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LEGAL ISSUES IN MEDICINE

DEATH BY PRESCRIPTION

The Oregon Initiative

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SOCIETY and physicians in the United States remain unable to accept death and thus unable to deal with the physical, psychological, and spiritual approach of death. The hour of death itself "is commonly tranquil," but "the serenity is usually bought at a fearful price — and the price is the process by which we reach that point"[1] — a process that has been described as "a purgatory that may last for weeks."[1] Suicide has been seen as a rational way to avoid that purgatory, especially as a response to end-stage cancer and AIDS, and proposals to "legalize" physician-assisted suicide in well-defined cases have persisted. Such proposals have been the subject of reports by commissions in New York[2] and Michigan,[3,4] and court decisions on the constitutionality of laws against assisted suicide, as they apply to physicians and their terminally ill patients, are currently on appeal in the states of Washington[5] and Michigan.[6]

In addition to courts and legislatures, there is a third way to change state law: almost half the states permit a direct vote by an initiative petition. Even though all "Death with Dignity" initiatives to date have come from a single lobbying group, the Hemlock Society, they have struck a responsive cord with the public and deserve to be taken seriously.

Two "Death with Dignity" initiatives have been voted on so far, one in Washington in 1991 (Initiative 119) and the other in California in 1992 (Proposition 161). On November 8, 1994, the voters of Oregon will decide the fate of a third (Ballot Measure 16). The drafters of the Oregon initiative are convinced that they have learned from the defeat of the two previous measures and, by incorporating these lessons into their much narrower proposal, have given it a much better chance of passage and implementation. A brief review of the Washington and California proposals will help explain the Oregon initiative.

WASHINGTON'S INITIATIVE 119

Washington's initiative was written by the state chapter of the Hemlock Society as a series of amendments to Washington's 1979 Natural Death Act (the nation's second living-will law). Initiative 119, however, went far beyond making it easier to refuse treatment in that it included both physician-assisted suicide and voluntary euthanasia in the term "physician aid-in-dying." The official ballot question was phrased simply: "Shall adult patients who are in a medically terminal condition be permitted to request and receive from a physician aid-in-dying?" Aid-in-dying is a term that disguises more than it reveals,[7] and few voters were likely to have had an accurate idea of what they were asked to vote on. Initiative 119 defined physician aid-in-dying as "a medical service, provided in person by a physician, that will end the life of a conscious and mentally competent qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive."

Campaigns for and against Initiative 119 provided the public with little useful information. Proponents concentrated on a straight "choice" message, using statements from terminally ill cancer patients asking for the right to choose "a humane and dignified death."[8] Opponents argued that Initiative 119 had "no safeguards"; their advertisements featured a nurse saying it would "let doctors kill my patients" and an elderly farmer saying it gave physicians too much power, "more or less a right to kill."[8] Ultimately the fear of a painful and degrading death was overcome by fear of killing by unaccountable physicians, and Initiative 119 was defeated, receiving 46 percent of the 1.5 million votes cast.[8,9] Opponents did, however, agree to support long-overdue changes in the 1979 Natural Death Act, and in 1992 the legislature enacted provisions that broadened patients' ability to use advance directives to order the withholding and withdrawal of treatment in the case of terminal illness or "a permanent unconscious condition." The experience with Initiative 119 also inspired a group called Compassion in Dying to challenge the constitutionality of the state's law prohibiting assisted suicide in the case of terminally ill persons. A federal district court judge, who also could not distinguish between refusal of treatment and suicide, ruled the statute unconstitutional because it denied equal protection under the law to competent terminally ill patients who had no life-sustaining treatment to refuse. The decision is currently on appeal.[5]

CALIFORNIA'S PROPOSITION 161

California's 1992 death-with-dignity initiative was based on an early Hemlock Society proposal (the Humane and Dignified Death Act) that failed to qualify for the 1988 ballot.[9] In its reincarnated form it was sponsored by a group called Californians against Human Suffering. It continued the use of the ambiguous phrase "physician aid-in-dying," although it more clearly defined the phrase to encompass voluntary euthanasia and assisted suicide:

> "Aid-in-dying" means a medical procedure that will terminate the life of the qualified patient in a painless, humane and dignified manner, whether administered by the physician at the patient's choice or direction or whether the physician provides means to the patient for self-administration.

In addition to being clearer than Initiative 119, Proposition 161 attempted to incorporate more safeguards to prevent abuses. Special protection, for example, was given to patients in skilled nursing facilities, whose written directives were invalid unless witnessed by a patient advocate or ombudsman designated by the state Department of Aging for this purpose. In addition, hospitals and health providers were required to keep records and to file an annual report to the state Depart-

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ment of Health Services that included each patient's age, type of illness, and the date on which the directive was carried out (but not the identity of the patient). The written directive itself was to be put into the patient's medical record "in each institution involved in the patient's care."

