisted suicide is that, once PAS legislation is enacted, the possibility for expansion will be too great. Sometimes referred to as "slippery slope" or "loose cannon" arguments, these concerns consist of the belief that there are no adequate roadblocks to prevent the deterioration of the practice to encompass unintended cases.[140] What opponents of PAS see as one of the major problems with the "roadblocks" set up by the Oregon and Washington laws is the definition of terminal illness. They are quick to point out that there is nothing sacred about the current six month requirement of a "terminal illness."[141] If it is considered humane, opponents argue, to allow someone with six months to live to choose to end their life through physician assisted suicide, surely it would be more humane to allow someone with nine months to live to make the same choice. If it is allowed for people with nine months to live, surely it is more humane to allow someone who will suffer for twelve months to chose to end their life through medical means. It

---

139 Killilea, interview by author.
140 Doerflinger, 315.
141 Schwarz, interview by author.

seems strange to some critics of PAS that a person in the early stages of a destructive disease like Alzheimer's will be ineligible for PAS because the disease has not progressed far enough.[142] For many opponents of the practice, the problem with terminal illness as a requirement for PAS is that the word "terminal" is a very relative term. Comparing the word "terminal" to words such as "near" and "far," Schwarz argues that their relativity often makes their use rather vague.[143]

The gradual expansion of the time period of what constitutes a terminal illness is especially dangerous because it is very rational on a step-by-step basis. The argument for small expansion is very strong and each small expansion serves as rationale for yet another small expansion. Before too long, the result is often drastic, unintended consequences that seemed preposterous before the legislation was enacted.[144] Many opponents of physician assisted suicide see this potential for seemingly rational expansion, coupled with the effects of coercion and the desires of the terminally ill not to be burdens on their friends and families, leading PAS legislation down a dark and dismal path.[145] Indeed, some of those opposed to physician assisted suicide argue, that path has already been mapped out for us in the experience with PAS in the Netherlands. As mentioned above, the courts in the Netherlands have readily expanded the definition of terminal illness when called upon to do so. Such a broad definition of terminal illness may seem unreasonable to many PAS proponents in this country but, argue the opponents, that is exactly what makes the slippery slope arguments so dangerous – the

---

142 Kamisar, 113.
143 Schwarz, interview by author.
144 Chamberlain, 123.
145 Schwarz, interview by author.

fact that some consequences that naturally follow from reasoning, as some would argue occurred in the Netherlands, seem impossible to those advocating PAS before it is on the books.

Furthermore, the possibility for expansion of the terminal illness requirement also presents the parallel of an Equal Protection argument. Some opponents of physician assisted suicide see an inconsistency in allowing suffering terminally ill patients to seek medical means to end their lives while, at the same time, refusing to allow those suffering mental or emotional anxiety to do the same. Chamberlain suggests that it is an inconsistent principle to allow some people who are suffering the choice to end their life while denying this choice to others.[146] Indeed, there have been several documented cases in the Netherlands of physically healthy people, enduring severe emotional and/or mental suffering, who are put to death at their request.[147] Can any set of physician assisted suicide legislation justify this distinction?

The arguments that opponents offer under the broad category of "slippery slope" arguments are valid ones, and ones with much merit. If it were impossible to argue against these positions, physician assisted legislation would seem to be simply too dangerous to enact. Proponents do acknowledge that the definition of terminal illness in PAS legislation is often vague and imprecise and they strongly urge that intense vigilance will have to be used to safeguard against any such "slip." On the other hand, while six months is a vague and imprecise limit, it is at least a starting point. Some advocates of physician assisted suicide claim that the six month requirement is better than turning a

---

[146] Chamberlain, 139.
[147] Reference needed.

blind eye to the needs of suffering terminally ill patients.[148] I would argue that the dangers suggested by those against PAS are both very possible and very horrendous.

