Journal of Civil Rights and Economic Development

Volume 12, Summer 1997, Issue 3 Article 7

The New York State Task Force on Life and the Law: Why It Concluded Physician-Assisted Suicide Should Not Be Legalized

Carl H. Coleman

THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW: WHY IT CONCLUDED PHYSICIAN-ASSISTED SUICIDE SHOULD NOT BE LEGALIZED

CARL H. COLEMAN*

My talk will focus on the Task Force's deliberations on assisted suicide that took place between 1992 and 1994.[1] I will examine the thinking that led to the Task Force's unanimous conclusion that assisted suicide should remain illegal as a matter of state law.

First, I would like to set the context for the Task Force's deliberations. The Task Force is a group of doctors, lawyers, religious leaders, philosophers, ethicists, and patient advocates. This broad-ranging group was not appointed to deal with the issue of assisted suicide specifically, but rather to deal with a broad range of issues involving medical ethics.[2]

Over its first seven years, the Task Force developed laws promoting the right of patients to make decisions about medical treatment for themselves and, if unable, to have family members make those decisions for them.[3] These laws protect the individual's right to withdraw and withhold life-sustaining treatment under appropriate circumstances.[4]

* B.S.F.S., Georgetown University; J.D., Harvard Law School. Mr. Coleman is the Executive Director of the New York State Task Force on Life and the Law, a nationally recognized governmental advisory commission that develops policy recommendations on issues raised by medical advances. He is also an adjunct professor at New York University School of Law, where he teaches a seminar on bioethical issues. Mr. Coleman has written and lectured extensively on the legal issues surrounding end-of-life medical care.

1 *See* THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994 & 1997 Supp.) [hereinafter WHEN DEATH IS SOUGHT].

2 *See id.* at vii (explaining that purpose of Task Force was to develop recommendations for public policy in New York on broad range of health care issues).

3 *See* Renee A. Rorsch, *Legal Aspects of the New York State Health Care Proxy, Pros & Cons*, N.Y.ST. B.J., Jan. 1994, at 10 (explaining that Task Force was instrumental in developing health care proxy legislation in New York).

4 *See* N.Y. PUB. HEALTH LAW ARTICLE 29-B (McKinney 1998) (Orders Not to Resusci-

It was in the context of focusing on the issue of patient rights and individual autonomy that the Task Force took up the issue of assisted suicide.[5]

Early in the Task Force's deliberations it became clear that there were at least two general positions on the question of whether it would ever be ethically acceptable for an individual physician to help an individual patient commit suicide.[6] There were some members who, from the start, took the position that it would never be ethically acceptable. Some of these views stemmed from general opposition to the deliberate taking of human life.[7] Others related more specifically to the physician's role, and to the effect that the legalization of assisted suicide might have on the physician-patient relationship.[8]

There were other Task Force members who took a different view. Many of these people felt that they could envision circumstances under which assisted suicide would be ethically acceptable.[9] Indeed, it was felt that circumstances could exist where it might even be commendable to help a dying patient commit suicide. Those circumstances, they agreed, would be relatively rare, as I think most people here would agree. At a minimum, they would have to involve a patient who is suffering terribly, who has no other options for relief of suffering, and who has made a voluntary, well settled decision that is stable over time.

Nonetheless, the group unanimously concluded that laws against assisted suicide should remain in force and that assisted

tate); N.Y. PUB. HEALTH LAW ARTICLE 29-C (McKinney 1998) (Health Care Agents and Proxies).

5 *See* WHEN DEATH IS SOUGHT, *supra* note 1, at ix (explaining context of Task Force's deliberations).

6 *See generally id.* at 138-41 (discussing different ethical positions of Task Force members).

7 *See* Daniel Callahan, *Can We Return Death to Disease?*, 19(1) HASTINGS CENTER REP. S5 (1989) ("No human being, whatever the motives, should have that kind of ultimate power over the fate of another. It is to create the wrong kind of relationship between people, a community that sanctions private killings between and among its members in pursuit of their individual goals and values.").

