In Defense of the Humane and Dignified Death Act

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Americans Against Human Suffering (AAHS), a nonprofit corporation, was established in 1986 for the purpose of changing state laws to permit physician aid-in-dying for the terminally ill. The organization has developed the Humane and Dignified Death Act Initiative, which it hopes to qualify in the 1990 general elections in California, Oregon, Florida, and Washington.

The proposed act permits an adult the right to request and receive a physician’s aid in dying under carefully defined circumstances. It enlarges upon the California Natural Death Act and the Durable Power of Attorney for Health Care Decisions Act. Under these statutes, an adult can declare that he does not wish to be kept alive artificially by life-support systems, and can provide in advance for the appointment of an attorney-in-fact or proxy decision-maker who can determine when life supports should be withheld or withdrawn if the patient becomes incompetent.

In addition to combining the two older laws and establishing the patient’s right to a physician’s aid, the initiative also protects and immunizes physicians and health-care workers from liability for carrying out a patient’s wishes. To take advantage of this law, a competent adult must sign a Humane and Dignified Death Act Directive in the presence of two disinterested witnesses.

Before signing the directive, the patient must inform his family and indicate that he has considered their opinion, though the patient still retains the right of final decision as long as he is competent. The directive is good for seven years, but can be extended if the seven-year period ends while the patient is incompetent.

Several conditions must be met before a physician may legally comply with a patient’s directive. First, the HDDA directive must have been properly signed by a competent adult and properly witnessed. Second, it may not have been revoked. Third, the action must be taken within the seven-year period allowed. Fourth, two licensed physicians must certify to a reasonable medical certainty that the patient is terminal and that death is likely to occur within six months. Fifth, if the patient becomes incompetent after that certification, and the final decision is made by his agent, the decision must be reviewed by a three-person ethics committee.

The initiative protects physicians and other health-care workers acting under a physician’s instructions from civil, criminal, and administrative liability. It requires hospitals and other health-care providers to keep records and to confidentially report certain information to the state health department. It also provides a means of limiting physicians’ fees for professional activities related to complying with patients’ directives.

The law specifically forbids aid-in-dying to any patient solely because he is a burden to anyone else. It does not change the law that makes aiding, abetting, advising, or counseling suicide a crime. It does not permit aid-in-dying to be performed by loved ones, friends, or strangers, and does not apply to children or to pregnant women. Indeed, it does not affect anyone who has not voluntarily and intentionally completed and signed a properly witnessed directive according to the law.

Following are twelve objections to the Humane and Dignified Death Act. The first nine are objections to the basic concept of physician aid-in-dying and voluntary active euthanasia, and the last three are specific technical objections to the law as written.

1. The law would be abused.

The principal objection to a law permitting physician aid-in-dying is that it may be abused; that is, a patient’s life may be ended without his consent, for malicious—not merciful—reasons.

The abuse of any law is always a possibility, and the HDDA is no different. However, law enforcement and the criminal-justice system exist so that we may identify, apprehend, and punish those who break the law. The HDDA has built-in protection from abuse: Only licensed physicians are permitted to give aid-in-dying to the terminally ill patient who requests it. Merciful euthanasia performed by friends or loved ones will remain illegal. Society in general—particularly the weak and the elderly, who are most vulnerable—is protected because licensed physicians are not likely to abuse the law, as they work under numerous constraints. Physicians are supervised by state licensing authorities and practice under a well-
recognized code of ethics. Also, they are partially controlled by peer pressure from colleagues, by hospital staff and administration guidelines, by the desire to protect their reputations, and by conscience and the law in general. Moreover, a physician's economic interests generally run counter to his desire to fulfill aid-in-dying. It is axiomatic that since most physicians get paid for treating patients, the longer the patient lives, the longer the treatments will continue, and the longer the physician will get paid. If purely mercenary considerations were involved, the physician would wish to keep the patient alive as long as possible. The physician would comply with a patient's directive to withhold or withdraw life-support measures or to give aid-in-dying out of compassion for the patient, as many physicians do today quietly and illegally at great risk to themselves. Under the HDDA, physicians could legally assist dying patients who request help with the training, skill, and license that laymen do not possess. In complying with patients' requests out of compassion, the physicians must conform strictly to the terms of the proposed act.