Due to these dangers, I believe, a legal justification exists to keep the terminal illness definition at six months. As mentioned above, the Supreme Court declined to find a constitutional fundamental right of a person to choose to end their lives through a physician assisted suicide. As it stands now, with no fundamental constitutional right to physician assisted suicide existing in the U.S. Constitution or any state constitution (the Oregon and Washington laws are statutory grants of the right, not constitutional), any PAS legislation being challenged by someone with an illness that will become terminal but that is currently outside the six month scope will most likely be upheld under the rational basis test.[149] Recall from the discussion of physician assisted suicide and the Supreme Court that legislation that burdens neither a fundamental right nor targets a suspect class will generally be upheld as long as it has some rational relation to a legitimate governmental interest. In *Glucksberg*, one of the governmental interests that the Supreme Court recognized that the State of Washington was trying to protect was the interest in "avoiding future movement toward euthanasia and other abuses."[150] Certainly it is conceivable that a court would hold that legislation that limits the right to physician assisted suicide to those with a terminal illness as having six months to live passes the rational basis test.

Additionally, let' s say, for the sake of argument, that the Court does reverse itself, overturn *Glucksberg*, and recognize a fundamental right to physician assisted

---

148 Killilea, interview by author.
149 Bender, interview by author.
150 *Washington v. Glucksberg*, 521 U.S. at 728, 117 S.Ct. at 2271; (1997).

suicide or that a state court recognizes a fundamental right in a state constitution to PAS. It is still possible for legislation that limits the practice to those with six months to live to be upheld. When legislation burdens a fundamental right, it must pass the strict scrutiny test. One of the hardest tests to pass in constitutional law, the strict scrutiny test requires that legislation infringing on the exercise of a fundamental right be narrowly tailored, so as to not place an undue burden on the right, and to advance a compelling state interest.[151] Courts will usually recognize that legislatures are engaged in arbitrary line drawing quite frequently. If the legislation in question were to give some legislative findings, pointing to the facts of the practice of PAS in the Netherlands and arguing that the six month requirement of the legislation was an essential roadblock necessary to prevent the practice from unintended consequences, then it is possible, but not certain, that a court would uphold this legislation as passing the strict scrutiny test.[152]

Similarly, some advocates of physician assisted suicide believe it is important to make a distinction between physician assisted suicides and other suicides. In some people's minds a "traditional suicide" involves the ending of a living process while PAS involves the ending of a dying process.[153] Although this line of thought is rejected by many opponents of physician assisted suicide, I think it is an important distinction to make. Typically, terminally ill patients who request to end their lives through medical means are considered to be in the dying process – there is no real hope of recovery.[154] Conversely, a physically healthy person who is suffering form mental or emotional

---

151 *Washington v. Glucksberg*, 521 U.S. at 721, 117 S.Ct. at 2268; (1997).
152 Bender, interview by author.
153 Chamberlain, 58-60.
154 Chamberlain, 60.

anguish is in no imminent threat of death and is, therefore, in what can be called a living process.[155] This argument was attempted, at least in part, by the attorneys of the physicians in both the *Glucksberg* and *Quill* cases.[156] This serves as a valuable basis for making a possible legal distinction between these two types of cases, thereby circumventing the argument that those suffering from mental and emotional distress would also be entitled to end their lives through physician assisted suicide. If this difference is established and the two types of situations are adequately differentiated, physician assisted suicide can legally condone one type of suicide, ending a dying process, while simultaneously not condoning all other suicide, ending a living process. While this approach may seem like technical hair-splitting at first, an important legal distinction may result. As discussed above, physician assisted suicide can potentially be upheld as constitutional in the face of Equal Protection claims brought against it, whether the right to physician assisted suicide is fundamental or not. For the same reasons mentioned in the above discussions of the rational basis test and the strict scrutiny test, it seems as though it is possible to legally contain the practice to mentally competent, terminally ill individuals who have six months or less to live.

Some proponents of physician assisted suicide attack the slippery slope argument on the grounds that the possibility of abuse is not a sufficient reason to destroy the possible liberty.[157] Even some of those who oppose PAS, like Latimer, see a problem with using the slippery slope argument as a means to proscribe physician assisted suicide legislation. She uses an example of building a new highway to illustrate her point. With