The patients who qualified for aid in dying were, like those covered by Washington's Initiative 119, only those who physicians believed had less than six months to live. Also like Initiative 119, Proposition 161 was defeated by a margin of 54 percent to 46 percent. Defeat was followed by renewed regulatory efforts to encourage physicians to deal more effectively with pain management, including a proposal to eliminate triplicate prescription forms for controlled substances, which are believed to inhibit the proper use of medication.[10,11]

Oregon's Ballot Measure 16

The Hemlock Society moved its national headquarters from California to Oregon in 1988. Nonetheless, it was not until 1994 that one of its initiatives, Ballot Measure 16, made it onto the Oregon ballot. The society's founder and former president, Derek Humphry, himself had difficulty locating a physician to supply the lethal drugs he ultimately used to help his first wife, who was dying of cancer, end her life. He expects Ballot Measure 16 to be successful, in large part because it is more limited than the Washington and California initiatives.[12] Specifically, although it has the same title as the previous two, the provisions of the Oregon Death with Dignity Act are limited to permitting physicians to comply with the request of a competent adult patient with less than six months to live for a prescription for lethal drugs:

> An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this act.

As with requests for euthanasia under Initiative 119 and Proposition 161, Ballot Measure 16 requires that the request for a drug prescription be in writing and signed in the presence of at least two witnesses who agree that the patient is competent and acting voluntarily. Required contents of the form are also specified. Residents of long-term care facilities must have at least one witness with qualifications specified by the Oregon Department of Human Resources. At least two physicians must agree that the patient is likely to die from a terminal illness within six months, the patient must be referred for counseling if a psychiatric or psychological disorder is suspected, and the attending physician must ask (but cannot require) the patient to notify his or her next of kin about the request. Records must be maintained, and a sample of records must be reviewed annually by the state's Health Division (but not made public except in a statistical report).

Two waiting periods are built into the act. Two oral requests are required, the second no less than 15 days after the patient's original oral request, before the required written request can be accepted, and the prescription itself cannot be provided less than 48 hours after the written request. No physician is required to write a prescription on request, but physicians are provided with immunity from "civil or criminal liability or professional disciplinary action" for "good faith compliance" with the act. This immunity specifically extends to "being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner."

Ballot Measure 16 seems to have been written in response to the generally favorable public reaction to the case of Dr. Timothy Quill, who prescribed lethal drugs to his patient Diane,[13] and to avoid the more negative public reaction to Dr. Jack Kevorkian, who used carbon monoxide in almost 20 cases.[4] It has proved difficult to make clear distinctions between these two activities that the public can understand, and most people probably agree with the American Medical Association's view that both doctors engaged in some form of physician-assisted suicide.[5,14,15] Nevertheless, the writers of Ballot Measure 16 have implicitly repudiated Kevorkian and his methods and have exclusively endorsed the Quill death-by-prescription model. This strategy is also consistent with Hemlock Society ideology, which sees a suicide by drugs as "peaceful, bloodless dying."[9]

Continuing Controversies

Its narrower scope makes Oregon's Ballot Measure 16 a much more reasonable initiative to put to a vote than either the Washington or California version. Nonetheless, several contentious issues remain. One is the persistent argument that physician-assisted suicide and killing by physicians (euthanasia) are essentially the same thing, so distinguishing between them, as Ballot Measure 16 does, is pointless.[16] This argument is ultimately not persuasive, because it ignores the identity of the person doing the actual killing and makes no distinction between self-killing (suicide) and the killing of another (homicide). Those worried about the slippery slope, however, will take Derek Humphry seriously when he says that Ballot Measure 16 is just the first step and that when people become "comfortable with this form of assisted dying . . . we may be able to go the second step," which is euthanasia.[12]

It is essential to understand existing law before trying to change it. Is there a need for such a narrow law, or could it do more harm than good? Providing terminally ill patients with drugs they might use to kill themselves does not currently constitute assisted suicide, even if the patient actually uses them for suicide, unless it is the physician's intent that the patient so use them.[4,13] Physicians legally can, and as a matter of good medical practice should, supply prescriptions for potentially lethal drugs that have a legitimate medical use to their terminally ill patients on request, if they believe that having these drugs is likely to permit the patient to live better.

More physicians must become comfortable taking the risk (along with their patients) that such drugs might actually be used for suicide, in much the same

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way as most physicians are comfortable risking the patient's life by performing surgery or using medical interventions that also might result in the patient's death. When patients die under medical care, even because of negligent medical care — as more than 75,000 have been estimated to die each year in the United States — their physicians are not charged with either murder or manslaughter, even though their direct actions have killed the patient.[17] This is because in the criminal law, intent matters.[2-4] Negligent acts are, by definition, not intentional. We assume that physicians are acting in the best interests of patients and with the patients' consent, and under these circumstances we think the criminal law has no part to play.