Ordinarily, the physician has no reason to abuse the system. However, for those who may be tempted to do so, the initiative provides an additional constraint: a limitation of fees that may be charged for complying with any part of the directive.

Moreover, permitting physicians to actively help patients to die upon request may be safer for society as a whole than is the present practice of passive euthanasia. Active euthanasia requires that the physician confront the act head-on because it is such an open deed. The morality of the act must be faced squarely since no one who is asked to help another to die will be indifferent to the request. Physicians in Holland who have helped patients to die on request say that it is always a very emotional act, whereas passive euthanasia allows the physician a certain lack of responsibility. When life-support systems are removed, the physician claims that he is simply letting nature take its course, or that it is now “in God's hands” and not his responsibility. The physician who decides to provide the help knows precisely what he is doing. He is not simply pulling a plug, walking from the room, and handing the responsibility to nature or God. He is deciding to help a fellow human being to ease out of this life, knowing full well the measure of his responsibility.

Some opponents say that irresponsible physicians will be able to sweep away their mistakes and dispose of incriminating evidence if physician aid-in-dying is legally permitted for the terminally ill.

Our response to this is simple. Regrettably, mistakes are made by everyone—including doctors. We see evidence of this in the numerous medical malpractice suits being brought to court throughout the country. But we find no evidence of physician abuse of living-will statutes, where physicians routinely remove life-support systems on the patient's prior written request. The living-will statutes contain specific constraints that guard against physician abuse—the Humane and Dignified Death Act contains similar constraints. Physicians have the opportunity to hide their mistakes under present law, but none of the opponents of HDDA claim that that is happening. Moreover, the medical profession is well aware of the risks presently associated with the removal of life-support systems. In any case, if misconduct is suspected, it must be investigated and those found guilty must be prosecuted by the appropriate authorities.

In one celebrated case in California, two doctors who removed life-support systems were charged with murder. They were exonerated by the appellate court, which found that the physicians were simply following the patient's previously expressed wishes and his family's instructions.

If a doctor ends a life on his own initiative or at his own discretion, without having been requested by the patient to do so, he has committed murder. But physicians do not simply murder their patients.

Some opponents claim that affirmatively ending life is an abuse of nature. But if active euthanasia is an abuse of nature because it involves our determining the time that death will occur, then we are also abusing nature in a similar way when we engage in passive euthanasia. In both cases, we choose death in preference to prolonging life—either by administering a lethal substance or by discontinuing life-sustaining treatment. Why is it an abuse of nature to determine the time of our own death when nature has given us autonomy, the ability to choose? Is it not precisely this ability that gives us special value and dignity as human beings? Is that not equally a part of human nature?

2. Diagnoses and prognoses may be erroneous.

Critics point out that physicians are fallible human beings like the rest of us, and may be mistaken in their diagnoses or prognoses. They say that sometimes doctors tell patients they only have a few months to live and the patients continue living for years.

The Humane and Dignified Death Act anticipates this problem and requires a second opinion. The initiative specifically requires that two licensed physicians agree that the patient is terminal; even then, the statute recognizes that two physicians may be mistaken as well.

In practice, physicians know end-stage disease when it exists. They know, for instance, that when a cancer is coursing through the body with massive metastatic processes at work, it is only a matter of days, weeks, or months. Physicians also know when treatment options have been exhausted. They should, and most do, inform patients and their families when this occurs. If there is any question about their opinion they inform their patient of that as well. Moreover, they should inform their patient of any new "medical breakthrough" that may yet save his life. Armed with this information, the patient can decide whether to continue to endure the pain and indignity a while longer, or request assistance in dying at the time and place of his own choosing and in the manner he sees fit.