---

155 Chamberlain, 59-60.
156 Kamisar, 101.
157 Chamberlain, 46.

the construction of a new highway come the obvious risks of more accidents, more drunk drivers, etc., but these risks are not sufficient to preclude construction of the highway. In Latimer's mind, "if I do have a right to physician assisted suicide, I don't think that right should be taken away just because, down the line, somebody may abuse that right.[158] While Schwarz agrees that Latimer's reasoning is valid in most cases, he believes strongly there are some cases in which potential dangers are so immense and threatening that an ban on potential action is warranted. He offers the case of a biological or chemical agent that has some beneficial effects for humankind when handled correctly, yet is lethal to all humans if it gets out of the lab and into the air supply. In this case, he reasons, the rationale behind the slippery slope argument holds up.[159] While I would agree with Schwarz in terms of the biological agent scenario, the critical question for me is does physician assisted suicide pose risks as great as the biological agent scenario or lesser risks, such as those found in the highway construction scenario? Although it is important not to undermine the seriousness of the effects posed in the slippery slope arguments against PAS, it seems as though they are clearly not as dire as the risks posed in the biological agent scenario.

Both advocates and opponents of physician assisted suicide are in agreement that maintaining quality of life for terminally ill patients is a top priority. When society makes a value judgment on peoples' lives problems usually ensue. Those against the legalization of PAS argue that if the practice becomes legal, society will endorse certain lives,

---

[158] Latimer, interview by author.
[159] Schwarz, interview by author.

particularly those of the disabled and the terminally ill, as lives "not worth living."[160] In addition to this danger, many opponents of physician assisted suicide point out that many currents in society have longstanding prejudice towards the disabled. This combination of prejudice and the notion that certain lives are "not worth living" could further mix with the potential problems listed above and increase the risk that PAS legislation succumbs to a "slippery slope."[161]

Like any issue in this contentious debate, where each side has an answer for one another's problems, proponents of physician assisted suicide have a response to these allegations about society placing values on people's lives. Firstly, advocates of PAS argue, while prejudice against those with disabilities may be prevalent in a large number of individuals in society, society as a whole makes conscious efforts to assist those with disabilities. Killilea points out that in both Portland, Oregon and Honolulu, Hawaii, all of the public buses are equipped with devices to assist those in wheelchairs and he reasons that this shows society's efforts to provide support for and to promote the rights of the disabled.[162] Secondly, while acknowledging the danger inherent in society deeming lives as "not worth living," proponents of PAS legislation also see as problematic society's deeming lives that are worth living irrespective of an individual's value judgment. As Killilea puts it, "there is always going to be a problem of society not sufficiently appreciating the plight of the people who have misfortunes that are not generally shared in society.[163] In a way, this argument relies on the personal choice arguments discussed

---

160 Chamberlain, 160-162.
161 Doerflinger, 318. Also Schwarz, interview by author.
162 Killilea, interview by author.
163 Killilea, interview by author.

above. By not allowing individual's to value their lives as "not worth living," society impedes on an individual's freedoms.

Intended vs. Foreseen Consequences

In discussions of why physician assisted suicide should not be legalized, much is made of the distinction between intended consequences and consequences that are not intended but merely foreseen. Examples of this distinction abound in everyday life and Schwarz is quick to put forth a vivid example to illustrate this distinction. In scene one of this scenario, a doctor notices a person injured on the road. This person requires immediate life saving surgery and no anesthesia is available. So the doctor performs the surgery with the intent to save the person's life, foreseeing that he will cause the person pain. In scene two of this scenario, the same physical actions are being performed by a sadist with the intention to inflict pain on the person. In the first situation the infliction of pain is merely foreseen but not intended. In the second situation the infliction of pain is the intent of the actions.[164] Opponents of physician assisted suicide believe that this is a crucial distinction to always keep in mind while dealing with issues of PAS legislation.

In medical terms this distinction manifests itself in the distinction between mercy killing, including both active and passive euthanasia, and "only caring." This distinction is laid out rather succinctly in Schwarz's article *Mercy Killing and Only Caring: A Clarification*. Essentially, the tenets of this position are as follows. Whenever possible, good medicine aims to cure and to prevent disease but at some point in the case of a

---

[164] Schwarz, interview by author.

terminal illness this becomes impossible. Schwarz then argues that "only caring" consists of either administering strong dosages of pain medication or withholding or withdrawing medical treatment that is pointless or very painful.[165] In this case, the intent of the action is to make a patient's death as comfortable as possible, even if it is reasonably foreseen that that the patient may die quicker. This is in direct contrast to what Schwarz and others call mercy killing. What is the difference between the two situations? In mercy killing, the intent of the act is to bring about death or to hasten it while in "only caring" the intent is to relieve the suffering of the patient.[166] Schwarz's contention is supported by others who oppose physician assisted suicide. Latimer argues that "you can do a lot to end suffering, including [administering] what you pretty much foresee will be a fatal dose of morphine or a sedative" as long as your intent is not to bring about death.[167]

