

# FIG Leaves

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Speaker: Richard T. Hull, Professor Emeritus of Philosophy, SUNY-Buffalo

## **T**he Case for Physician-Assisted Suicide

In the absence of the FIG President, Program Director Joe Levee introduced the speaker. He pointed out that Professor Hull's wife was here attending a conference at the University of Cincinnati and Joe was therefore able to persuade him to talk to our group while in Cincinnati. Professor Hull mentioned that his interest in philosophy was concentrated in the field of bio-ethics while his wife, a neuroscientist was studying the sexual behavior of males, using rats as models for research.

Study of "male sexual behavior" can have interesting ramifications. When they moved into a new house in an upscale neighborhood near Buffalo they had visits from 27 Girl Scouts selling cookies the first year. They bought from every one. They anticipated a greater number the next year but they had none. They observed the girls move from the house on one side of them to the house on the other side and avoid their property completely. They eventually learned the reason from a friend. He attended a planning session for neighborhood caroling during the Yuletide. In attempting to avoid offending anyone in this diverse neighborhood they were careful in their selection. Someone on the committee asked, "What about the sex therapists?" Their friend asked, "Who?" The answer was "The Hulls." So that's why their house had been avoided during the Girl Scout cookie sale.

The speaker then shifted focus to the subject at hand. He told how he had become interested in end-of-life decisions and physician-assisted suicide through personal experiences with these issues in his own family. In 1974, his father-in-law, a retired postal worker, collapsed in a department store. Two clerks gave him CPR while they waited for the ambulance to arrive. In the ride to the hospital, the emergency technicians failed to continue the

compression and gave the patient oxygen alone. At the hospital, the ER physicians managed to restart his heart but the patient sustained a permanent loss of brain function although he was not classified as brain-dead. The treatment consisted of forced nutrition and hydration. The son and daughter of the patient asked the attending physician about discontinuing this program, but were told they could not do so without specific instructions from the patient. Even with such instructions, they could not do so if one member of the family objected. His wife would most certainly have objected. They continued the treatment for three weeks when a second heart attack took his life.

Professor Hull's next personal experience involved his brother, John, a horticulture scientist. His specialty was thornless blackberries and elm trees. In 1976, John Hull, a smoker and heavy drinker was diagnosed with neck cancer. He underwent radiation therapy followed by what was called radical dissection of the neck. His recovery was slow and required a hospital stay of 78 days. After a brief period out of hospital, he experienced difficulty in swallowing, and was readmitted. Upon examination another tumor was found in his esophagus. He was referred to another physician who had a more focused protocol of radiation. While this treatment was being arranged, the attending physician discovered that the original tumor had reseeded itself and had grown around his right carotid artery. This was inoperable, neither could it be treated with radiation. John Hull was eventually referred to hospice care where it was determined that since he had such a strong family support, the hospice type care could best be delivered at home. Eventually as his condition worsened, he developed delusions, hallucinations and psychotic episodes. The attending physician eventually told Professor Hull she couldn't understand why his

brother didn't simply pull out his feeding tube. If he did that she could not reinstall it unless he gave permission. If he refused, all she could do was administer morphine to relieve his pain and he would then die within a few days. This exchange was reported to John Hull. After an episode of difficulty in breathing, John pulled out his feeding tube. The doctor was called and when she arrived she asked John Hull if he wanted her to reinstall the tube. He said, "No." She gave him an injection of morphine, which failed to act because of his circulatory problems. She then gave him a second injection in the vein in his hand. This had a more immediate effect. John Hull lived for several more days. His death certificate read: "Cause of death: Cancer and sequelae."

The third experience involved Professor Hull's parents and occurred about five years later. In 1981, he received a telephone call from his father who said that he had made a promise to his wife, an Alzheimer patient, that he would not die before she did. He went on to say that he was feeling increasingly that he was not going to be able to keep this promise unless they could go together. He asked his son to call any physicians he knew who might be able to suggest a way to accomplish this. The physicians mostly suggested that this was probably a passing irrational fear and that if he had really wanted to commit suicide, he would already have found a way. His father died the next morning while trying to get out of bed. His mother found the body. Despite the promise, his mother took her husband's death calmly. She lived another six years going in and out of periods of lucidity. When she had a stroke that prevented her from swallowing, the doctor asked if he could install a feeding tube. Professor Hull asked if this was a treatment or a way of life. The doctor indicated that it was the latter and that she would have to continue on the tube to keep her alive. Hull knew from discussions they had had about his brother's situation that she would not have wanted such treatment. He declined to have the feeding tube installed. His mother died five days later.