Specifically in relation to the HDDA, many claim that a physician's prognosis is always imprecise and that it is impossible for any physician to determine with any degree of precision whether a person will die within six months. But the directive specifically states:
3. The right to die will become a duty to die.

Opponents claim that if we are given the legal right to decide the time, place, and manner of our own death, many people will be psychologically pressured by family, friends, the government, health-care providers, social workers, or other terminally ill patients to exercise that right against their will.

However, the will to live is enormously strong, too strong to give way to the suggestions of others. The dying person may lovingly consider his survivors' well-being. But it is more likely that the pain, indignities, and loss of control resulting from the dying process will be the motivation for requesting help in dying. Self-interest will prevail, though it may involve great loving concern. Psychologically, it is not likely that a third person's malevolent suggestion will motivate the patient to make the request.

The right to die becoming a duty to die is a concern only in the abstract. If a greedy relative wants his dying loved one out of the way sooner, he will have to convince a treating physician that the dying person’s life should be ended for reasons not involving the terminal illness but for other, malicious reasons. The principal check on this kind of abuse is obviously the presence of a doctor.

If pressure is applied to patients to end their lives, those persons pressuring their dying relative, friend, or ward should be prosecuted for aiding, abetting, and advocating a suicide, which is now a crime in every state in the union. Encouraging a suicide will remain a crime after the Humane and Dignified Death Act is passed.

4. The patient/physician relationship will be weakened.

Opponents claim that if physicians are given the right to end their patients’ lives when the patients request it, patients will lose trust in their doctors. Some critics have even suggested that people in rest homes will be afraid to drink their tea for fear that it is poisoned.

This claim is farfetched, but deserves attention. We must be vigilant and careful of the interests of the weakest and most susceptible members of society. We must give them the love and treatment they deserve. We must constantly guard against any abuses of their rights as human beings.

A doctor who could gently relieve the suffering of his dying patient but refuses to do so because it is illegal does not generate confidence in either the patient or his family. Honesty and the knowledge that the physician will relieve the patient of the horrible suffering associated with a terminal illness when requested will in fact strengthen the patient/physician relationship and create greater confidence in the physician.

Today, despite the fact that abetting a suicide is a felony, compassionate and caring doctors, at risk to themselves, surreptitiously help their patients with end-stage disease to die. They do this in the name of pain control. However, they are well advised not to discuss this with other health-care professionals or with their patients, as several recent prosecutions have demonstrated. Aside from the risks involved for compassionate physicians, the real question becomes one of patient autonomy: “Whose life is it, anyway?” The answer is clear.

Simply saving life and prolonging it for years is an improper goal of medicine. The question for medicine today should be whether the patient is better off after the treatment than before. We traditionally value length of life, but we must now learn to focus on the quality of life instead; and the true goal of medicine should be to improve the quality of life. Patients understand this better than doctors; seldom are they obsessed with surviving at all costs, and they often become less concerned with it as their illnesses become more severe. Most American doctors feel compelled to treat those they can neither save nor comfort. It seems paradoxical that in a nation where doctors may through abortion end what could be a productive life, they are charged with murder for ending a life where hope no longer exists.

5. Physicians should not be executioners.

Our more strident opponents say that doctors should not kill their patients. They should not be executioners. Get someone else to do this dirty job, they say.

The merciful ending of suffering at life's end upon a patient's request is not killing. Killing implies ending the life of someone who does not want to die. The man on the gallows, in the electric chair, or in the gas chamber usually wants to live; the person who ends the condemned criminal's life is an executioner. But abiding by a terminally ill patient’s own request for release from the agonies of the final days of the natural dying process simply is not killing in the ordinary sense of the word. It is an act of mercy. The disease or the trauma is the killer, not the gracious human being who helps the patient out of his final agony. To suggest that this humane act of a physician makes him an executioner is to misuse terms.

Physicians have the knowledge necessary to help us the way we sometimes want and need help at life's end. The merciful application of their knowledge upon request is appropriate, as physicians are often with us at life's end anyway: Eighty percent of Americans today die in some kind of health-care facility under a doctor's control and management. Physicians are licensed and have access to the needed drugs. Therefore, because of the doctor's knowledge, license, and proximity and because merciful release on request is not killing, physicians are the appropriate helping agents.