The distinction between intended and merely foreseen consequences is also a big distinction in Catholicism. Killilea explains that the Catholic Church does not condone the use of condoms yet condones medical procedures like hysterectomies. With condoms, the effect on the pregnancy of a woman is a direct one while with hysterectomies and the like, the effect on the pregnancy of a woman is an indirect one.[168] Opponents of PAS believe that legalization of this practice will signify a crossing of a threshold by condoning actions done with the intent to bring about death.

---

165 Stephen D. Schwarz, *Mercy Killing and Only Caring: A Clarification*, p.2, paraphrasing Thomas D. Sullivan, "Active and Passive Euthanasia: An Important Distinction?" in Robert M. Baird and Stuart E. Rosenbaum (eds.), *Euthanasia: The Moral Issues*, (Prometheus Books, 1989), 57.

166 Schwarz, interview by author.

167 Latimer, interview by author.

168 Killilea, interview by author.

Although the arguments for this distinction between intended and simply foreseen consequences are convincing, several proponents of PAS legislation are not sure that the distinction is as large as the opponents of PAS would have us believe. In the minds of some physician assisted suicide advocates, there is little to no moral difference between killing and letting die in circumstances where a terminally ill patient wishes to end their life.[169] Proponents of PAS who feel this way often see an inconsistency in the current laws – patients on respirators, ventilators and the like are allowed to end their life by refusing treatment while patients without the need for respirators or ventilators but who still wish to end their lives are unable to do so.[170] Most proponents of physician assisted suicide acknowledge that a distinction does exist, but they are skeptical about how large this distinction is. Killilea points out the contradictions of the Catholic Church's adherence to the idea of the distinction as being clear-cut – they do not condone condoms because they value life but, as a result, the effects of this policy in Africa are the rapid spread of the AIDS epidemic and large numbers of unwanted pregnancies. How can the Church claim to value life when one of the results of this doctrine is a large amount of unwanted pregnancies?[171] This question certainly points out that the distinction between intended and foreseen is not always as clear and convincing as opponents of PAS legislation make it out to be.

It seems to me that the crucial question to be answered to overcome this distinction is what the primary intent of the doctors who aid a patient in dying is. Is it really done with the intent to make a person dead? Perhaps, but is this the primary intent

---

169 Chamberlain, 28.
170 Chamberlain, 43-44.
171 Killilea, interview by author.

of the action? I would argue that it is not; the primary intent of the action of the physician who assists a terminally ill patient in ending their life is the permanent relief of suffering. I'm sure opponents of the practice will argue rather forcefully that this action is done through the direct bringing about of a patient's death. Admittedly, that is a direct result of the actions of the physician in this case. I do think, however, that those who cling to the idea of a huge difference between intending something to happen and merely foreseeing that it will happen need to acknowledge that there is often more than one intention at work in the performance of a certain act. These multiple intentions are of differing degrees of importance. I argue that more attention needs to be attributed to an act's primary intention. In the case of physician assisted suicide, this act may be the only adequate means to relieve the pain of the terminally ill patient. After all, the act of physician assisted suicide is a quite permanent relief from pain for a suffering patient. In my mind, the primary intent of the act of physician assisted suicide is the relief of pain and I am hopeful that the distinction between intended and merely foreseen consequences will soon be viewed as a surmountable one.

Building on this distinction between intended and foreseen consequences of actions, opponents of physician assisted suicide argue that legalizing the practice could have a detrimental effect on the medical profession. After all, they argue, physicians today are called on to work tirelessly to save lives and to cure diseases and ailments. If we legalize PAS would this be turning doctors into killers?[172] Turning to history, some opponents of the practice are wary that allowing doctors to focus on ending lives of individuals will bring a repeat of the atrocities committed during the Nazi regime's years

---

[172] Schwarz, interview by author.

of dominance. Doerflinger points out that many of those who conducted the "mercy killings" of the 1930s were readily recruited to operate the killing chambers of the concentration camps.[173] Opponents use this analogy to argue that if the distinction between healing and killing is erased by PAS legislation, the whole system can once again succumb to the "slippery slope" and the consequences could be disastrous.

