

## EUTHANASIA AND ASSISTED SUICIDE IN THE UNITED STATES

### Recent Developments Undermine the Sanctity of Life Ethic

Euthanasia and physician assisted suicide (PAS) are *current* problems in the United States. In a non-random sample of 190 health care professionals from the Midwest and West coast, 77% of whom were affiliated with long-term care facilities, the authors found that 21% approved of active euthanasia, and 20% had taken direct action to shorten or end a patient's life.<sup>1</sup> A national sample survey of 355 oncologists (cancer doctors) found that 10.7% admitted to having participated in active euthanasia or physician-assisted suicide.<sup>2</sup> In 2014, a poll of 21,531 physicians in Europe and the U.S. asked, "Should physician-assisted suicide be allowed?" Fifty-four percent of the U.S. physicians said yes, with only 31% saying no.<sup>3</sup>

As a result of the pivotal Nancy Cruzan case, withdrawal of food and hydration tube-feeding, causing the patient to die of starvation and dehydration in 3 to 21 days, is legal in all 50 states. Cruzan was a car accident victim, who, although in a coma, was not terminally ill, and did not require a respirator or dialysis. In May 1987, her parents sued the hospital to remove food and fluids. The case eventually went to the U.S. Supreme Court, which ruled that tube feeding was a medical "*treatment*" and therefore could be withdrawn at the patient's or guardian's request.<sup>3</sup> But feeding a living individual is more correctly considered necessary *care*, like providing warmth and cleanliness, and not medical *treatment*.

Withdrawal of food and fluids has since been attempted to be applied even to patients who are not in a coma. A 1993 car accident left Robert Wendland, 48, physically and cognitively impaired and requiring a feeding tube. Recovering from his initial coma, Wendland could operate a wheelchair on his own, retrieve and return colored pegs into a peg board when asked, take and return a ball, write the first letter of his name, and at times use buttons to accurately answer simple yes and no questions. His wife wanted his feeding tube removed, but was challenged in court by his mother and sister. Wendland died of pneumonia on July 17, 2001, before court proceedings were completed.<sup>4,5</sup>

Marjorie Nighbert, a successful Ohio business woman, was felled by a stroke while visiting family in Alabama. She was not terminally ill, and was expected to benefit from rehabilitation. Marjorie once told her brother she didn't want a feeding tube if she became *terminally ill*. He ordered the feeding tube removed. According to her lawyer, Marjorie began to ask the staff for food and water. Some of them began to sneak her small amounts thereof, but when one informed the authorities, an investigation ensued.

The judge appointed a lawyer as her temporary guardian and instructed him to determine whether she was mentally competent when she requested food and water. The lawyer reported he was unable to determine whether she was competent when dehydration began, but she did not appear to be competent at present (she had, after all, been intentionally malnourished for several weeks). The judge decided to allow the dehydration to continue, and Nighbert died as a result on April 6, 1995.<sup>6</sup>

Dr. Jack Kevorkian, a pathologist, assisted in the suicide of some 130 persons<sup>7</sup> before he was tried and convicted for killing Thomas Wouk, who had Lou Gehrig's disease, an event which was aired on the *60 Minutes* TV program. A study of the deaths of 69 persons whom Kevorkian assisted to commit suicide in Oakland County, Michigan from 1990-1998 found that 75% were not terminally ill (defined as being expected to live for less than six months), and five revealed no anatomical disease at autopsy.<sup>8</sup>

#### **Assisted Suicide is Legalized**

Oregon enacted a Death with Dignity Act on October 27, 1997. It allows doctors to prescribe a dose of lethal drugs which the patient may then administer. From its inception through 2014, 859 persons have committed suicide under its provisions.<sup>9</sup>

Washington State passed a similar law in November, 2008. From the time it took effect in March of 2009, through 2013, 383 people have committed suicide.<sup>10</sup> Keeping accurate statistics under Washington's law may be difficult, as it states that if the person died using the Death with Dignity Act's provisions, 1) the underlying terminal disease must be listed as the cause of death, 2) the manner of death must be marked as "Natural," and 3) the cause of death section may not contain any language (e.g., suicide, assisted suicide, etc.) that indicates the Death with Dignity Act was used.<sup>11</sup>

In January, 2009, Helena Montana District Judge Dorothy McCarter handed down her second ruling legalizing assisted suicide. The Montana Supreme Court also ruled 4-3 on December 31, 2009 that Montana law does not prevent physicians from assisting patients in killing themselves.<sup>12</sup> On May 20, 2013, an assisted suicide bill was signed into law by Vermont Governor Peter Shumlin.