6. A new law is unnecessary.

Opponents claim that it is possible to control the pain associated with terminal illness in ninety-five percent of the cases;
all that is needed is to teach doctors not to worry about making addicts of dying people. If physicians would only learn to administer enough morphine or other narcotics, patients would never suffer.

On the contrary, in many cases the pain of terminal illness cannot be controlled. Even if it were true that pain could be lessened for ninety-five percent of the patients, the other five percent deserve consideration.

Furthermore, many of those patients who are not in a great deal of pain nonetheless do not wish to live the final days, weeks, or months of their lives in a zombielike stupor with nearly no cognition remaining and little control over most aspects of their lives. They may not be able to control bodily and/or mental functions, perceptions, and responses. Those terminal persons who are not in great pain and agony should have the right to make their own decisions about their own lives. They should not be compelled to be dependent on others for every menial function; for most people it is important to retain personal dignity and self-control. They should have the freedom to choose when death is imminent and treatment options have been exhausted.

7. Physicians who administer aid-in-dying will violate the Hippocratic oath.

The full text of the Hippocratic oath reads:

I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following oath:

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction.

I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.

To no one will I give a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners. In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

Few, if any, physicians today believe in the Greek gods, much less swear by them. To many Catholic, Protestant, and Jewish physicians, taking such an oath would be anathema. Many doctors have never taken the oath; it is not routinely administered by medical schools or by state licensing authorities. It is recited at some graduation ceremonies and is studied by medical students only as a part of medical history and tradition.

Nevertheless, the oath has served as a reminder to those who practice the healing arts of their high obligation to patients and their corresponding duty to sublimate their own good and passion for the concern of patients. The essential provision of the oath is: “I will prescribe regimen for the good of my patients according to my ability and my judgment and will never do harm to anyone.”

The oath has not remained inviolate and sacrosanct throughout the years. One of its prescriptions provides: “Nor will I give a woman a pessary to procure abortion”; yet most physicians in this country now agree with freedom of choice for pregnant women. The medical profession has not blindly followed the dictates of the oath, but applied common sense and modern understanding in a way that sometimes violates the oath’s literal terms.

If Hippocrates were alive today and could see the extent of medical technology, the pumps, tubes, syringes, dialysis machines, respirators, and endless numbers of drugs that exist, controlling nearly every life function, he would probably word his oath differently. The oath is more than two thousand years old, and following its terms literally surely is not required, particularly when many physicians do not actually swear to it in the manner prescribed.

8. Legalizing physician aid-in-dying is the first step on a slippery slope.

Critics suggest that once society accepts physician aid-in-dying for the terminally ill, there is no rational way to limit voluntary active euthanasia and prevent its abuse; once voluntary euthanasia is legalized, it will lead to involuntary euthanasia and society will seek to kill those of its members who are a burden to others.

But the slope is not slippery, because the distinction is clear. It is a matter of rightfully ending one’s own life with a physician’s assistance, as opposed to wrongfully ending someone else’s life for whatever reason. The laws in our society make the distinctions every day. Men and women of ordinary conscience make them every day as well. There is no slippery slope; it is but a step in the right direction.

9. We may become like Nazi Germany if we adopt the Humane and Dignified Death Act.

It has been suggested that we run the risk of becoming a violent and uncaring nation if we adopt the Humane and Dignified Death Act. Opponents claim that euthanasia was permitted in Nazi Germany and escalated into mass genocide.

Answering this criticism is hardly necessary because it is apparent that America is not Nazi Germany and Americans
are not Nazis. This is not to say that we should be complacent or that we should allow our government to violate basic human rights. If a government, a family member, or a health-care provider arbitrarily decides that someone must die, it is murder, and the perpetrator must be prosecuted.

