Death with Dignity – Should a Patient Be Entitled to Exercise a Right to Die?

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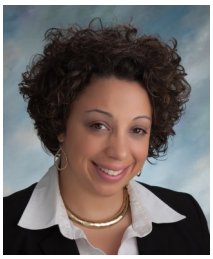

Controversy surrounding an individual's right to end his or her own life dates back through the ages. In ancient Greece and Rome, suicide was a relatively common occurrence, though particular circumstances might cause the act to be viewed as either honorable or disgraceful. In the Middle Ages, the Christian church excommunicated people who attempted suicide, and those who succeeded were refused burial in church cemeteries. Up through the late 19th century, in fact, most of the world treated suicide as a crime.

Although the criminal distinction has largely been removed from our law books, the social stigma remains. Many of us may still remember some highly publicized cases of the 1990s involving physician-assisted suicide. One involved Terri Schiavo, a vegetative patient at the center of a prolonged legal battle seeking to lawfully discontinue all life-prolonging treatment. Other memorable headlines concerned Dr. Jack Kevorkian, also dubbed 'Dr. Death,' a notorious physician who assisted patients in ending their lives by performing certain lethal procedures.

The campaign in favor of 'death with dignity,' sometimes referred to as a 'right to die,' has recently been revived by the 2014 decision of 29-year-old Brittany Maynard, a young woman suffering from terminal brain cancer, to end her life with the use of physician-prescribed medication, pursuant to Oregon's Death with Dignity Act.

In an article written by Maynard and published by CNN, Maynard described her quality of life with brain cancer as non-existent. After being given a prognosis of only six months, doctors prescribed treatment options which would have, according to Maynard, reduced her quality of life to an unbearable degree. Maynard's article goes on to explain that she felt she had no choice but to face that there was no treatment to save her life, and any recommended treatments would have only destroyed the time she had left.

Brittany Maynard was only one American out of many facing the stark realities of terminal illness. Patients across the country have been petitioning their state courts and legislators to give them the right to die and choose for themselves their ultimate fate. Currently, only three states allow physician-assisted suicide — Washington, Oregon, and Vermont.

In Massachusetts, this issue has been raised on two recent occasions. In 2012, voters were asked to weigh in on proposed legislation that would allow terminally ill patients meeting certain criteria to obtain doctor-prescribed medication to end their lives. The proposed legislation was ultimately defeated, but only by the narrowest of margins, with 49% in support of the right to die and 51% opposed.

The same question was raised again in 2013 by Massachusetts Bill H-1998, referred to as the Massachusetts Compassionate Care for the Terminally Ill Act. This bill is still pending and was recently referred to the Mass. Joint Committee on Public Health for study and analysis.

One of the most common arguments made in favor of death-with-dignity legislation revolves around an individual's right of self-determination. Such arguments, however, mischaracterize the issue. By arguing for a right of self-determination, or a right to die, advocates for physician-assisted suicide are overlooking an important consideration — under Massachusetts law, a patient's right to die is already established through several avenues.

For example, a person may have a health-proxy document with language specifying a desire to be taken off life support at the end of life. Patients may also refuse medical treatment if that is their wish.

In 1991, in a case known as *Norwood Hospital v. Munoz*, the Supreme Judicial Court of Massachusetts decided that the right of a patient to make her own decisions regarding treatment outweighed the Commonwealth's interest in preserving life or maintaining the ethical integrity of the medical

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profession. In support if its decision, the court noted that the right to refuse medical treatment is grounded in our constitutional right to privacy. However, the court's decision in the *Munoz* case confirmed only a patient's right to refuse medical treatment and did not address whether a patient has a right to request certain lethal medications. Many proponents of the current death-with-dignity legislation seem to view physician-assisted suicide as a natural outgrowth of the court's 1991 ruling in *Munoz*, and believe that, in addition to the right to refuse treatment, a patient should have a right to seek particular courses of treatment including obtaining medications designed to end their own lives. The issue at hand in Massachusetts' current proposal, therefore, is not a question of whether a patient has a right to die, but whether a patient should be entitled to exercise that right by obtaining and taking doctor-prescribed medication.

By redefining the issue in this way, and recognizing that, as citizens of the Commonwealth, we already possess the right to die, both advocates and opponents of death-with-dignity legislation can shift the analysis, educate the public, and perhaps assist legislators in navigating these murky waters, all in the service of providing voters more clarity in reconsidering whether Massachusetts wants to be a death-with-dignity state.

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