### **Medical Professionals and Pro-Euthanasia Organizations**

U.S. hospitals are now developing Futile Care protocols, which allow medical personnel to assert *their* autonomy in denying care to patients when in the staff's judgment, it will not lead to a good quality of life. This is done in spite of the patient's or the patient's family's wishes.<sup>13</sup> As early as 1989, Massachusetts General Hospital's optimum care committee directed a Do Not Resuscitate (DNR) order for Catherine Gilgunn, a 71-year-old woman with brain damage, against her prior wishes and the express directions of her daughter. When the denial of resuscitation resulted in her death, her daughter sued. On April 21, 1995, a Suffolk County Superior Court jury found a) Gilgunn would have wanted the treatment, but b) the hospital had no obligation to fulfill her wishes.<sup>14</sup>

The Netherland's long experience with euthanasia shows that it is a slippery slope. A Dutch government report indicates that over 14,500 cases of *non-voluntary* euthanasia occur each year in that country. Both the Dutch and Belgian experiences with euthanasia and assisted suicide show that once they become legalized, the circle of who may be killed and for what reasons grows wider and wider.<sup>15</sup>

Pro-euthanasia forces have been active in the U.S. since 1938 when The Euthanasia Society of America was founded. They have taken different names such as Concern for Dying, the Society for the Right to Die, Compassion in Dying, the Hemlock Society, Choice in Dying, End of Life Choices, and now, Compassion & Choices. Some have been quite active in holding educational conferences for doctors, nurses and lawyers.

Rita Marker of the International Anti-Euthanasia Task Force reports that pro-euthanasia forces have also succeeded in promulgating their ideas in students' textbooks. She notes that one middle school textbook has a section on Down Syndrome and cystic fibrosis. Two of the discussion questions ask:

1. Should we allow children to be born with serious or fatal genetic disorders?
2. When such children are born, who should be responsible for the cost of the expensive treatment they require?

A high school textbook asks, "What about the terminally ill?" The teacher's edition suggests students be assigned to read one of two books. One was written by Dr. Jack Kevorkian, and one by Derek Humphrey (*Final Exit*), the Hemlock Society's founder. The latter book contains specific instructions on how to kill yourself or someone else.<sup>16</sup>

In our society, economic motives present strong pressures to kill the ill and disabled. As early as 1977, Robert A. Derzon, administrator of the then Department of Health, Education and Welfare's Health Care Financing Administration, suggested that Medicare funds be withheld from states that fail to enact "living will" laws. He wrote, "The cost-saving from a nationwide push toward 'living wills' is likely to be enormous. Over one-fifth of Medicare expenditures are for persons in their last year of life."<sup>17</sup> (No surprise that, we are often ill the year before we die).

In the summer of 2005, Missouri lawmakers cut 90,000 people from their Medicaid program, citing budget deficits. The cuts included funds for durable medical equipment which includes feeding tubes and the nutritional formula that flows through them. While patients can apply for exceptions to the law, most were not informed about this option. There is an appeals process, but as of August 24, 2005, 396 appeals out of 427 were denied.<sup>18</sup>

In June, 2008, lung cancer patient Barbara Wagner was notified that her oncologist-prescribed medication that would slow the growth of cancer would not be covered by the Oregon Health Plan; the plan, however, she was informed, would cover doctor-assisted suicide should she wish to kill herself. Similarly, in July, 2008, Randy Stroup, a 53-year-old Oregon resident with prostate cancer, but no medical insurance, was initially denied chemotherapy by the state because it was too expensive. However, they offered to pay for his assisted suicide drugs.<sup>19</sup> (Both individuals subsequently received the assistance they needed).

Daniel Callahan, a well-known ethicist who advocates health-care rationing as a way of dealing with rising health care costs (i.e., not everyone who needs treatment would receive it) states that to implement a rationing

system, “The aim is to overcome the present assumption that health care should be tailored to individual needs.” That is, what is good for the individual may be too costly for society.<sup>20</sup>

The 13-day starvation/dehydration court-ordered death of Terri Shiavo on March 31, 2005 illustrates what happens when we replace the sanctity of life ethic with a quality of life ethic. Although Shiavo was not terminally ill, was not in pain, and was capable of human interaction, she was killed because others thought her life not worth living. History has demonstrated that once we decide to “solve” life’s problems by killing some categories of innocent human beings, the circle of whom we may kill grows wider and wider.