Thus, no changes in current law are needed to legalize the prescription of lethal drugs that have a legitimate medical use to terminally ill patients.[4] Although the clear purpose of Ballot Measure 16 is to encourage this prescription practice, the act of putting this proposal into legislative language may itself create the erroneous impression that current legitimate prescription practices are illegal and should be discontinued.

Ballot Measure 16 may also decrease the number of physicians who are willing to prescribe potentially lethal drugs because the patient must make a request for lethal medication not because he or she will feel more secure if it is available and therefore be able to live better, but only "for the purpose of ending his or her life." Likewise, the physician's purpose in writing the prescription must be to end the patient's life. In short, under Ballot Measure 16, the physician must agree with an explicit plan of suicide by the patient and must participate in the suicide directly and unambiguously.

Federal Law

Even if Oregon adopts a state law legalizing the prescription of drugs for the purpose of committing suicide, this may not satisfy federal regulations governing the prescription of drugs. The types of drugs that would be prescribed for this lethal purpose are likely to be those that are regulated under the federal Controlled Substance Act. To be lawful, a prescription for a controlled substance "must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[18] The question remains whether, under federal law, prescribing drugs for a patient to use to commit suicide would constitute a legitimate medical purpose. It is unclear whether, if a state authorizes a physician to engage in certain practices, they are considered "legitimate" under federal law, since the drafters of the federal statute certainly did not have this purpose in mind. What case law exists indicates that the physician must have some therapeutic purpose to prescribe lawfully.

Likewise, although the Food and Drug Administration is not required to certify drugs used in executing condemned prisoners as "safe and effective" for this purpose,[19] to gain immunity under Ballot Measure 16 a physician prescribing such drugs must act in "good faith." Since the physician is required to prescribe a drug regimen that induces death in a "humane and dignified manner," and since no drugs have been approved for this use, additional data could reasonably be required before concluding that any such drug was prescribed in good faith. All this is not to say that Ballot Measure 16 necessarily conflicts with federal law, only that it is unlikely to reassure physicians who do not already help their dying patients by prescribing potentially lethal drugs because of fear of potential legal entanglements.

Pharmacists

Pharmacists face similar quandaries, since it is the pharmacist who actually supplies the drugs to the individual patient. Pharmacists will have to decide not only whether they are violating federal law, but also what their own ethical and professional standards demand in this situation. Pharmacists are not even mentioned in Ballot Measure 16, and it is doubtful that the drafters took this group into consideration at all; rather, the authors of the proposal probably considered pharmacists simply as agents of the attending physician. This view may be reasonable when pharmacists are dispensing drugs to help patients live better or longer, but it is not tenable in this situation. Patients and their families will naturally have questions for pharmacists about how the drug is likely to act and how it should be taken, for example. What should pharmacists' role be? What advice on suicide can and should they provide?

Enactment of Ballot Measure 16 would also create a new paradox in our drug laws. Physicians would be permitted to prescribe drugs with the intent that patients use them to kill themselves, but they could not prescribe less dangerous drugs, such as heroin, marijuana, and lysergic acid diethylamide, that might prevent suicide. Drugs not only can relieve depression and pain, they can also give patients a sense of control that permits them to live. One dramatic example is the most famous suicidal patient of the 1980s, Elizabeth Bouvia.[20] Quadriplegic and in pain, she abandoned her legal quest to commit suicide with medical assistance after she was given control over the administration of her own morphine and has continued to live ever since. A necessary prerequisite to legalizing death by prescription should be the ability to prescribe similar drugs to prolong life. Of course, supporters of Ballot Measure 16 would probably favor laws permitting the terminally ill to take any drugs their physicians believe might prevent them from committing suicide by enhancing the quality of their lives. However, this is not only a state issue, but a federal issue as well.

Better or Worse?

Since physicians will want to be covered by the immunity provisions of Ballot Measure 16, those who now supply potentially lethal drugs to their patients will probably do so only in the manner prescribed by the measure if it passes (including the requirements for a minimal 17-day waiting period, the witnessed written request, record keeping, and the involvement of a sec-

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ond physician). These requirements will make the practice of prescribing such drugs much more bureaucratic and burdensome, and less private and accountable. It seems better to retain the current system — in which physicians can act to favor life, with therapeutic intent (accepting the risk of suicide) and with flexibility, while accepting responsibility for their actions — than to replace the current system with a more mechanical one in which physicians are not responsible for their actions and must specifically intend the deaths of their patients.

