Center for Health Ethics
Health Management and Informatics
University of Missouri

David A. Fleming, MD
315 Clark Hall
Columbia, MO 65211

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Ethical Issues: Assisted Suicide Upheld

On January 17, 2006 the U.S. Supreme Court by a vote of 6 to 3 upheld the State of Oregon's right to allow its citizens to choose death by suicide rather than continue suffering with end stage disease.[i] Had the court ruled the other way it would have effectively nullified Oregon's 1994 Death with Dignity Act, which for nearly twelve years has allowed doctors to prescribe controlled substances, for the purpose of ending life, to those patients requesting them who have been certified by two physicians as psychologically unimpaired and having less than six months to live.[ii] From 1997 to 2004 there have been 208 physician-assisted suicides in Oregon.[iii]

The ethical controversy invited by legally allowing physician assisted suicide is a familiar and complex one in which personal rights, states' rights, professional obligation, and the federal government's sense of global obligation to protect human life come into conflict. The U.S. Attorney's office has recently argued that, under the 1971 Controlled Substances Act, they can and should limit the use of drugs that have no "legitimate medical purpose" and can take action against physicians who use controlled substances for "illegitimate purposes" as defined by law. Current law and DEA regulations already acknowledge that the prescribing of narcotic medication is appropriate in the treatment of pain, and that there is no intent to limit a physician's prescribing for intractable pain, even if the use of such substances may increase the risk of death.[iv] Under current federal law, according to the U.S. attorney General, the professional use of controlled substances to relieve suffering through assisted suicide becomes a felony punishable by imprisonment, substantial monetary fine, and loss of licensure. Physicians (in Oregon) who assist patients to die in this way place their sense of professional obligation to help suffering patients in conflict with what society (or at least what the law of the land) claims is a physician's legal obligation to use controlled substances responsibly, which means to not purposefully take life, even if for beneficent purposes. The ethical and legal question rests on the arguable difference between passive and active euthanasia. Passive euthanasia is the compassionate and voluntary withholding or withdrawing of medical treatment for or by a patient who is dying. A right of refusal has been generally accepted both ethically and legally as standards of medical practice, especially when the patient is suffering while terminally ill.[v] [vi] [vii] The legal argument for there being a "right" of suicide is grounded in the liberty interest protected under the Fourteenth Amendment to the Constitution which confirms a right to privacy. The U.S. Supreme Court has also recognized that patients suffering from terminal illness have a right to adequate pain control and palliative care, even if such treatment hastens death, but it does not recognize a Constitutional "right" to death services such as active euthanasia or physician-assisted suicide. In 1997 the Supreme Court unanimously ruled that there is no constitutional right

to assisted suicide, but states could decide whether to allow assisted suicide to take place. In the cases reviewed, Washington v. Glucksburg and Vacco v. Quill, the court upheld laws against assisted suicide in both Washington and New York.

Palliative care specialists argue that the punitive nature of allowing the DEA to evaluate the end of life practices of physicians whose patients die while receiving prescribed controlled substances, such as opioids and barbiturates, would have a chilling effect on end of life care by limiting physicians' willingness to prescribe adequately due to the threat of investigation.[viii] It has also been argued that applying the controls of the Controlled Substances Act would not stop physician-assisted suicide in Oregon because it only considers drugs regulated by that law, not other means of assisting or committing suicide. Other means could be devised, or physicians could evade the "intent" determination by adequately documenting the aim of relieving symptoms, and thus expanding the scope of the principle of "double effect".

Physician assisted suicide remains a morally contentious and ethically challenging question as to whether patients have the right to physician assisted suicide as a means to eliminate suffering and whether physicians ought to have the power to provide such services. The ethical question, therefore, is not whether physicians can and should do all in their power to relieve patients' suffering, but whether the tradition and profession of medicine should incorporate the intentional taking of human life as an extension of that obligation and as a standard of care. The "slippery slope" argument claims that if assisted suicide becomes acceptable legally and professionally, the need and demand to eliminate suffering may ultimately encourage a belief that benevolent actions to end life are indicated early in the course of disease before suffering becomes intolerable. There has also been concern that those deemed suffering who cannot speak for themselves, such as children or adults with irreversible coma, should be, and perhaps have been, considered for such services in societies where physician assisted suicide and active euthanasia are legal. When the therapeutic option of ending life becomes acceptable and even expected as a standard of care in our society, will research and therapeutic developments in medicine be redirected toward cost containment and the "quick fix" rather than that of optimizing palliative care services and providing care for the most vulnerable in our society? Food for thought...

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[i] Totenberg N. High Court Backs Oregon Assisted Suicide Law. NPR.org *Morning Edition*. January 17, 2006

[ii] The Oregon Death with Dignity Act. Ballot Measure #16 (1994); Revised Statute 127.800-.995 (1995)
[iii] Lane C. Justices Uphold Oregon Assisted-Suicide Law. *Washington Post*. January 18, 2006. A01
[iv] DEA Physician's Manual, March 1990. 21
[v] Griswold v. Connecticut, 381 U.S. 479 (1965).
[vi] Pellegrino E. Withholding and Withdrawing Treatments: Ethics at the Bedside. *Clin. Neuro*.1989; 35
[vii] Pellegrino E. Decisions to Withdraw Life-Sustaining Treatment. A Moral Algorithm. *JAMA*. 2000; 283(8):1065-67.
[viii] Quill T and Meier D. The Big Chill—Inserting the DEA into End-of-Life Care. *NEJM*. 2006; 354(1): 1-3