Indeed, American professionals have started to ponder the question, “Is it ethical to kill newborns?” In the January/February, 2008 issue of the prestigious journal, *The Hastings Center Report*, bioethicists Hilde Lindemann and Marian Verkerk review the Dutch Groningen Protocol, which applies quality of life criteria to determine which Dutch newborns ought to be euthanized. They conclude that, “When a tragically impaired infant is born into society that is hospitable to its children, offers universal access to decent health care, and promotes an ethos among its citizens whereby they look after each other as a matter of course, we believe that the doctor’s ending the baby’s life could be the best, most caring response.”<sup>21</sup> In the May/June, 2008 issue of the *Journal of Pediatric Nursing*, J. Catlin and Renee Novakovich also examine the Groningen Protocol. Calling the issues it raises complex, they describe the work undertaken by the American Nurses’ Association to help nurses define “the differences between euthanasia, assistance in dying and palliative care.” The authors note that although there are wide divisions in opinion on the direct killing of disabled babies, countries must continue to examine the moral, medical, ethical and legal aspects of these situations.<sup>22</sup>

Noted bioethicist Wesley J. Smith has warned us that as soon as academics start approaching an issue of life and death with terms like “complex” and “gray areas” and “difficult,” the ground has already been laid for acceptance. He states, “It wasn’t many years ago that almost everyone accepted that infanticide is intrinsically and inherently wrong. No more. With personhood theory and the ‘quality of life’ ethic increasingly permeating the highest levels of the medical and bioethical intelligentsia, we are moving toward a medical system in which babies are put down like dogs and killing is redefined as compassion.”<sup>23</sup>

Although pro-euthanasia organizations have suffered voting referendum setbacks in the U.S., they are currently making headway with some professional organizations. At their 2006 conference, the World-Wide Federation of Right to Die Societies explained that they have two focuses.<sup>24</sup> The first was to change the language. Through polling and focus groups they found that the word “suicide” had negative connotations, so they decided not to use it. (We know what changing language from “abortion” to “choice” did for one movement.) The second focus was to get leading medical associations to take a position of “studied neutrality.” To date, at least three U.S. organizations have decided to follow these guidelines.

At its annual meeting in November, 2006, the American Public Health Association indicated it wants health educators, policy-makers, journalists and health care providers to begin using “aid in dying” or “patient-directed dying,” to describe assisted suicide.<sup>25</sup>

The Oregon Department of Human Services, which reports on its state’s legal assisted suicides, has determined that it will begin referring to them as “physician-assisted deaths.”<sup>26</sup>

The American Academy of Hospice and Palliative Medicine, the organization of physicians who specialize in taking care of people at the end of life, approved a position statement on February 14, 2007 which says in part, “a patient may ask his physician for assistance in ending his life by providing Physician-assisted Death (PAD). ...The term PAD is utilized in this document with the belief that it captures the essence of the process in a more accurately descriptive fashion than the more emotionally charged designation Physician-assisted Suicide. AAHPM takes a position of ‘studied neutrality’ on the subject of whether PAD should be legally regulated or prohibited.”<sup>27</sup>

At least since the 1990s, pro-euthanasia forces have begun to influence the hospice and palliative care movements in the U.S. Funded in part by the Robert Wood Johnson Foundation and George Soros’ Open Society Institute, they have focused on changing professional education (doctors, nurses, chaplains, social workers), changing institutions, and changing public opinion.<sup>28</sup> Supporting organizations like Compassion & Choices, Choice in Dying, and Death With Dignity, they promote “terminal sedation,” “voluntary” refusal of food and fluids, and withholding or withdrawing nutrition and hydration from patients in comas, even though some persons in this state have been found to be fully conscious, although totally paralyzed.

## **Farther Down the Slippery Slope?**

On March 23, 2010, President Barack Obama signed H.R. 3590, The Patient Protection and Affordable Care Act (Health Care Act). Will this law lead to health care rationing and encourage euthanasia or assisted suicide? The answer to this question is, most probably, yes.

### ***Background***

Prior to the passage of the Health Care Act, about 800,000 doctors treated the 250 million Americans who had health insurance. With no increase in the number of doctors or nurses provided for in the law, the addition of some 30 million uninsured would seem to result in increased waiting times for care, scarcer resources, increased costs, and a decrease in quality.

