When Death is Sought—Assisted Suicide and Euthanasia in the Medical Context

1995, New York State Task Force on Life and the Law

Preface
Governor Mario M. Cuomo convened the Task Force on Life and the Law in 1984, giving it a broad mandate to recommend public policy on issues raised by medical advances. That mandate included decisions about lifesustaining treatment. Assisted suicide and euthanasia were not on the agenda initially presented to the Task Force. Nor was the prospect of legalizing the practices even remotely part of public consideration at that time.

Recently, however, public debate about the practices has intensified. Although no major efforts to legalize assisted suicide and euthanasia have been launched in New York State, we chose to examine the practices and to release this report in order to contribute to the debate unfolding in New York and nationally.

Since the Task Force’s inception, we have proposed four laws to promote the right to decide about medical treatment, including life sustaining measures. Three of those proposals, establishing procedures for do-not-resuscitate orders in health care facilities and in community settings, and authorizing individuals to create health care proxies, are now law. Our fourth proposal for legislation is pending before the New York State Legislature. It would grant family members and others close to the patient the authority to decide about treatment, including life-sustaining measures, for individuals who are too young or too ill to decide for themselves and who have not left advance treatment instructions or signed a health care proxy.

In this report, we unanimously recommend that New York laws prohibiting assisted suicide and euthanasia should not be changed. In essence, we propose a clear line for public policies and medical practice between forgoing medical interventions and assistance to commit suicide or euthanasia. Decisions to forgo treatment are an integral part of medical practice; the use of many treatments would be inconceivable without the ability to withhold or to stop the treatments in appropriate cases. We have identified the wishes and interests of patients as the primary guideposts for those decisions.

Assisted suicide and euthanasia would carry us into new terrain American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

The distinction between the refusal of medical treatment and assisted suicide or euthanasia has not been well-articulated in the broader public debate. In fact, the often-used rubric of the “right to die” obscures the distinction. The media’s coverage of individual cases as a way of presenting the issues to the public also blurs the difference between a private act and public policy; between what individuals might find desirable or feasible in a particular case and what would actually occur in doctors’ offices, clinics, and hospitals, if assisted suicide and euthanasia became a standard part of medical practice. Public opinion polls, focusing on whether individuals think they might want these options for themselves one day, also offer little insight about what it would mean for society to make assisted suicide or direct killing practices sanctioned and regulated by the state or supervised by the medical profession itself.

We hope that this report will highlight certain critical distinctions and questions for public consideration. We also hope that the report and our recommendations will improve access to pain relief and the palliation of symptoms, not only for those who are terminally ill or contemplating suicide, but for all patients.

We sought the opinions and expertise of many individuals while developing our recommendations. We extend our gratitude to all those who generously lent their time and perspective to our discussion. Four individuals served as consultants in our deliberations: Nessa Coyle, R.N., Jimmie Holland, M.D., Diane Meier, M.D., and Norton Spritz, M.D. The report does not necessarily reflect their personal views about assisted suicide and euthanasia, but it does reflect their experience and insight in caring for those who are severely and terminally ill. We benefitted greatly from their expertise and their participation with us as we explored these difficult questions. We also extend our gratitude to Chris Hyman and Peter Millock who provided invaluable guidance throughout our deliberations.

Executive Summary

• Over the past two decades, the right to decide about medical treatment, including the right to refuse life-sustaining measures, has become a fundamental tenet
of American law. The Task Force has sought to make this right a reality for the citizens of New York State, recommending legislation on do-not-resuscitate orders, health care proxies, and, most recently, surrogate decision making for patients without capacity. The Task Force’s legislative proposals reflect a deep respect for individual autonomy as well as concern for the welfare of individuals nearing the end of life.

- Recent proposals to legalize assisted suicide and euthanasia in some states would transform the right to decide about medical treatment into a far broader right to control the timing and manner of death. After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh any possible benefits. In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.

- In the course of their research, many Task Force members were particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or unmanaged pain, both of which can ordinarily be treated effectively with current medical techniques. As a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection.

**In General**

- This report, like much of the current debate, focuses solely on assisted suicide and euthanasia by physicians, nurses, or other health care professionals.

- In this report, “assisted suicide” refers to actions by one person to contribute to the death of another, by providing medication or a prescription or taking other steps. With assisted suicide, the person who dies directly takes his or her own life. In contrast, “euthanasia” refers to direct measures, such as a lethal injection, by one person to end another person’s life for benevolent motives. Both practices are distinct from the withdrawal or withholding of life-sustaining treatment in accord with accepted ethical and medical standards.

- Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal. Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide.

- Depression is distinct from the normal feelings of sadness generally experienced by terminally ill patients. It is a myth that major clinical depression ordinarily accompanies terminal illness.

- While thoughts about suicide (“suicidal ideation”) are a significant risk factor for suicide, many individuals experience suicidal ideation but never commit or attempt suicide. These thoughts can be an important and normal component of coping with terminal illness.

- Uncontrolled pain, particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor for suicide and suicidal ideation. Medications and pain relief techniques now make it possible to treat pain effectively for most patients.

