THE RIGHT TO DIE

By Michael Kirkland:

Nothing arouses passions both inside and outside the courtroom more than the theoretical right to die -- in effect, to be free from a life of constant pain and a terminal illness, or from being hooked up to multiple medical devices designed to keep the body, if not the brain, alive.

Opposing such a right, religious conservatives warn that government is entering dangerous and unholy territory when it allows doctors and patients to determine when life should end, and there is a very short distance between choosing to die voluntarily and choosing to die under pressure from family and medical bills.

The right to die, at least the right to a do-not-resuscitate order, is fairly well established, and hard to attack in court. But a rising storm is brewing, pitting those patients who do not want to be kept alive by extraordinary measures and those medical professionals or institutions who say they will not perform procedures that outrage the conscience.

People with opposing views are already battling in the lower courts, but any final resolution would have to be hammered out on the anvil of the U.S. Supreme Court, which has shown increasing sympathy for the right to die but has never ruled on the right of conscience.

The process of dying has become far more complicated than it once was.

A century ago, most people died at home of illnesses that medicine could do little to defeat. Today, a hospital, nursing home or hospice is a far more likely setting, but the place of death is not the only thing that has changed. Technology has created choices for patients and their families - choices that raise basic questions about human dignity and what constitutes a "good death."

Most people die in hospitals or institutions where the staff makes a valiant effort to keep patients alive until there is no reasonable chance of recovery. That's exactly what many people want: a no-holds-barred effort to fight off death as long as possible.

For others facing terminal illness, however, there may come a point when the fight no longer seems worth it. Those patients may find their wishes and those of their families overlooked as physicians juggle medical, legal and moral considerations. In most cases, medical professionals have considerable discretion in deciding when additional efforts to sustain life are futile and a patient should be allowed to die.

People face these decisions even before such dire situations come up. Patients undergoing even relatively minor surgical procedures are routinely asked if they would like to fill out a document, known as an "advance directive" or "living will," stating their
wishes in the event that they become unable to communicate. Many people choose to prepare living wills in the same way people prepare traditional wills regarding personal property whether they're sick or not.

Court rulings have firmly established a patient's legal right to discontinue life-sustaining treatment, such as respirators or artificial nutrition. There is also extensive precedent for allowing family members to decide whether to continue treatment or end feeding when incapacitated patients are no longer able to decide for themselves.

But the debate over such decisions is far from settled, as was underscored by the 12-year-long legal battle over the fate of Terri Schiavo, who died in 2005 when a court backed her husband's decision to stop feeding her even though her wishes were not in writing.

Another key issue which is unresolved is whether individuals should be able to ask physicians to hasten their deaths --- in effect, help them end their lives -- and whether it is morally acceptable for physicians to do so.

**Fundamental questions**

The debate over "end-of-life issues" is rooted in a number of fundamental questions.

Who decides whether a life is worth living or not? Many people say they would rather die than suffer in great pain or endure life trapped in a vegetative state. Should individuals have the right to decide when and how they will die? Should others – their families, their doctors, the government – be able to decide for them?

What is unbearable? What condition would qualify? Terminal illness? Chronic physical pain? Debilitating, although not fatal, illness? What about severe disabilities?

Is euthanasia – hastening the death of a terminally ill patient – an act of kindness prompted by a sense of mercy and respect for an individual's wishes? Or is it an act of murder and a violation of the Hippocratic Oath?

When physician-assisted suicide is legal, is it a question of giving dying people a measure of control over the timing and manner of their death? Or does it lead to a slippery slope of neglect for the old, the poor, the disabled and those who are emotionally distraught or seriously ill? Could a right to die become a duty to die if the continued life of a patient began to be viewed in terms of the cost for both patients and their families?

What are the religious and moral questions here? For people of many faiths, these decisions touch on deeply held beliefs that life and death should be left to God, not human beings. Others argue that life is something to be cherished and not abandoned, no matter what the circumstances.
Are there other alternatives? Advocates of palliative care for terminal patients say the real problem is that not enough is done to reduce pain and that patients are not getting enough emotional support. They argue that doctors should be more aggressive in their use of painkillers and do more to address the treatable clinical depression that afflicts many patients.

In the past few decades, especially following Medicare's 1983 addition of some hospice care to its coverage, hospice care has become more common although its availability is poor in many parts of the country.

**Assisted Suicide**

Although it is widely condoned around the world, only a handful of nations—the Netherlands, Belgium, Switzerland and Luxembourg—have made physician-assisted suicide legal. In the United States, those who help someone commit suicide may face criminal charges, though laws can vary from state to state. The most famous example is Dr. Jack Kevorkian, who publicly acknowledged helping 130 people commit suicide during the 1990s and served eight years in a Michigan prison for administering a fatal injection to a terminally ill man.

