

California Faces End of Life Choice
Symposium Summary
By
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The Fall Social Justice Symposium welcomed a panel of doctors, practicing attorneys, and law professors who discussed a proposed California law, similar to Oregon's Death With Dignity Act, which would legalize physician-assisted suicide.

Moderated by Prof. Michelle Oberman, the symposium was entitled "California Faces End of Life Choice: Legal Issues and the Contemporary Controversy". Panelists from around the nation presented their views on the issue, followed by comments from SCU law faculty.

Dr. Robert V. Brody, Clinical Professor of Medicine and Family & Community Medicine at the University of California, San Francisco, emphasized the importance of language in framing the debate over physician-assisted suicide. "Euthanasia" and "assisted suicide" are two-often employed terms, but according to Brody, both are problematic.

"Euthanasia" implies that the doctor is the one killing the patient. Under Oregon's law and the proposed California law, the doctor merely prescribes the lethal medication, and the patient self-administers it. "Assisted suicide" is a preferable term because it makes clear that the patient is the actor.

"Terms change to fit the perception of the situation," Brody said. For instance, it is now accepted in the legal and medical communities that patients and their families may decide to withdraw artificial life-sustaining treatment. This practice was once called "passive euthanasia," but due to euthanasia's negative connotations, "the term has disappeared."

Similarly, according to Brody, if "physician-assisted suicide" becomes accepted, the term "assisted suicide" will ultimately be rejected because "suicide" implies depression. The Oregon law and the proposed California law both contain safeguards to ensure that patients are not depressed.

Dr. Joel E. Frader, Division Head of General Academic Pediatrics at Children's Memorial Hospital in Chicago, discussed end-of-life issues with respect to children. Several factors change the relevant issues for children. First, parents would be making the final decision instead of the patient. Second, childhood death is rare, thus very few pediatricians are skilled in advising families on end-of-life decisions. Terminally ill children are usually treated by specialists who do not have long-standing relationships with the child and the family, making the process that much more difficult.

Furthermore, it is extremely difficult for children to receive hospice care. As a prerequisite to hospice care, most states require the attending physician to certify that death is imminent and to give up treatment. It is often difficult to predict when a child will die, and it is often the case that continuing treatment will keep the child active until days or hours before death.

“We’re asking states to alter the rules for children in order to allow us to continue things so that children can continue to be active and comfortable,” Frader said.

Since parents are making end-of-life decisions for their children, another issue is discerning whether the parents are acting in their own or their child’s best interest. In other words, is the family deciding to end the child’s life because the child can not take any more suffering or because they can not stand to watch the child suffer any longer?

“Pediatricians are used to thinking about the best interest of the child, but in the world of end-of-life care, we have to go beyond that notion and be concerned with the best interest of the entire family,” Frader said.

Kathryn L. Tucker, Director of Legal Affairs for Compassion & Choices, spoke about the lessons California can take from Oregon’s experience with physician-assisted suicide. According to Tucker, the availability of physician-assisted suicide has improved end-of-life care in Oregon, and opponents’ predictions have not come true.

While rampant use of physician-assisted suicide was predicted, use has been limited to about thirty patients per year. Also, many more patients are prescribed life-ending medication than actually use it. “This shows that terminally ill patients are comforted by having this option available,” Tucker said.

Studies have shown that 99 percent of patients who have taken advantage of Oregon’s law were insured, and 86 percent were under hospice care. These statistics dispel fears that physician-assisted suicide would be used disproportionately by poor and minority patients who could not afford continuing treatment.

“End of life care has improved across the board,” Tucker said. Following Oregon in promoting physician-assisted suicide would be consonant with California’s historical role as a “leader in promoting good pain and symptom management.”

Sylvia A. Law, Elizabeth K. Dollard Professor of Law, Medicine and Psychiatry at New York University School of Law, highlighted the possibility that physician-assisted suicide would become a uniting cause for liberals and conservatives. By promoting physician-assisted suicide, liberals can promote their humane-end-of-life-care agenda and conservatives can promote their states’-rights agenda.

Law explained that state law became the leading front for the battle over physician-assisted suicide after the Supreme Court failed to recognize a constitutional right in *Washington v. Glucksberg*.