Under the Humane and Dignified Death Act, the decision is an individual action made by an autonomous person about his own life and no one else's. Freedom to choose the time and place of your own death is a part of the inalienable right of self-determination.

10. The Humane and Dignified Death Act is not limited to persons in intractable pain.

The criticism is unjustified that the initiative is not restricted to persons in intractable pain and arguably should be. Most dying people wish to end their lives because of the indignities of the dying process and because of their loss of control, not because of intractable pain. Terminally ill people who are unable to control any of their bodily functions, who cannot move their limbs, are unable to talk, and are totally dependent upon others for every element of their existence should have the same rights as those who are in intractable pain. Their self-determination is of overriding importance.

11. The law is not limited to cases where all treatment options have been exhausted.

This objection is based on doubletalk. The Humane and Dignified Death Act is limited to people suffering from a terminal condition, which is defined as "an incurable condition which would, in the opinion of two certifying physicians exercising reasonable medical judgment, produce death" within six months, "when the application of life-sustaining procedures would serve only to postpone the moment of death of the patient."

If the condition is incurable, surely there can be no treatment option available, and conversely, if there were treatment options, surely the condition would be curable. Moreover, the law requires that two physicians declare the patient to be terminal before he can legally receive aid in dying.

However, the HDDA does not contemplate precise prognosis; it requires only that the physician determine with reasonable medical judgment that death will occur within a six-month period. This is certainly well within most physicians' prognostic abilities. Indeed, most physicians agree that they can determine when death is imminent within a time span much narrower than that delineated in the HDDA. Moreover, the possibility that a physician may make a mistake must be assumed by the patient.

12. Surrogate decision-making is inappropriate.

Some criticize the Humane and Dignified Death Act's durable power-of-attorney-for-health-care provision, which permits the patient to designate an attorney-in-fact or surrogate decision-maker to act in his stead. These critics assert that the provision is too risky because the dying person might change his mind while incompetent or might have changed his mind while competent but failed to notify anyone of that change. They maintain that the request for aid in dying should be limited only to those persons who can have a face-to-face conversation with their physician.

Thousands of people would be excluded from the operation of the act if the surrogate decision-maker concept were eliminated from its provisions.

Alzheimer's victims and others who become incompetent after signing a directive would not have their wishes carried out, since the condition for its activation—that is, concurrence of two licensed physicians that the patient is terminal—would not occur until after the patient had become incompetent. At that time, a face-to-face patient/physician conversation would be neither meaningful nor legally binding. Since cases of Alzheimer's disease are increasing throughout the country at an enormous rate, the provision for a surrogate decision-maker seems appropriate. Moreover, the statute provides for revocation by several means and there is the added safeguard of review by an ethics committee when a decision is made by an attorney-in-fact.

Summary

Although Americans Against Human Suffering continues to receive formal opposition from the California Medical Association, California medicine is a house divided on this issue. In the May 1988 issue of Physician, published by the Los Angeles County Medical Association, a survey of members indicated that forty percent of the physician respondents favored the initiative, and forty-two percent favor active euthanasia. This survey is supported by the National Hemlock Society's California Physician's survey made in November 1987, which indicated that nearly two-thirds of the physician respondents believed the law should be changed to allow doctors to take active steps to bring about a patient's death under some circumstances. Fifty-one percent of those surveyed indicated they would practice active voluntary euthanasia if it were legal. On May 8, 1988, the Los Angeles Times reported on a survey conducted by the San Francisco Medical Society of its members: Of the 750 physicians who participated, seventy percent supported making voluntary euthanasia legally available to patients. Forty-five percent said they would carry out the request for euthanasia from patients.

Though the Catholic church and a few Protestant denominations, as well as the Jewish hierarchy, are officially opposed to legislation such as the HDDA, the Unitarian church and the Humanist Society support the initiative. Furthermore, surveys indicate that as much as two-thirds of the American public, including those who identify themselves as religious, favor active voluntary euthanasia.

Though it still has a long way to go, AAHS has come a long way in the fight for the right of self-determination for the terminally ill. Achievement of this goal is inevitable.