- Despite the fact that effective treatments are available, severely and terminally ill patients generally do not receive adequate relief from pain. Studies report that over 50 percent of cancer patients suffer from unrelieved pain, even though patients with cancer are more likely than other patients to receive pain treatment.

- Numerous barriers contribute to the pervasive inadequacy of pain relief and palliative care in current clinical practice, including a lack of professional knowledge and training, unjustified fears about physical and psychological dependence, poor pain assessment, pharmacy practices, and the reluctance of patients and their families to seek pain relief.

**Existing Law**

- Under New York law, competent adults have a firmly established right to accept or reject medical treatment, including life-sustaining measures. Competent adults also have the right to create advance directives for treatment decisions, such as a living will or health care proxy, to be used in the event they lose the capacity to make medical decisions for themselves.

- New York is one of two states in the nation that does not currently permit the withdrawal or withholding of life-sustaining treatment from an incapacitated adult patient who has not signed a health care proxy or
provided clear and convincing evidence of h is or her treatment wishes. Legislation proposed by the Task Force, under consideration by the New York State Legislature, would permit family members and others close to the patient to decide about life-sustaining treatment in these circumstances.

• Neither suicide nor attempted suicide is a criminal offense in any state. Like most other states, New York prohibits assisting a suicide. Euthanasia is barred by law in every state, including New York.

• Suicide assistance generally constitutes a form of second-degree manslaughter under New York law. Euthanasia falls under the definition of second-degree murder, regardless of whether the person consents to being killed.

• The provision of pain medication is legally acceptable even if it may hasten the patient’s death, if the medication is intended to alleviate pain or severe discomfort, not to cause death, and is provided in accord with accepted medical standards.

• Neither the United States nor the New York State Constitution grants individuals a “right” to suicide assistance or euthanasia. Although the right to refuse life-sustaining treatment is constitutionally protected, the courts have consistently distinguished the right to refuse treatment from a right to commit suicide. In affirming the right to forgo treatment, the courts have recognized the state’s legitimate interest in preventing suicide.

Ethical Issues

• Three general positions about assisted suicide and euthanasia have emerged in the ethical and medical literature. First, some believe that both practices are morally wrong and should not be performed. Others hold that assisted suicide or euthanasia are legitimate in rare and exceptional cases, but that professional standards and the law should not be changed to authorize either practice. Finally, some argue that assisted suicide, or both assisted suicide and euthanasia, should be recognized as legally and morally acceptable options in the care of dying or severely ill patients.

• While many individuals do not distinguish between assisted suicide and euthanasia on ethical or policy grounds, some find assisted suicide more acceptable than euthanasia, either intrinsically or because of differences in the social impact and potential harm of the two practices.

The Ethics of Assisted Suicide and Euthanasia

• The members of the Task Force hold different views about the ethical acceptability of assisted suicide and euthanasia. Despite these differences, the Task Force members unanimously recommend that existing law should not be changed to permit these practices.

• Some of the Task Force members believe that assisted suicide and euthanasia are inherently wrong, because the practices violate society’s long-standing prohibition against ending human life. These members believe that one person should not assist another’s death or kill another person, even for benevolent motives.

• Other Task Force members are most troubled by the prospect of medicalizing the practices. They believe that physician-assisted suicide and euthanasia violate values that are fundamental to the practice of medicine and the patient-physician relationship.

• Some Task Force members do not believe that assisted suicide is inherently unethical or incompatible with medical practice. On the contrary, they believe that providing a quick, less prolonged death for some patients can respect the autonomy of patients and demonstrate care and commitment on the part of physicians or other health care professionals. Nonetheless, these members have concluded that legalizing assisted suicide would be unwise and dangerous public policy.

The Social Risks of Legalization

• The Task Force members unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients. For purposes of public debate, one can describe cases of assisted suicide in which all the recommended safeguards would be satisfied. But positing an “ideal” or “good” case is not sufficient for public policy, if it bears little relation to prevalent social and medical practices.

• No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.

• The growing concern about health care costs increases the risks presented by legalizing assisted suicide and euthanasia. This cost consciousness will not be diminished, and may well be exacerbated, by health care reform.

The Task Force’s Recommendations: Crafting Public Policy
• The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases. For example, most doctors do not have a long-standing relationship with their patients or information about the complex personal factors relevant to evaluating a request for suicide assistance or a lethal injection. In addition, neither treatment for pain nor the diagnosis of and treatment for depression is widely available in clinical practice.

• In debating public policies, our society often focuses on dramatic individual cases. With assisted suicide and euthanasia, this approach obscures the impact of what it would mean for the state to sanction assisted suicide or direct killing under the auspices of the medical community.

• From the perspective of good health, many individuals may believe that they would opt for suicide or euthanasia rather than endure a vastly diminished quality of life. Yet, once patients are confronted with illness, continued life often becomes more precious; given access to appropriate relief from pain and other debilitating symptoms, many of those who consider suicide during the course of a terminal illness abandon their desire for a quicker death in favor of a longer life made more tolerable with effective treatment.