On this issue proponents of PAS argue that this transformation between attempting to save lives and aiding in the dying process is already underway. According to Killilea, "already…compassionate doctors see their role as helping people to die and helping families to accept that."[174] Proponents argue that this desire to help patients in their dying process is only natural in trying to achieve the patient's wishes. Would it really be a monumental crossing of the Rubicon to ask doctors to continue their assistance to patients who are dying by asking them to assist in a patient's desire to end their life through medical means? Advocates of the practice certainly don't think so.

Recommendation for Rhode Island

After a semester of complete and total immersion into the topic of physician assisted suicide, I have come to the conclusion that Rhode Island needs to adopt legislation similar to the laws of Oregon and Washington. While I acknowledge the very real potential for abuse brought up in the many strong arguments made by the opponents of PAS, I feel that an individual's right to choose the course of his or her treatment should reign supreme. Indeed, because some of the arguments against legalizing PAS are

---

[173] Doerflinger, 319.

[174] Killilea, interview by author.

so persuasive, any successful piece of legislation enacted in RI needs to adequately address these problems. In particular, there are three very strong arguments against legalization of the practice which all PAS legislation must take into account.

The first problem that must be addressed is the danger of the elderly and terminally ill choosing to end their lives through PAS out of a feeling of a "duty to die." As mentioned above, many elderly and terminally ill patients already feel like a burden to friends and families. Opponents of the practice argue that if PAS were legalized, patients would feel a need to justify their own existence. This will be increasingly difficult for such vulnerable patients in the years ahead, in large part because of the high cost of both health care in general and end-of-life care in particular. This problem will be even more pressing for poorer patients. Due to the very real nature of this danger, a physician assisted suicide law in RI will need to address this issue. I feel that the most effective way to address the problem would be to initiate a universal health care system in RI. While the implementation of this system may sound costly, keep in mind that Western European countries that have universal health care systems spend far less on health care per capita than we do here in America, as discussed in the previous pages. I believe that this is the only effective means of preventing all patients, and poorer patients especially, from choosing to end their lives out of a "duty to die." Furthermore, the RI legislation would need to stipulate that physicians be extremely vigilant in determining whether a patient is making a request for a physician assisted suicide as a result of any undue influence from any friends, family members, or caregivers.

The second and third strong arguments against the legalization of the practice of PAS are essentially two sides of the same coin. On the one hand, argue the opponents of physician assisted suicide, the current definition of a terminal illness as being one in which the patient has six months to live will be easily expanded. If it is considered compassionate to allow someone suffering for six months to choose PAS, then it seems even more compassionate to allow someone suffering for a longer period of time the same choice, they argue. Critics of the practice conclude that the strong incentive for expansion of physician assisted suicide will prove that PAS legislation will be impossible to contain. Similarly, opponents of PAS argue that to differentiate between physical suffering, on the one hand, and mental and emotional suffering, on the other, is an unfair concept. They argue that the practice, if legal, will logically be expanded to be available to the physically healthy, mentally and/or emotionally suffering person as well. The end result would be a situation like that existing in the Netherlands today.

It is precisely because these arguments against expansion have so much merit, that it is essential for a RI law allowing physician assisted suicide to limit the practice to the mentally competent, terminally ill patients with six months to live or less. As discussed in the preceding pages, it is possible for a legal distinction to be made and enforced. Whether the RI Supreme Court finds a fundamental right to PAS in the state constitution or the U.S Supreme Court reverses itself and finds a fundamental right to PAS in the U.S. Constitution, legislation in RI that limits the practice can conceivably be upheld if the State makes the argument that the legislation is narrowly tailored and advances a compelling state interest. By explaining legislative findings in the proposed

legislation that detail the dangers of the practice if it is not held in check, the State may successfully contain the practice. If both the RI Supreme Court and the U.S. Supreme Court decline to find a fundamental right in either constitution, then RI legislation limiting the practice of physician assisted suicide to mentally competent, terminally ill patients who have six months or less to live will be even more likely to be upheld in the face of any challenges to it.