8 *See* Willard Gaylin et. al., *Doctors Must Not Kill*, 259 JAMA 2139, 2140 (1988) ("[I]f physicians become killers or are even merely licensed to kill, the profession—and, therewith, each physician—will never again be worthy of trust and respect as healer and comforter and protector of life in all its frailty.") .

9 *See* WHEN DEATH IS SOUGHT, *supra* note 1, at 140 (noting that some Task Force members believed assisted suicide may be acceptable in certain rare cases). *See also* John D. Arras, *Physician-Assisted Suicide: A Tragic View*, 13 J. CONTEMP. HEALTH L. & POL'Y 361 (1997) (discussing the perspective that physician-assisted suicide may be acceptable in certain cases).

suicide by physicians or others should not be legalized as a matter of New York law.[10]

How was it possible for those in that second group, who could see circumstances under which it might be ethically acceptable to assist in a suicide, to believe that the law should not permit it? How could they conclude that an absolute legal prohibition is the best course for public policy?

At the heart of this issue is the difference between individual ethics and the development of public policy.[11] This, I believe, is the central issue that underlies the debate over the legalization of assisted suicide.

The individual case raises a lot of deeply personal, philosophical, and religious issues, and people can, and do, disagree strongly about these matters.[12] The question for public policy, however, is not whether it is possible to identify one or even several cases where it could be ethically acceptable to assist in a suicide. Rather, the question is whether the law could ever establish a system that would ensure that the practice of assisted suicide is used only for that ethically acceptable group.[13]

I want to emphasize that this question of what is ethically acceptable and what is not is determined primarily by the patient. It is not someone else's view of whether assisted suicide is appropriate that is the key issue, but whether the patient has truly made an informed, settled, non-coerced decision to commit suicide.[14] Therefore, the question is, how can we be confident that assisted suicide would be exercised only by those individuals whose suffering cannot be relieved by other means, and who have made an informed decision that is stable over time? The fear, of course, is that physician-assisted suicide might be exercised in certain circumstances as a result of inappropriate medi-

10 *See* WHEN DEATH IS SOUGHT, *supra* note 1, at vii (concluding that New York laws prohibiting physician-assisted suicide should not be changed).

11 *See* Joan Teno & Joanne Lynn, *Voluntary Active Euthanasia: The Individual Case and Public Policy*, 39 J. AM. GERIATRICS SOC. 827 (1997).

12 *See* Lawrence Gostin, *Deciding Life and Death in the Courtroom: From* Quinlan *to* Cruzan, Glucksberg *and* Vacco, 278(18) JAMA 1523, 1523 (1997) (discussing public opinion polls).

13 *See* Carl H. Coleman & Alan R. Fleischman, *Guidelines for Physician-Assisted Suicide: Can the Challenge Be Met?*, 24 J.L. MED. & ETHICS 217, 218-19 (1996) (evaluating proposed guidelines regulating physician-assisted suicide).

14 *See* WHEN DEATH IS SOUGHT, *supra* note 1, at 120 (explaining that even under ideal circumstances where proper safeguards are in place, legalized assisted suicide is still likely to lead to widespread error and abuse).

cal care, pressure, or coercion.[15]

Given the well-acknowledged problems with our system of end-of-life care, the Task Force concluded that it would be unrealistic to assume that physician-assisted suicide, if legalized, could be limited to the relatively small category of ethically acceptable cases. The question became one of balancing.[16] To what extent is a prohibition on assisted suicide unfair to people in those cases in which the practice would be ethically acceptable? To what extent would legalization harm people who might be assisted in suicide for unacceptable reasons?

Is this second group a large group? Is it larger than the group who may, given the prohibition, arguably be burdened by not having access to what might be an ethically acceptable option in their particular circumstances? How does one compare the harm of being assisted in committing suicide inappropriately against the harm of not getting assistance in suicide when such assistance might be ethically acceptable? It is a balancing process.