• The Task Force members feel deep compassion for patients in those rare cases when pain cannot be alleviated even with aggressive palliative care. They also recognize that the desire for control at life’s end is widely shared and deeply felt. As a society, however, we have better ways to give people greater control and relief from suffering than by legalizing assisted suicide and euthanasia.

• Depression accompanied by feelings of hopelessness is the strongest predictor of suicide for both individuals who are terminally ill and those who are not. Most doctors, however, are not trained to diagnose depression, especially in complex cases such as patients who are terminally ill. Even if diagnosed, depression is often not treated. In elderly patients as well as the terminally and chronically ill, depression is grossly underdiagnosed and undertreated.

• The presence of unrelieved pain also increases susceptibility to suicide. The undertreatment of pain is a widespread failure of current medical practice, with far-reaching implications for proposals to legalize assisted suicide and euthanasia.

• If assisted suicide and euthanasia are legalized, it will blunt our perception of what it means for one individual to assist another to commit suicide or to take another person’s life. Over time, as the practices are incorporated into the standard arsenal of medical treatments, the sense of gravity about the practices would dissipate.

• The criteria and safeguards that have been proposed for assisted suicide and euthanasia would prove elastic in clinical practice and in law. Policies limiting suicide to the terminally ill, for example, would be inconsistent with the notion that suicide is a compassionate choice for patients who are in pain or suffering. As long as the policies hinge on notions of pain or suffering, they are uncontainable; neither pain nor suffering can be gauged objectively, nor are they subject to the kind of judgments needed to fashion coherent public policy. Euthanasia to cover those who are incapable of consenting would also be a likely, if not inevitable, extension of any policy permitting the practice for those who can consent.

• These concerns are heightened by experience in the Netherlands, where the practices have been legally sanctioned. Although Dutch law requires an explicit request for euthanasia by the patient, a national study in the Netherlands found that of approximately 3300 deaths annually resulting from mercy killing, 1,000 deaths from euthanasia occurred without an explicit request. Moreover, in some cases, doctors have provided assisted suicide in response to suffering caused solely by psychiatric illness, including severe depression.

Caring for Severely Ill Patients

• Professional medical standards should recognize the provision of effective pain relief and palliative care, including treatment for depression or referral for treatment, as a basic obligation all physicians owe to their patients. The legal prohibition age inst assisted suicide and euthanasia should also guide professional standards of conduct.

• Physicians should seek their patients’ participation in decisions about withdrawing or withholding life-sustaining treatment early enough in the course of illness to give patients a meaningful opportunity to have their wishes and values respected.

• Health care professionals have a duty to offer effective pain relief and symptom palliation to patients when necessary, in accord with sound medical judgment and the most advanced approaches available.

• New York State statutes and regulations should be modified to increase the availability of medically necessary analgesic medications, including opioids. This should be done in a balanced manner that acknowledges the importance of avoiding drug diversion. Chapter 8 sets forth specific recommendations for legal reform.
• Physicians, nurses, and patients must be aware that psychological and physical dependence on pain medication are distinct phenomena. Contrary to a widely shared misunderstanding, psychological dependence on pain medication rarely occurs in terminally ill patients. While physical dependence is more common, proper adjustment of medication can minimize negative effects.

• The provision of appropriate pain relief rarely poses a serious risk of respiratory depression. Moreover, the provision of pain medication is ethically and professionally acceptable even when such treatment may hasten the patient’s death, if the medication is intended to alleviate pain and severe discomfort, not to cause death, and is provided in accord with accepted medical practice.

• The education of health care professionals about pain relief and palliative care must be improved. Training in pain relief and palliative care should be included in the curriculum of nursing schools, medical schools, residencies, and continuing education for health care professionals.

• Hospitals and other health care institutions should explore ways to promote effective pain relief and palliative care, and to remove existing barriers to such care.

• Public education is crucial to enhance pain relief practices. Like many health care professionals, patients and families often have an exaggerated sense of the risks of pain medication, and are reluctant to seek treatment for pain. Nurses and physicians should create an atmosphere that will encourage patients to seek relief of pain. Strategies for pain relief should also maximize patients’ sense of control.

• Insurance companies and others responsible for health care financing should promote effective pain and symptom management and address barriers that exist for some patients.

• Health care professionals should be familiar with the characteristics of major depression and other common psychiatric illnesses, as well as the possibility for treatment. Major clinical depression is generally treatable, and can be treated effectively even in the absence of improvement in the underlying disease. Patients should also receive appropriate treatment for less severe depression that often accompanies terminal illness.

• Physicians should create an atmosphere within which patients feel comfortable expressing suicidal thoughts. Discussion with a physician or other health care professional about suicide can identify the need for treatment and make the patient feel less isolated. This discussion does not prompt suicide; on the contrary, talking with health care professionals often decreases the risk of suicide.

• When a patient requests assisted suicide or euthanasia, a health care professional should explore the significance of the request, recognize the patient’s suffering, and seek to discover the factors leading to the request. These factors may include insufficient symptom control, clinical depression, inadequate social support, concern about burdening family or others, hopelessness, loss of self-esteem, or fear of abandonment.