In sum, I believe that physician assisted suicide legislation, when fashioned with adequate safeguards, can be contained to benefit the people who need it most. While there is no question that great potential dangers to society exist if this practice is abused, it is not impossible to forestall any drastic consequences of physician assisted suicide if the law is vigilant and firm. The personal autonomy of the dying patient should extend to the choice of the time, manner, and location of death. It is without doubt that the issue of physician assisted suicide will soon erupt to onto the national agenda. The question is what role will Rhode Island play in this national debate? Will it be a leader or a follower? The State of Rhode Island needs to pass a Death with Dignity Act, similar to the laws of Washington and Oregon, and assume a leadership role in deciding the inevitably contentious question of when life ends.

Works Cited

"2008 Summary of Oregon's Death with Dignity Act." *Oregon Department of Human Services*, March 2009. <http://egov.oregon.gov/DHS/ph/pas/docs/year11.pdf>.

"Abortion Clinic Violence." *MSNBC*, 1997. <http://msnbc.com/modules/clinics/>.

"An Act Authorizing and Regulating Physician Assisted Suicide," H 7918, RI General Assembly, January 1998 Session, <http://www.rilin.state.ri.us/billtext98 /housetext98/h7918.htm>.

"Anxiety, Delirium, and Depression," EndLink, Northwestern University, <http://endlink.lurie. northwestern.edu/index.cfm>.

Arias, Elizabeth. "U.S. Life Tables, 2004." *Centers for Disease Control and Prevention*, 28 Dec 2007. < http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_09.pdf>.

Bender, Thomas R. Esq. Interview by author. Providence, Rhode Island. 17 April 2009.

Byock, Ira. *Dying Well: The Prospect for Growth at the End of Life*. New York: Riverhead Books, 1997.

Chamberlain, Paul. *Final Wishes: A Cautionary Tale on Death, Dignity and Physician-Assisted Suicide*. Illinois: Intervarsity Press, 2000.

"Characteristics and end-of-life care of 401 DWDA patients who died after ingesting a lethal dose of medication, by year, Oregon, 1998-2008." Oregon Department of Human Services. <http://www.oregon.gov /DHS /ph/pas/docs/yr11-tbl-1.pdf>.

"Chronology of Dr. Jack Kevorkian's Life and the Assisted Suicide Campaign." *Frontline: The Kevorkian Verdict*. PBS. <http://www.pbs.org/wgbh/pages/ frontline/kevorkian/chronology.html>.

Cornyn, John, U.S. Senator. "An Abortion Litmus Test for Judge John Roberts." *The San Diego Union Tribune*, 7 August 2005. <http://www.signonsandiego.com/ uniontrib/20050807/news_mz1e7cornyn.html>.

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 110 S.Ct. 2841; (1990).

"Death with Dignity Act History." Oregon Department of Human Services, March 2006. <http://www. oregon.gov /DHS /ph/pas/docs/History.pdf>.

Doerflinger, Richard. "Assisted Suicide: Pro-Choice or Anti-Life?" in *The Right Thing to Do: Basic Readings in Moral Philosophy, 5th ed.,* ed. James Rachels and Stuart Rachels. Boston: McGraw Hill, 2007.

"Euthanasia in the Netherlands." *International Task Force*. No date of publication given, <http://www. internationaltaskforce.org/fctholl.htm>.

Founding Fathers and Justiceleaning.org. *The United States Constitution: What it Says, What it Means*. (New York: Oxford University Press, 2005).

Freyer, Felice J. "A Time to Die." *The Providence Journal*. 16 February 1997. Special Report: Section 1.

"Health Insurance Costs." *National Coalition on Health Care*, 2009. <http://www.nchc .org/facts/ cost.shtml>.

Humphry, Derek. "Evaluating Dr. Kevorkian's Contribution to the Right-to-Die Movement in America." 1 June 2007. *Euthanasia Research & Guidance Organization*. < http://www.assistedsuicide.org/Kevorkian_contribution_to_the_ right_to_die_movement_in_America.html>.

Humphry, Derek. “Tread Carefully When You Help to Die: Assisted Suicide Laws Around the World.” *Euthanasia Research and Guidance Organization*. 1 March 2005. <http://www.assistedsuicide.org/ suicide_laws.html>.