Another question involves the ability to regulate the harm.[17] One could argue that there would be people at risk of coercion, or those who might make a decision because of pressure, but that these people could be protected through safeguards and regulations.[18] One of the critical questions the Task Force looked at, therefore, was whether this is possible. Could we establish a framework that would allow doctors to weed out the inappropriate cases and ensure that physician-assisted suicide is limited to the acceptable cases?

Another question has to do with the alternatives. If assisted suicide remains illegal, even for those cases where it might be

15 *See* Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on* Roe, Casey, *and the Right to Die*, 44 AM. U. L. REV. 803, 807 (1995) ("[P]ermitting such assistance risks the unwilling or manipulated death of the most vulnerable members of society, and the erosion of the normative structure that encourages them, their families, and their doctors to choose life.").

16 *See* WHEN DEATH IS SOUGHT, *supra* note 1, at 119-42 (explaining factors Task Force considered in deciding whether assisted suicide should be legalized).

17 *See* Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICHMOND L. REV. 1 (1996) (arguing that effective regulation of physician-assisted suicide would not be possible); *see also* COLEMAN & FLEISCHMAN, *supra* note 13, at 218-19.

18 *See, e.g.*, Charles H. Baron et. al., *A Model Statute to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. LEGIS. 1, 12-3 (1996) (stating that there is no guarantee against abuse, but "that strong and effective safeguards, together with a clear understanding of the rational for the practice and the limits to which it applies, can reasonably meet concerns about the slippery slope").

ethically acceptable, what can we do for these patients? Are we really condemning them to die in pain, or to die an undignified death?[19] It is a group of questions that involves a balancing, a prediction of what the likely consequences are for society as a whole. The focus is not just upon the individuals who might benefit from a change in the law. There must be a balancing of the benefits and the risks at stake. That was the ethical and public policy framework that the Task Force used to analyze the question.

There were certain facts that stood out when the Task Force addressed these issues, including the risks of pressure, the fact that many physicians do not recognize symptoms of depression, and the undeniable fact that many patients do not get the kind of palliative and supportive care that could make the process of dying comfortable and pain free. These types of facts caused the Task Force a great deal of concern about the ability to limit assisted suicide to a narrowly defined class of ethically acceptable cases.[20]

A second area of concern was the pressure that legalization of assisted suicide itself might create. We live in a world now where somebody who is very sick, who is suffering, does not have to justify why she wants to continue to live. Everyone has a right to continue to live. No one needs to ask herself, "I am a drain on other people. Why don't I commit suicide?" It is not considered an available option.

If assisted suicide is made an option for people who meet certain criteria, for example, a specific medical diagnosis of six months or less to live, then anyone who falls within those criteria is implicitly going to be asked, and will ask herself, even if other people do not ask, "Why not?" Many of the Task Force members felt this was inherently coercive and unfair.[21]

The final point I would like to make in terms of the concerns about risk has to do with drawing the line at terminal illness, at capacity, and at self administration. If the premise of legalization is that physician-assisted suicide is ethically acceptable only

19 *See* WHEN DEATH IS SOUGHT, *supra* note 1, at 153-81 (proposing measures to improve care of seriously ill patients).

20 *See generally id.* at 121-42 (delineating principal risks of concern to Task Force).

21 *See* J. David Velleman, *Against the Right to Die*, 17 J. MED. & PHIL. 665, 674 (1992) (arguing that providing patients with option of physician-assisted suicide would harm patients by forcing them to justify decision to continue living).

for a very small group of people defined as terminally ill and close to death, there must be a logical reason for excluding others who might request assisted suicide, such as individuals with chronic illnesses who have years of suffering ahead of them. If not, it will be impossible to hold the line where it was initially drawn.[22]

22 *See* Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—and Why These Reasons are not Convincing*, 12 Issues L. & MED. 113, 128-30 (1996) (arguing that right to physician-assisted suicide could not effectively be limited to the terminally ill).