These experiences conditioned the speaker's thinking about physician-assisted suicide and other end-of-life issues. In his father-in-law's case, there had never been any discussion about what his wishes might have been if such an event ever occurred. In view of the practice at the time and the lack of any prior discussion, Professor Hull felt that the physicians had acted properly. He viewed his brother's case differently. When John Hull started treatment his chances of survival were deemed to be 25 percent. With the finding of a second tumor, they dropped to ten percent and with the re-emergence of the initial tumor they dropped to zero. His wish to die

was not unreasonable but his care giver was licensed to provide only terminal care and could not legally assist in his suicide as might be done in Oregon or The Netherlands. She did, however, give him information as to how he, himself, could get around the legal prohibitions by refusing forced nutrition. She then would be able to give him palliative care, morphine injections that might deaden his pain.

Professor Hull pointed out that his father's case illustrates points that opponents of physician-assisted suicide make. First the patient's request to die was made only once and was not the result of a terminal diagnosis. Further, his decision to die, because of the promise made to his wife, would not be taken seriously even in a permissive legal physician-assisted suicide environment. Third, he was not experiencing any severe physical suffering and fourth his motivation was to spare his wife's concern about being left alone by killing her first. His was not the kind of motivation that would have been recognized by any well-regulated scheme.

The ability to invoke physician-assisted suicide is the only element in the dying patient's dwindling resources that can send a message to physicians, insurance carriers and politicians that care is not adequate. Far too many patients spend their last days without adequate palliation. Those physicians sensitive to their cries are reluctant to write prescriptions for additional narcotics in the present political climate for fear of criticism by state health departments and federal drug agents. In New York State in the 80's there was a lawsuit brought by Dr Timothy Quill and a number of his patients against the state and which sought to overturn the law prohibiting physician-assisted suicide. The State Supreme Court decided in favor of the State. The Federal Appeals Court reversed that decision. However, the Supreme Court of the United States held that there is no constitutional right to physician-assisted suicide. But they did find that states could enact such legislation if they so desired. Oregon then passed its physician-assisted suicide law, which has been confirmed twice by the voters. US Attorney General John Ashcroft has issued a directive that prohibits the use of narcotics in physician-assisted suicide because this does not fall within the definition of medical usage under the Controlled Substances Act. A Federal judge has stayed the implementation and the appeal is now working its way back through the Federal Court system. Some physicians view it as an affront to their profession to suppose their work extends to a duty to kill by assisting at suicide. But it is an affront to dying patients and their families to be forced to beg for more narcotics to relieve pain. This is especially true when the response to their pleas

often is an insensitive: "we don't want to make an addict of you."

There are three main arguments in opposition to physician-assisted suicide. The first is the religious view that we do not "own" our lives. They are owned by god and the termination of any life is his decision. The flaw in this argument is that if it is used to justify legislation, it violates the Establishment Clause of the First Amendment. A second argument in opposition turns on the consequences supposed to follow any favorable physician-assisted suicide legislation. This is the so-called slippery slope argument. If we allow competent individuals to opt for physician-assisted suicide, then we might extend it to formerly competent who have become incompetent meanwhile. We will then find it irresistible to extend it to severely handicapped newborns so the end result would be to extermination of the incompetent, the insane and finally to euthanasia. The third argument is that it will radically change the practice of medicine. People will fear that their physicians will no longer fight to keep them alive. Arguments in favor focus on the suffering and despair of patients who are dying or are suffering from degenerative diseases for whom a continuation of life no longer holds any interest. The "slippery slope" can be blocked by careful wording of the legislative enactment. The Oregon law requires (1) that two physicians certify to the competence and terminal state of the patient, (2) mandatory waiting periods, (3) the patient must have a consistent and unwavering desire to die and (4) an annual review of all cases of assisted suicide in the state. Another argument in favor points out that all patients who have to rely on artificial support systems to sustain life can request that they be removed. They thus have an option that would be denied to persons not requiring such support system, and that is discrimination.

--George Maurer