Oregon voters will also have to decide whether providing lethal drugs to a few who cannot now get them from their physicians is sufficient reason to put disadvantaged Oregonians, who are already relegated to the country's only formally rationed medical service delivery system, at even higher risk of underservice, alienation, and abandonment. The New York Task Force on Life and the Law, for example, unanimously concluded that "ideal" cases, like that described by Quill, are an insufficient basis for changing public policy in a country where medicine continues to be practiced in the context of bias and social inequality, and where hospice care is not generally available. They rightly concluded that in the real world, legalizing assisted suicide would "pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care."[2]

The Initiative Approach

Initiatives let the public vote on issues on which elected representatives have no special expertise, and they can circumvent unresponsive legislatures. On relatively simple questions this method is reasonable. But neither euthanasia nor physician-assisted suicide is a simple question, and legalizing either or both requires not only carefully worded legislation but also a thorough and detailed public debate and discussion. Contemporary initiative petitions tend to degenerate into televised sloganeering and permit neither of these. That is probably why both the Washington and the California initiatives went down to defeat, even though public opinion polls consistently showed large majorities in favor of them.

Opinion polls measure what people say, but they cannot measure what people mean unless very sophisticated and complete questions are asked.[10,21] In the early stages of the debate over euthanasia, people may hold opinions that are inconsistent (for example, supporting both the belief that everyone should be treated equally under the law and the belief that only competent adults who are terminally ill should have access to lethal drugs)[22] without even realizing it. Only as the public debate matures do "people's views become more integrated and thoughtful."[21] It is only then that public opinion can be accurately measured, and it is only then that it should be taken seriously. In my view, Oregon's Ballot Measure 16 should be rejected by the voters because it is likely to do more harm than good for terminally ill patients. Even if it does pass, it will be some time before either the people of Oregon, or their physicians, will know what it means.

References

1. Nuland SB. How we die. New York: Alfred A. Knopf, 1994:288.
2. When death is sought: assisted suicide and euthanasia in the medical context. New York: State Task Force on Life and the Law, 1994.
3. Final report of the Michigan Commission on Death and Dying. Lansing: Michigan Death and Dying Commission, 1994.
4. Annas GJ. Physician-assisted suicide — Michigan's temporary solution. N Engl J Med 1993;328:1573-6.
5. Compassion in Dying v. Washington, 850 F. Supp. 1454 (D.C. Wash. 1994).
6. People v. Kevorkian, 205 Mich. App. 194, 518 N.W. 2d 487 (1994).
7. Capron AM. Euthanasia in The Netherlands: American observations. Hastings Cent Rep 1992;22(2):30-3.
8. Carson R. Washington's I-119. Hastings Cent Rep 1992;22(2):7-9.
9. Humphry D. Dying with dignity: understanding euthanasia. Secaucus, N.J.: Carol Publishing Group, 1992.
10. Skelly FJ. California protects doctors who prescribe for pain. American Medical News. September 12, 1994:19.
11. Overview. In: Management of Cancer Pain Guideline Panel. Management of cancer pain. Clinical practice guideline no. 9. Rockville, Md.: Department of Health and Human Services, 1994:16-9. (AHCPR publication no. 94-0592.)
12. Gianelli DM. Oregon voters face 'RX-only' suicide initiative. American Medical News. September 12, 1994:1, 34.
13. Quill TE. Death and dignity — a case of individualized decision making. N Engl J Med 1991;324:691-4.
14. Council on Ethical and Judicial Affairs, American Medical Association. Decisions near the end of life. JAMA 1992;267:2229-33.
15. Cohen JS, Fihn SD, Boyko EJ, Jonsen AR, Wood RW. Attitudes toward assisted suicide and euthanasia among physicians in Washington State. N Engl J Med 1994;331:89-94.
16. Callahan D. The troubled dream of life: living with morality. New York: Simon and Schuster, 1993.
17. Weiler PC, Hiatt HH, Newhouse JP, Johnson WG, Brennan TA, Leape LL. A measure of malpractice: medical injury, malpractice litigation, and patient compensation. Cambridge, Mass.: Harvard University Press, 1993:55.
18. 21 CFR 1306.04.
19. Annas GJ. Killing with kindness: why the FDA need not certify drugs used for execution as safe and effective. Am J Public Health 1985;75:1096-9.
20. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).
21. Yankelovich D. What polls say — and what they mean. New York Times. September 17, 1994:23.
22. Orentlicher D. Physician-assisted dying: the conflict with fundamental principles of American law. In: Blank RH, Bonnicksen AL, eds. Medicine unbound: the human body and the limitations of medical intervention. New York: Columbia University Press, 1994:256-68.

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