Law would have preferred a constitutional right because “only federal law can secure basic rights to liberty and equality for everyone; rights should not depend on where you live.”

But, she conceded, “In retrospect, our actions in *Glucksberg* were a mistake. It was naïve to assume that the Court would recognize a federal constitutional right when no state had recognized one.”

Gonzales v. Oregon, the case currently pending before the Court that will decide whether Oregon may allow physician-assisted suicide without federal interference, addresses a much narrower issue, involving interpretation of the Controlled Substances Act (CSA).

Under the CSA, doctors may not prescribe drugs for other than a “legitimate medical purpose.” The question is who may determine whether physician-assisted suicide is a legitimate medical purpose: the federal government, which has authority over prescription drugs or the states, which have authority over medical care in general.

If the Court sides with the federal government, proponents of physician-assisted suicide would be forced to resort to Congress. But with Republicans controlling the Congress and the White House, “the best we can hope for is to hold onto state sovereignty” in this area, Law said.

John Eisenberg, Professor of Law at University of California, Hastings School of Law, began with “Welcome to the Culture Wars.”

According to Eisenberg, who was a member of Michael Schiavo’s legal team, the Schiavo case became such a “huge national spectacle” because the lawyers who argued against withdrawing treatment were funded by conservative right-to-life groups. These same groups are funding lawyers who argue against physician-assisted suicide and against federal prosecution of abortion clinic violence, and they are generally “funding the conservative side of the Culture Wars,” Eisenberg said.

“There’s one man you see in all this,” Eisenberg said. “His name is Jay Sekulow and he’s chief counsel for the American Center for Law & Justice, which is Pat Robertson’s legal arm. He is also one of Bush’s advisors on appointees to the Supreme Court,” Eisenberg said. For this reason, Eisenberg does not anticipate that newly appointed Chief Justice John Roberts will be “friendly” to Oregon’s Death With Dignity Act.

“As in any war, the first casualty of the Culture Wars is truth. There were lots of lies in the Schiavo case, and we’re hearing the same thing from the advocates in *Gonzales*. Look very carefully for the truth because it can be elusive,” Eisenberg said.

Prof. Margaret Russell commented that, while the physician-assisted suicide movement “resonates with [her] as a matter of individual choice.” She retained some concerns about the practice, citing the common adage, “No good deed goes unpunished.” She worried that the law would have a disproportionate impact on minorities and the poor.

“The affluent will benefit, but the less privileged will be more vulnerable,” Russell said. “Poor people have never had the power to control the circumstances of their deaths or their lives.”

The proposed California law would supposedly safeguard against patients' requesting physician-assisted suicide out of depression. But, "what about undiagnosed depression?" Russell asked.

Russell noted that many disability rights organizations disapprove of physician-assisted suicide because they "fear that the whole notion of death with dignity will lead people to think that there's something undignified about the way many people with disabilities live their lives. They fear this will erode our sense of humanity," Russell said.

Prof. Bradley Joondeph disagreed with his colleagues, as well as the Ninth Circuit, on how *Gonzales v. Oregon* should be decided. While the issue in the case has been portrayed as whether the State of Oregon or the federal government has authority over physician-assisted suicide, Joondeph said that where medical care and prescription drugs intersect, the states and the federal government have concurrent authority. So, while Oregon has decided not to criminalize physician-assisted suicide, the federal government, through its long-recognized power under the CSA, may still criminalize dispensation of prescription drugs for that purpose.

"It's a political question, not a legal question," Joondeph said. "Congress didn't anticipate this issue when they drafted the CSA, so to resolve the ambiguity, we have two choices: trust the courts, or trust the executive branch and secondarily Congress. In the long run, it's better to defer to the executive branch because it is more politically accountable."

Prof. Margalynne Armstrong echoed and expanded on Brody's comments regarding the importance of language in how we frame the debate over physician-assisted suicide.

"It's important to abandon the language of the law and of the 'Culture Wars,'" Armstrong said. "We need to talk to the middle."

The process of physician-assisted suicide is more accurately the process of "hastening imminent death under certain circumstances with controls and checks," Armstrong said. "So many people have seen first-hand that technology can push life further than comfortable. If someone chooses death with dignity, we should allow it."

Oberman closed with a quote from Pablo Neruda: "So short life, so long dying."