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Purported Safeguards in Physician-Assisted Suicide Are Ripe for Abuse

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Allowing physician-assisted suicide (PAS) would be a grave mistake for four reasons, as explained in a Heritage Foundation *Backgrounder*, "Always Care, Never Kill."[1] First, it would endanger the weak and vulnerable. Second, it would corrupt the practice of medicine and the doctor–patient relationship. Third, it would compromise the family and intergenerational commitments. And fourth, it would betray human dignity and equality before the law. Instead of helping people to kill themselves, we should offer them appropriate medical care and human presence.

This *Issue Brief* focuses on how purported safeguards in PAS are ripe for abuse. Even if one were to accept an argument for PAS on the basis of autonomy and compassion, one would be forced to conclude that neither value is sufficiently protected in laws that have been enacted in several states and in current bills that would authorize it in additional jurisdictions. One of the greatest concerns is that autonomy will be violated and people pressured or coerced into killing themselves.

The Purported Safeguards in Physician-Assisted Suicide Laws

The District of Columbia's Death With Dignity Act of 2015 would authorize physicians to prescribe deadly drugs to patients.[2] This act is substantially similar to the laws passed in Oregon, Washington, and Vermont and others pending in various jurisdictions.[3] None of the purported protections offered in the bill are sufficient; the experience with PAS to date shows that all will prove ineffective. Professor Alexander Capron, a leading health lawyer, has concluded that the Oregon safeguards are "largely illusory."[4] So, too, are those in the DC proposal.

The DC bill states that to receive a physician's assistance in suicide, the patient must make two oral requests, separated by 15 days, to a physician of the patient's choice. Before the second request, the patient must also make a written request, no less than 48 hours before the lethal drugs are prescribed or provided. This written request must be witnessed by two individuals, neither of whom may be the physician and only one of whom may be related to the patient, stand to inherit upon the patient's death, or be an owner or employee of a health care facility where the patient is residing. The witnesses must attest that the patient is capable and acting voluntarily.

Likewise, the chosen physician must judge the patient to be capable and acting voluntarily and that the patient will likely die within six months. Then the physician refers the patient to a consulting physician who must verify these judgments.

Why the Purported Safeguards Are Insufficient

Despite the purported safeguards, this system is ripe for abuse. One of the witnesses may be a family member with a financial or emotional incentive to see the patient die, and the other may simply be a friend willing to affirm that judgment. Patients or

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their more powerful guardians could shop around for a doctor who is willing to make the judgment that they are capable, acting freely, and likely to die within six months.

Moreover, the bill does not specify whether death need be likely *with* medical treatment or *without*. As a team of physicians has noted, “Deciding who should be counted as ‘terminally ill’ will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide.”[5]

Of course, there is no reason to assume that all doctors will seek to make a serious diagnosis, because a patient can shop around for a compliant physician. Richard Doerflinger notes that Compassion and Choices (C&C), formerly known as the Hemlock Society and one of the advocacy groups pushing for assisted-suicide laws nationwide, keeps a list of “friendly” doctors:

> The doctors who declare patients qualified for assisted suicide are not randomly selected. C&C has boasted of its direct involvement in the vast majority of such cases in Oregon, as it has its own list of doctors who are willing and able to get patients around any pesky “safeguards.” If the patient’s own physician, or the next physician, discovers a disorder such as depression, the patient can simply shop around to find one who won’t care (or just call C&C in the first place).[6]

Such shopping around for doctors claimed the life of Helen, a woman in Oregon. Judge Gorsuch recounts:

> Helen was a breast cancer patient in her mid-eighties when the Oregon law went into effect. Helen’s regular physician refused to assist in her suicide; a second doctor was consulted but also refused, on the stated ground that Helen was depressed. At that point, Helen’s husband called Compassion in Dying. The medical director of the group spoke with Helen and later explained that Helen was “frustrated and crying because she felt powerless.” Helen was not, however, bed-ridden or in great pain.... The Compassion in Dying employee recommended a physician to Helen. That physician, in turn, referred Helen to a specialist (whose specialty is unknown), as well as to a psychiatrist who met Helen only once. A lethal prescription was then supplied.[7]

Remarkably, the DC bill provides explicit protections for doctors to engage in such judgments by providing immunity from liabilities: “No person shall be subject to civil or criminal liability or professional disciplinary action for: (A) Participating in good faith compliance with this act.” Doerflinger explains:

> “Good faith” is the loosest of legal standards, much weaker than the negligence standard physicians are generally held to. Instead of meeting the objective standards for what doctors *should* know, a doctor need only say that he sincerely didn’t know that he failed to live up to them.[8]

The political left is ordinarily quite opposed to tort reform or medical malpractice limitations, yet here they explicitly support them. Doerflinger concludes:

> So, in a matter of literal life and death, standards are much lower than anywhere else in law or medicine. You’re likely to be seen as terminal (hence a

1. See Ryan T. Anderson, “Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality,” Heritage Foundation Backgrounder No. 3004, March 24, 2015, http://www.heritage.org/research/reports/2015/03/always-care-never-kill-how-physician-assisted-suicide-endangers-the-weak-corrupts-medicine-compromises-the-family-and-violates-human-dignity-and-equality.
2. Death with Dignity Act of 2015, B21-0038, Leg. Sess. 20, http://lims.dccouncil.us/Legislation/B21-0038 (accessed January 28, 2015).
3. Oregon, O.R.S. § 127.800-995 (1994); Washington, R.C.W § 70.245 (2008); and Vermont, 18 V.S.A. § 5289 (2013).
4. Alexander M. Capron, “Legalizing Physician-Aided Death,” Cambridge Quarterly of Healthcare Ethics, Vol. 5, No. 1 (Winter 1996), p. 14.
5. Joanne Lynn et al., “Defining the ‘Terminally Ill’: Insights from SUPPORT,” Duquesne Law Review, Vol. 35, No. 1 (Fall 1996), p. 334.
6. Richard M. Doerflinger, “Flirting with Death,” Public Discourse, January 5, 2015, http://www.thepublicdiscourse.com/2015/01/14217/ (accessed February 4, 2015).
7. Neil M. Gorsuch, The Future of Assisted Suicide and Euthanasia (Princeton, NJ: Princeton University Press, 2006), p. 124.
8. Doerflinger, “Flirting with Death” (emphasis in original).

> candidate for assisted suicide) if the doctor feels that you are, or thinks that you could become so without treatment. If you take the lethal drugs in a few weeks based on that prediction, there is, of course, no chance to prove him wrong.[9]

The disability-rights group Not Dead Yet agrees:

> [I]t cannot be seriously maintained that assisted suicide laws can or do limit assisted suicide to people who are imminently dying, and voluntarily request and consume a lethal dose, free of inappropriate pressures from family or society. Rather, assisted suicide laws ensure legal immunity for physicians who already devalue the lives of older and disabled people and have significant economic incentives to at least agree with their suicides, if not encourage them, or worse.[10]

Moreover, there are no protections relating to the time when the lethal drugs are taken. Once the requirements are met, a doctor may prescribe the deadly drugs and send the patient home to self-administer them. The DC bill, like the state bills, provides no safeguards to ensure that the patient is mentally competent when he or she takes the drugs and is not being pressured to do so. The lack of any legal protections ensuring autonomy at the time the lethal choice is made led Judge Gorsuch to ask: "How does it serve the putative goal of autonomous patient decision making to set up a regime that allows people to commit suicide without considering whether they are, in fact, acting freely, competently, and autonomously at the time of suicide?"[11]

Conclusion

The purported safeguards in PAS are ripe for abuse. Neither autonomy nor compassion is sufficiently protected in laws that allow PAS. A family member or friend who might benefit financially from the death of a patient may act as a witness that the patient is voluntarily requesting the lethal prescription, and doctors who support the ideology of death and have never before met the patient (or the patient's family) can judge the patient to be "qualified" under the law. Finally, at the time of administering the deadly drug, there are no safeguards to ensure voluntariness or competence or to guard against coercion. Such a measure woefully fails to protect autonomy.[12]

Instead of helping people to kill themselves, we should offer them appropriate medical care and human presence. We should respond to suffering with true compassion and solidarity. Doctors should help their patients to die a dignified death of natural causes, not assist in killing. Physicians are always to care, never to kill.[13]

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9. Ibid.
10. Diane Coleman, "Assisted Suicide Laws Create Discriminatory Double Standard for Who Gets Suicide Prevention and Who Gets Suicide Assistance: Not Dead Yet Responds to Autonomy, Inc.," Disability and Health Journal, Vol. 3, No. 1 (January 2010), p. 48, http://www.disabilityandhealthjnl.com/article/S1936-6574(09)00089-2/fulltext (accessed March 5, 2015).
11. Gorsuch, *The Future of Assisted Suicide and Euthanasia*, p. 180.
12. In some of the newly introduced bills, these problems are actually far worse, not better. For example, the California bill introduced in 2015 is modeled on Oregon's law but greatly weakens its provision on psychological counseling, dropping the requirement that, once referred for counseling, a patient must be found competent before the assisted suicide can proceed. The bill introduced in Maryland removes the language stating that an illness must be considered irreversible and incurable in order to be considered terminal and says a doctor need only find that it is "more likely than not" that the patient will die of the illness in six months.
13. Anderson, "Always Care, Never Kill."