



EUGENE F. SCOLES

Jack Liu, Photographer

FOREWORD: ACCELERATION OF DEATH OF THE TERMINALLY ILL WITH PHYSICIAN ASSISTANCE

Eugene F. Scoles

I am highly gratified to be honored by this issue of *The Elder Law Journal*. The appreciation and respect of one's peers and those involved in the development of law is one of life's greatest rewards. That most of my peers are also friends is even more rewarding, not withstanding the occasional practical joke or bit of humor that relieves academic life.¹

The Elder Law Journal plays an important role in the development of law in an area of increasing concern to the legal profession and to society. Matters within the scope of elder law have an ever-growing relevance as well to the practice of many other professionals such as care managers, health care providers, social workers, gerontologists, and financial and insurance advisors.

The issues treated in the *Journal* demonstrate the complexity of this sphere of the law. The articles in this issue serve as an illustration. Professor Harris explores a subtle but strikingly persistent phenomenon that is highly significant in political and legislative activity. Messrs. Middleditch and Trotter address an important conflict that is,

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1. Earlier references to some such whimsical relief may be found in 63 OR. L. REV. 533-56 (1984); 1989 U. ILL. L. REV. 829-44. As a former colleague once observed, "It's nice to hear these things while you are alive."

in part, an outgrowth of the cost and limited availability of health care services in this country. The piece by Professor Pickering Francis, as well as those by law students Zieger, Herrington, and Hedges, reflect the overwhelming impact of the often overweening governmental involvement in highly personal decisions and needs.

All of these pieces reflect the need for exploration, discussion, and understanding of the complex interwoven fabric of law, economics, social policy, and ethics in what has come to be called elder law. Most of the attorneys now concerned with this area of the law have been previously involved with matters of individual and family protection involving family law, the planning and administration of intergenerational property transactions, or poverty law. These areas have always involved matters of personal autonomy and competence requiring consideration of the influence of all family members, resources, and events. Where personal ambitions, affections, and financial concerns are complicated by health care factors, such as insurance and Medicare, in an aging population, elder law has emerged as a near specialty to address the resulting complexity.

In this constant tension among individuals, their family and associates, and our governmental and social infrastructure, the relative force of the policies furthering the personal autonomy of competent individuals, group protection, as well as social and economic responsibility, fluctuate with the changing circumstances. Assuring and protecting fully informed decisions by competent persons is most important. Consequently, adequate representation and advice for all the participants is critical and is often limited. The particular need for ombudsman assistance and protection increases with the expanding elderly segment of our nonaffluent citizenry if they are to avoid substantial loss of effective personal autonomy.

Health care matters demand particular attention because the necessity for care increases with age and often overwhelms family resources. Social and governmental attempts to meet individual needs necessarily involve legal guidelines for providers. Existing guidelines for near-death decisions are unclear as the nature and extent of governmental or legislative interest is still evolving. One instance involves pain management for the seriously or terminally ill, a situation in which reasonably careful providers following directions of their patients need protection from the risk of criminal or civil liability or professional discipline. Recently, health care issues have focussed on

whether appropriate care in extreme cases includes medical assistance in hastening death at the request of a competent patient.

Physician assistance in hastening death at the request of competent terminally ill patients is a complicated issue and one on which many different views currently are held. The following is submitted as an appropriate resolution of the governmental interest in this most personal matter.²

Many of our early, historically developed concepts simply are not compatible with the present state of health care. For example, many people inappropriately refer to physician-assisted death of the terminally ill as "assisted suicide." The term "suicide" traditionally connoted self-inflicted death that prematurely terminated a life that held the promise of meaning, value, and enjoyment, a life during which the person's present problems might be overcome. Common comments following a suicide were, "He was so young," or "What a waste," all reflecting the premature termination of life that was potentially valuable to the individual and to society. Accelerating the death of a terminally ill person is quite different from the historical concept of suicide. Modern technology frequently extends our physical bodily existence beyond any prospect of value or enjoyment. A terminally ill person who hastens death just has not committed "suicide" in the traditional sense. Rather, we are talking about brief shortening of the last days of life when the quality of living is gone and there is no potential for its improvement. This distinction is tacitly reflected in the absence of prosecutions of doctors who quietly help a terminally ill patient briefly hasten death.