The government has noted that our over-65 population is increasing, and that health care costs rise with increasing age. Accurately or not, President Obama repeatedly reminds us that half of all such costs are incurred in the last six months of life. Hence, the elderly are a logical target group for those seeking to cut costs. The Health Care Act is to be financed in part by cuts to the Medicare program which, for many of the elderly, is their primary source of health insurance. Democrat House Majority Leader Steny Hoyer has said, “Medicare is going to be available for seniors—at the levels they need.” The question, however, is who will determine what levels they “need.”? One provision of the law actually prevents “older Americans from making up any Medicare shortfall with their own funds—taking away their right to spend their own money to save their own lives.”<sup>29</sup>

A new federal agency, the Patient Centered Outcomes Research Institute, will determine need after conducting comparative effectiveness research. The purpose of the research is to determine which treatments, technologies and medicines work best (or cost least) in which situations. While on the positive side this could share medical information and improve care, on the negative side, it may lead to “one size fits all” solutions and allow a federal agency to determine how our doctors treat us. A second federal agency, the Medicare Advisory Board, is empowered to make annual changes in Medicare payments with an eye to controlling costs, and to propose other payment reforms. These would be automatic, unless the President or Congress disapproved and moved to block or change its provisions.

### ***Details***

One of the underlying problems of the Health Care Act is that it is written in generalities. Federally appointed administrators are empowered to determine the specifics. Hence, the devil may be in the (as yet unspecified) details. The section of the law entitled Advanced Care Planning Consultation is one such controversial area. This section authorizes reimbursements to physicians and other health care practitioners to engage in consultations with individuals about “advanced care planning” (i.e. end-of-life decisions) which will lead to “actionable orders of life sustaining treatment or similar orders.” The government decides which doctors and health care practitioners are authorized to engage in advanced care planning consultation and can issue “orders for life sustaining treatment or similar orders.” (In states where assisted suicide is legal, the similar orders could include lethal drug prescriptions).

The government-approved physician or practitioner is to explain “the continuum of end-of-life services and supports available, including palliative care and hospice.” Among four levels of end-of-life treatments mentioned that the individual may consider are these two: “the use of antibiotics; and the use of artificially administered nutrition and hydration.” In other words, the individual is asked to consider whether he or she wishes to employ antibiotics or to be given nutrition and hydration, or whether they would prefer to have infection or starvation and thirst take their lives.

Referring to this consultation section of the law, House Minority Leader John Boehner and Republican Policy Committee Chairman Thaddeus McCotter said, “that section of the bill may place seniors in situations where they feel pressured to sign end-of-life directives they would not otherwise sign. This provision may start us down a treacherous path toward government-encouraged euthanasia...”

### ***Pro-Euthanasia Influences***

The authors of the advanced care planning consultation section of the Health Care Act included Rep. Earl Blumenauer (D, OR) who submitted an amicus brief to the Supreme Court in support of assisted suicide in 2005 in the case of *Gonzalez vs. Oregon*. Assisted suicide was legalized in Oregon that year.

Moreover, when accessed on August 15, 2009, the website of Compassion & Choices, a pro-assisted suicide group, stated: “We are working hard to reach our goal to make end-of-life choice a centerpiece of national health insurance reform. The technical term for our goal is ‘Physician Order for Life Sustaining Treatment.’ In practical terms, it’s a new requirement for Medicare to provide coverage for the ‘conversation’--the dialog between doctor and patient about a patient’s wishes and options for end-of-life treatment ... Winning Medicare coverage to fund the discussion will be transformational.”

### ***President Obama’s Perspective and Appointments***

When asked by a reporter in 2008 if he supported Oregon’s assisted suicide and medical marijuana laws, Barack Obama responded, “I think that the people of Oregon did a service for the country in recognizing that as the population gets older, we’ve got to think of issues of end-of-life care.”<sup>30</sup> Apparently, when you ask Obama about assisted suicide, he thinks of the elderly.

During his debate with Hillary Clinton in the Democratic presidential primary, Obama said his biggest mistake was voting with a unanimous Senate to help save Terri Schiavo by transferring her case to federal court. Thomas Perrelli, who worked with pro-euthanasia lawyer George Felos to help Michael Schiavo have Terri’s nutrition and hydration withdrawn, served as the third highest attorney in the Justice Department from March, 2009 to February 2012.

President Obama’s administration reinstated a pamphlet entitled “Your Life, Your Choices,”<sup>31</sup> which the Bush administration had dropped. Published by the Veteran Administration’s National Center for Ethics in Health Care, it was intended for veterans, many of whom had been wounded and disabled in the service of their country. Page 21 of this publication presents the reader with a checklist entitled, “What makes your life worth living?” The veteran is asked to “express how you would feel if this factor by itself described you.” Among the 19 items on this checklist are these:

- I can no longer walk but get around in a wheelchair.
- I rely on a feeding tube to keep me alive.
- I can no longer control my bowels.
- My situation causes severe emotional burden for my family.
- I am a severe financial burden on my family.