Over the past decade or so, voters in six states have initiated ballot measures to legalize physician-assisted suicide. All except two have failed. In Oregon, voters in 1994 approved the Death with Dignity Act, which permits doctors to prescribe – but not administer – a lethal dose of drugs. The law also established rules to ensure that patients seeking assisted suicide are mentally competent, in great pain and intent on ending their lives. Since the law took effect, about 300 people have committed suicide with the aid of a physician, according to the Oregon Department of Human Services. In Washington this year, voters approved a similar bill. Initiative measure 1000, the Washington Death with Dignity Act, allows mentally competent, terminally ill adults to request and self-inject a lethal overdose of medication. It unequivocally prohibits euthanasia and lethal injection.

The U.S. Supreme Court has waded into this arena, but the net effect has been to let states decide what to do. In two unanimous 1997 decisions, the high court upheld assisted-suicide bans in New York and Washington states, ruling that terminally ill patients have no constitutional right to medical help in committing suicide. But in 2006, the high court rejected the federal government's effort to block Oregon's law by using its authority to regulate how doctors use prescription drugs.

**Physician's dilemma**

Physicians continue to face a pointed dilemma. "For over 2,000 years, the predominant responsibility of the physician has not been to preserve life at all costs but to serve the patient's needs while respecting the patient's autonomy and dignity," the American Medical Association said in one legal brief. But according to its policy, "physician-assisted suicide is fundamentally incompatible with the physician's role as healer."
Hippocratic Oath, traditionally taken by doctors, states: "To please no one will I prescribe a deadly drug, or give advice which may cause his death."

A 2007 national poll of doctors points to mixed feelings on the issue of assisted suicide. Fifty-seven percent said it is ethical to assist an individual who has made a rational choice to die due to unbearable suffering; 39 percent said it is unethical. The survey, by the Louis Finkelstein Institute for Social and Religious Research and HCD Research, found 41 percent of physicians support legalization of assisted suicide in a wide variety of circumstances, 30 percent support legalization only in some cases and 29 percent oppose it without exception.

The numbers are a bit different when doctors are asked whether they personally would assist in a suicide. Forty-six percent said they would not, 34 percent said they would do it in some cases and 20 percent said they would assist in suicide in a wide variety of circumstances. Another key finding: 54 percent believe assisted suicide should be a matter between patient and doctor alone and that government should not regulate the practice. Forty-six percent said the government has a legitimate interest in regulating it.

**Deciding in advance**

For a vast majority of people, assisted suicide is not a legal option and even if it were, surveys find large numbers who say they would not consider it. For most, the more relevant question is how to control their medical treatment.

Every state now allows people to specify in advance, by means of a living will, whether they would want to accept or refuse medical treatment in various circumstances. Individuals looking ahead to the possibility that they might not be able to speak for themselves or otherwise communicate can also choose to use a health care proxy to name someone who can make medical decisions on their behalf in such circumstances.

In practice, laws allowing living wills have been limited in their impact. Only about four in ten Americans have advance directives. The wishes outlined in such documents can be difficult to interpret. And many physicians are unaware of their patients' wishes or might be unwilling to implement them. Realistically, if an advance directive has not been discussed and agreed to by family members and doctors, it may not carry much weight.

The Schiavo case, which riveted the nation for weeks in 2005, demonstrated the worst-case scenario in an end-of-life situation: a brain-damaged patient without a written advance directive, a family bitterly divided over what to do, years of litigation and heavy pressure from politicians and advocacy groups.

The courts consistently ruled that Michael Schiavo had the right to remove his wife's feeding tube despite her parents' objections. One consequence of the case was a surge of public interest in living wills. A second effect has been the clarification, by about twenty states, of state laws on advance directives and guardianship for the incapacitated.
Conflicted public

This is an intensely personal issue. Surveys show about one-third of Americans say they have had to decide whether to use extraordinary means to keep a loved one alive. About 70 percent of Americans – twice as many as fifty years ago – say doctors should be allowed to help end an incurably ill patient's life when that request is made by the patient and the patient's family.

But polls also show that support falls dramatically when the question is posed in less abstract terms – such as using the phrase "assisted suicide." In a 2009 Gallup poll, for example, 49 percent of Americans said doctor-assisted suicide is morally acceptable; 46 percent disagreed.

There also seems to be a distinction in the public's mind between what they would choose for themselves and what they would choose for others, with far fewer saying they would choose to end treatment for a spouse or child than for themselves. People are divided on whether they would help a terminally ill relative or friend commit suicide to end their suffering.

The public does seem to feel strongly that these are decisions best made by families and doctors, not the government, and most disapproved of Congress' effort to intervene in the Schiavo case.