“Important Questions About Physician Assisted Suicide,” EndLink, Northwestern University, <http://endlink.lurie.northwestern.edu/index.cfm>.

Kamisar, Yale. “Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy.” *Issues in Law and Medicine*, Fall 2008.

“Kevorkian Released From Prison After 8 Years,” *MSNBC*, 1 Feb. 2009, <http://www. msnbc.msn.com/ id/18974940/>.

Killilea, Dr. Alfred G. Interviewed by author. Kingston, Rhode Island. 2 April 2009.

Nelson-Marten, Paula. “‘Duty to Die?’ – An Ethical Dilemma.” in *Death: Completion and Discovery*, ed. Charles A. Corr and Richard A. Pacholski. Ohio: Association for Death Education and Counseling, 1987.

“OECD Factbook 2009.” *Organization for Economic Co-operation and Development*. <http://oberon.sourceoecd.org/vl=581474/cl=18/nw=1/rpsv/factbook2009/11/01/01/index.htm>.

ORS 127.800 to 127.897.

Oxford American Dictionary. 2006. s.v. “euthanasia.”

“Physician Aid-in Dying.” *Ethics in Medicine*. University of Washington School of Medicine, April 2009. <http://depts.washington.edu/bioethx/topics/pad.html>.

Raphael, Carol et al. “Financing End-of-life Care in the USA.” *Journal of the Royal Society of Medicine* 94 (January 2001): 458-461.

RI Gen.Laws, 1956, § 11-60.

RI Gen.Laws, 1956, § 23-4.

Schwarz, Dr. Stephen D. Interview by author. Kingston, Rhode Island. 27 March 2009.

Schwarz, Stephen D. *Mercy Killing and Only Caring: A Clarification*. paraphrasing Thomas D. Sullivan, "Active and Passive Euthanasia: An Important Distinction?" in Robert M. Baird and Stuart E. Rosenbaum (eds.), *Euthanasia: The Moral Issues*, (Prometheus Books, 1989), 57.

Smith, Wesley J. "Death on Demand: The Assisted-Suicide Movement Sheds Its Fig Leaf." *The Daily Standard*, 5 July 2007. < http://www.discovery.org/a/4121>.

"Table 1. Consumer Price Index for All Urban Consumers (CPI-U): U.S. city average, by expenditure category and commodity and service group." *Bureau of Labor Statistics*, March 2009.

"Table 2. Projections of the Population by Selected Age Groups and Sex for the United States: 2010 to 2050." National Population Projections, 2008. *U.S. Census Bureau*.

Table 4: Interim Projections: Change in Total Population and Population 65 and Older, by State: 2000 to 2030." State Interim Population Projections by Age and Sex: 2004-2030. *U.S. Census Bureau*.

"Table 47. Age of Reference Person: Shares of average annual expenditures and sources of income." Consumer Expenditure Survey, 2007. *Bureau of Labor Statistics*.

"The Rhode Island Death with Dignity Act," H 6080, RI General Assembly, January 2007 Session, <http://www.rilin.state.ri.us/billtext07/housetext07/h6080.htm>.

"The Thanatron." *Frontline: The Kevorkian Verdict*. PBS. <http://www.pbs.org/wgbh/ pages /frontline/ kevorkian/aboutk/thanatronblurb.html>.

Vacco v. Quill, 521 U.S. 793, 117 S.Ct. 2293; (1997).

Washington v. Glucksberg, 521 U.S. 702, 117 S.Ct. 2258; (1997).

Wineberg, Howard. "Physician-assisted Suicide in Oregon: Why So Few Occurrences?" *Medical Journal of Australia* 174 (2001): 353-354.

Wolpert, Bruce. Esq. Interview by author. Providence, Rhode Island. 17 April 2009.

Acknowledgements

The following people really made this project into something special. Without them, this paper would not have the same spark. I owe them all tremendous thanks for their generous, selfless support and assistance.

-My Faculty Sponsor, Dr. Art Mead

-Dr. Stephen D. Schwarz

-Kiki Latimer

-Dr. Alfred G. Killilea

-Bruce Wolpert, Esq.

-Thomas R. Bender, Esq.

Thank you all for everything you did to make this project into something more than an average term paper.

Keywords

1. Physician assisted suicide (PAS)
2. Death With Dignity Act
3. End-of-life care