The respondent is given four columns to check, headed by these words: “Life would be like this.” The first and most positive of the choices is “difficult, but acceptable.” The next three choices are: “worth living, but just barely,” “not worth living,” and “can’t answer now.” To make sure the respondent does not miss the point, he or she is instructed: “If you checked worth living, but just barely, for more than one factor, would a combination of these factors make your life ‘not worth living’? If so, which factors?” This is followed by: “If you checked ‘not worth living,’ does this mean that you would rather die than be kept alive?”

More ominous for the general public are the appointments President Obama made to key health care positions. For example, he appointed Dr. Ezekiel Emanuel as health policy advisor at the Office of Management and Budget and as a member of the Federal Council on Comparative Effectiveness Research. Writing in *The Wall Street Journal*,<sup>32</sup> Betsy McCaughey notes that Dr. Emanuel “has written extensively about who should get medical care, who should decide, and whose life is worth living.” Following are brief excerpts from her lengthy article: “Dr. Emanuel says that health reform will not be pain free, and that the usual recommendations for cutting medical spending ... are mere window dressing. ... True reform, he argues, must include redefining doctor’s ethical obligations. ... Dr. Emanuel chastises physicians for thinking only about their own patient’s needs. ... Dr. Emanuel believes doctors should serve two masters, the patient and society.” Quoting Dr. Emanuel, McCaughey notes that he believes that only “services that promote the continuation of the polity--those that ensure healthy future generations, ensure development of practical reasoning skills, and ensure full and active participation by citizens in public deliberations--are to be socially guaranteed as basic. Covering services provided to individuals who are

irreversibly prevented from being or becoming participating citizens are not basic, and should not be guaranteed. An obvious example is not guaranteeing health services to patients with dementia.”

McCaughey notes that Dr. Emanuel and co-authors presented a “complete lives system” in an article in a medical journal in 2009. They state, “When implemented, the complete lives system produces a priority curve on which individuals aged roughly 15 and 40 years get the most substantial chance, whereas the youngest and oldest people get chances that are age attenuated.” Dr. Emanuel concedes that his plan appears to discriminate against older people, but he explains, “Treating 65-year-olds differently because of stereotypes or falsehoods would be ageist; treating them differently because they have already had more life-years is not.” That is, his logic suggests that denying care to a 65-year-old that you would give to a 20-year-old is not age discrimination, because the 65-year-old is older!

Again quoting Emanuel, McCaughey notes that he also puts the youngest at the back of the health care line because: “Adolescents have received substantial education and parental care, investments that will be wasted without a complete life. Infants, by contrast, have not yet received these investments.”

“Dr. Emanuel says the ‘major contributor’ to rapid increases in health spending is ‘the constant introduction of new medical technologies, including new drugs, devices, and procedures.’” Therefore, “Dr. Emanuel says the United States should erect a decision making body similar to the United Kingdom’s rationing body--the National Institute for Health and Clinical Excellence (NICE)--to slow the adoption of new medications and set limits on how much will be paid to lengthen a life.”

Cass R. Sunstein, appointed Obama’s Regulatory Czar, who reports to the Office of Management and Budget, agrees with Dr. Emanuel’s logic. Writing in the *Columbia Law Review* in 2004, Sunstein said, “Other things being equal ... the welfare gain from a program saving (say) one thousand people between forty and sixty-five is unquestionably higher than the welfare gain from a program saving (say) one thousand people who are sixty-five and over. ... After all, the sixty-five-year-olds were themselves forty once.”<sup>33</sup> (Both Dr. Emanuel and Sunstein have since resigned from the Obama administration and returned to private life).

Finally, we should note that during committee deliberations, three amendments in the Senate and two amendments in the House that were meant to ensure that “comparative effectiveness research” was not used to ration health care, were voted down. As an editorial in *The Wall Street Journal* concluded, “The core problem with government-run health care is that it doesn’t make decisions in the best interests of patients, but in the best interests of government.”<sup>34</sup>

### ***The Push for Assisted Suicide***

Taking advantage of Oregon’s “Death with Dignity” law, Brittany Maynard killed herself on November 1, 2014, becoming the media’s poster child for assisted suicide. By February 2015, it was reported that Compassion & Choices was instrumental in obtaining assisted suicide proposals in almost two dozen states.<sup>35</sup>

### **Notes**

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