There are many things we ought not frame as legal issues, and perhaps this is one of them. However, our "overlawed" society has thrust this matter into the legal realm and upon our courts. The issue demands careful analysis that goes beyond the value-laden generalizations and emotions that cloud our thinking.

There are competent people who are in such extreme discomfort from terminal illness that they seriously want to accelerate their death. There are competent doctors who believe their patients' wishes and

2. The remainder of this piece is reprinted from *Early Concepts of Life and Death Are Not Compatible with the Present State of Health Care*, REGISTER-GUARD (Eugene, Or.), May 18, 1997, at B1. This piece, which appeared on the editorial opinion pages of the *Register-Guard*, was written before the more recent U.S. Supreme Court cases and the legislative referral referendum on the Death with Dignity Act of 1994, OR. REV. STAT. §§ 127.800-.897 (1996).

directions should be honored and that those patients should not be forced to suffer a horrible, lingering, but certain death. Thus narrowed, the question as restated is whether those patients and those doctors should be free of restraint by the rest of us to do what they competently and conscientiously decide is best to do. Should the closing of life in these circumstances be regarded as a private matter between physician and patient? Protection of the *autonomy* of the individual in private matters is highly valued and one of the strongest policies in our law. In the provision of medical care, the law protects that autonomy by assuring that the patient is *competent* and that patient decisions are *informed*. At the core of the debate over physician-assisted death of the terminally ill are these two basic legal principles: *autonomy of competent persons* and *informed consent* to medical procedures.

Generally, in our society, we legally recognize personal autonomy by permitting people to do what they want as long as it does not unduly interfere with others. Broadly stated, this right to do in private anything that does not adversely affect or endanger others is the starting point for measuring governmental regulation of our activities. We protect vulnerable persons by establishing standards to assure the competence and understanding necessary for a valid decision. Health care providers, along with the lawyers who advise them, are greatly experienced experts in assuring competence and informed consent. There seems no reason why reliance on that expertise is not as appropriate in the matter of accelerating death as it is in open heart surgery.

The law has long recognized the right of the individual to reject medical treatment for prolonging life when others are not endangered. More recently, the law has recognized the right of a competent person or the person's authorized agent to withdraw life support such as respirators or tubal feeding and hydration. Some suggest significant difference exists between the affirmative act of withdrawing life support with knowledge of the certain result of death and the act of administering a drug with knowledge of the same certain result of death. However, both involve an affirmative act taken in the best interests and consistent with directions of the patient with knowledge that death is certain to follow.

The alternative to physician-assisted death can be a prolonged, painful death, traumatic to all concerned, which in many instances would not have occurred had not prior "semiheroic" medical intervention failed. In this situation, some physicians offer hospice care

and extensive palliative or pain management therapy. Commonly prescribed pain relief medication seems to be medically acceptable even if the medication not only kills the pain but also kills the patient by causing heart or respiratory failure. Hospice care is also well accepted, a practice in which death can result from starvation or dehydration. To suggest that a doctor “doesn’t intend death,” and is therefore not morally responsible when death is a known consequence of heavy sedation or pain-relieving medication, appears to be a semantic screen to accommodate the existing practice of physician-assisted death without admitting it. It appears that many patients seek and obtain medications from their family physicians that permit the patients to die in their sleep.

What are the interests of the state, of our government, in precluding competent, informed, terminally ill patients from obtaining the assistance of physicians in briefly shortening their unbearable lives? When is the life of an individual worth more to the state than it is to the person living it? The protection of the public is the usual reason for limiting the otherwise autonomous acts of individuals. What is the danger to the public from the private, consensual acts of physician and patient when each is competent, fully informed, and free from coercion?

In bluntly realistic economic terms, the extension of a non-productive life that burdens the health care system with fruitless efforts weighs in favor of a public interest in supporting assisted death of the terminally ill. However, this economic burden argument in an era of limited resources and managed health care underlies the “slippery slope” argument. This danger is avoided by appropriate safeguards assuring patient autonomy and informed decisions.

Economic considerations are also sometimes an expressed concern in family relationships and surrogate decisions for fear of coerced decisions. However, standards assuring patient autonomy seem an adequate safeguard. Further, the intimate concerns of a competent patient may well include economic factors supporting accelerating death, particularly for those who would prefer that their property go to support and protect their loved ones rather than to the health care industry for expensive but futile ministrations.

There is another stark truth that is seldom articulated. People can and do kill themselves. For one who is fully physically able, there are many ways to self-destruct. Anyone who is reasonably mobile can terminate his life. However, because of limited mobility, the termi-

nally ill person may lose that opportunity and have to rely on others for assistance. Such a person naturally turns to a physician who has the knowledge necessary for a dignified, clean, and quiet death. Should the state discriminate against these persons to preclude them from exercising their choice as physically able people can and do?

Physician assistance in accelerating death at the insistence of a terminally ill patient raises ethical and moral concerns which may control the attitudes of most people regarding it. But, the state's governmental interests need to be separated from our private preferences. Laws can regulate only conduct and not the moral attitude of individuals. Further, in our system of government, we assiduously avoid imposing the moral, or concomitant religious, views of the majority upon others by governmental action. Thus, personal preferences are not a reason to restrict the choices of patients so long as their actions do not endanger or unduly interfere with others.

On the other hand, professional ethical standards concern fair conduct toward others and are appropriately the subject of governmental regulation of specialized professions serving the public. The medical profession's ethical standards govern the conduct of physicians to insure that physicians further their patients' well-being. Traditionally, medical ethics have required physicians to try to cure patients and overcome disease, not to aid in dying. Modern medicine often extends patients' physical life far beyond hope of cure and results only in the artificial extension of physical life. In this new situation, in which cure or recovery of the patient is not a prospect, the well-being and comfort of the patient has become more and more a focus of medical treatment rather than the traditional sole object of curing the patient. Pain management, palliative care, and hospice reflect this trend. This change of direction has led many doctors and others to believe that the patient's well-being and quality of life is the primary object of the medical profession. In the case of the competent terminally ill patient this latter view may include assisting the patient to achieve a reasonable end to a futile life. Whether the patient's well-being ethically extends to hastening death centers on the dubious difference between withdrawal of life support or ministrations of pain and body numbing drugs while the body dies of disease, on the one hand, and on the other, ministrations of life-terminating drugs to the terminally ill patient certain to die within a short time. In this narrow area of disagreement within the medical profession, the direction of the competent patient should control. The only governmental interest

would seem to be the concern for patient autonomy and informed consent, just as in other areas of health care.

In assessing the interwoven issues and concerns incident to competent and fully informed terminally ill patients seeking the assistance of their physicians, several elements stand out. This really is a new social issue in a new health care setting and is unlike the historically familiar suicides of the past. It needs to be addressed as a new issue. Many patients feel that a quiet, dignified end of life is preferable to an expensive, lingering, and painful degradation to ultimate physical death. Many physicians believe that their professional obligation to treat their patients during life includes accommodating the patients' wishes for ending life with dignity. There is evidence that physicians frequently quietly accede to patient wishes to help them slip out of life in a private, dignified manner. For purposes of assessing the role of government, there is little difference between this matter and other serious health care decisions. The governmental interest is not to prohibit but to assure that the patient and the physician are protected when they competently choose an alternative after being fully informed in the circumstances. Legislation which provides standards assuring patient autonomy and fully informed decisions is essentially the only appropriate legislative intrusion in this most private and personal aspect of an individual's life.

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