

Medical Ethics:

From Hippocrates to Oregon Measure 16

- Arthur Kavanaugh, M.D.

NATIONAL

Judge blocks assisted-suicide law

Associated Press
SALEM, Ore. — A judge blocked

Oregon doctors divided
on assisted suicide

Hard Ethical Issues

Sunday, December 4, 1994

The Dallas Morning News

Doctor-assisted suicide: Is it murder or mercy?

New law poses tough
choices for medicine

Euthanasia
debated

in Holland

Doctor is charged
in newborn's death

By Dick Polman
Philadelphia Inquirer

PURMEREND, Netherlands —

The University of Texas Southwestern Medical Center at Dallas

Internal Medicine Grand Rounds

March 16, 1995

"The call came in the middle of the night. As a gynecology resident rotating through a large, private hospital, I had come to detest telephone calls, because invariably I would be up for several hours and would not feel good the next day. However, duty called, so I answered the phone. A nurse informed me that a patient was having difficulty getting rest, could I please see her. She was on 3 North. That was the gynecologic-oncology unit, not my usual duty station. As I trudged along, bumping sleepily against walls and corners and not believing I was up again, I tried to imagine what I might find at the end of my walk. Maybe an elderly woman with an anxiety reaction, or perhaps something particularly horrible.

I grabbed the chart from the nurses station on my way to the patient's room, and the nurse gave me some hurried details: a 20-year-old girl named Debbie was dying of ovarian cancer. She was having unrelenting vomiting apparently as the result of an alcohol drip administered for sedation. Hmmm, I thought. Very sad. As I approached the room I could hear loud labored breathing. I entered and saw an emaciated, dark-haired woman who appeared much older than 20. She was receiving nasal oxygen, had an i.v., and was sitting in bed suffering from what was obviously severe air hunger. The chart noted her weight at 80 pounds. A second woman, also dark-haired but of middle age, stood at her right, holding her hand. Both looked up as I entered. The room seemed filled with the patient's desperate effort to survive. Her eyes were hollow, and she had suprasternal and intercostal retractions with her rapid inspirations. She had not eaten or slept in two days. She had not responded to chemotherapy and was being given supportive care only. It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, "let's get this over with."

I retreated with my thoughts to the nurses station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 mg of morphine sulfate into a syringe. Enough, I thought, to do the job. I took the syringe into the room and told the two women I was going to give Debbie something that would let her rest and to say good-bye. Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and watched to see if my calculations were correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. The older woman stroked the hair of the now-sleeping patient. I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. The dark-haired woman stood erect and seemed relieved.

It's over, Debbie".

(Anonymous, JAMA 1988)

This provocative case serves as a useful starting point for a review and discussion of medical ethics for several reasons. First, as can be said for many issues in medical ethics, it has the potential to generate an intense and immediate emotional reaction. Whether that reaction is "I remember being in a similar situation...", or "What that physician did was terribly wrong...", few physicians can read this story dispassionately. Second, this story deals with an issue as old as medical ethics itself; namely, euthanasia. As even a casual perusal of recent news reports will attest, this issue is one that has reemerged as the focus of countless heated debates. A catalyst

for the renewed interest in this issue was the approval by Oregon voters of Measure 16, the so-called 'Death with Dignity' act, last November by a 51 to 49% margin. Although the implementation of this law has been deferred pending legal appeal, this vote placed Oregon in competition with Australia's Northern Territory to become the modern world's first jurisdiction to legally sanction euthanasia. (N.B. Contrary to a widespread belief, euthanasia remains illegal in the Netherlands. However, prosecutors are allowed not to pursue indictment in individual cases if the actions of the physician involved are determined to have been within certain established guidelines; *vide infra*).

Proponents and opponents of euthanasia have weighed in with their opinions on the 'Debbie' case and similar cases. Anti-euthanasia forces, or 'vitalists' as they have been disparagingly called, have condemned the specific actions in the case. In addition, they have questioned its veracity, suggesting that the story may have been concocted by pro-euthanasia forces to bring wider publicity to the euthanasia debate. 'Right-to-die' advocates, on the other hand, have said that this case is illustrative of a common clinical quandary, and that it highlights the need for legalized euthanasia. They would suggest that what occurred in this case happens all the time surreptitiously, so why should it not be brought out into the open and regulated? A relevant footnote is that most pro-euthanasia forces, such as the Hemlock Society, have condemned the specific actions of the physician in the 'Debbie' case, even while approving the idea of euthanasia in other circumstances.

In today's grand rounds, we will review the history, principles and applications of medical ethics, in order to understand how this discipline might be utilized in the context of challenging clinical dilemmas. We will also return to the 'Debbie' case, to see how the principles of ethics may help us identify why the particular features of this case may make us feel ill at ease.

I. Introduction

Medical ethics is among the oldest disciplines of modern medical practice. The basic tenets of medical ethics originated with the works of Hippocrates almost 2500 years ago. However, medical ethics is also one of the most dynamic and rapidly changing areas of medicine. Alterations in our understanding and perception of the various principles of medical ethics occur almost continuously. These changes have been driven predominantly by breakthroughs in medical technology as well as alterations in societal norms. In many instances, relevant concepts in contemporary medical ethics have been reinforced by the imprimatur of legal opinion.

Concerns relevant to the field of medical ethics are very prominent in the daily practice of Internal Medicine. This is perhaps most apparent in the instance of medical decisions concerning the end of life. For example, in the Netherlands, a decision not to use life-sustaining treatment is made in approximately 40% of all non-sudden hospital deaths. In the United States, 40 to 65% or more of ICU deaths have been preceded by decisions to withhold or withdraw life support. Furthermore, it has been estimated that as many as 70% of deaths in community hospitals involve some sort of negotiated agreement not to use all available life-sustaining technologies. Of course, issues in medical ethics are not limited to end-of-life decisions. It has been estimated that about 30% of Internal Medicine outpatient visits involve some medical ethics problem. The

most common issues include competence in decision making, informed consent, and factors affecting patient preference. Recently, with the growing awareness of the costs of health care and the increased prevalence of 'managed care' arrangements, the most important ethical issue facing many physicians may relate to the 'bedside rationing' of health care.

Despite the prevalence of ethical issues in contemporary medical practice, many clinicians maintain what might be described as a healthy skepticism regarding ethical issues. Several considerations probably contribute to this perception. Because much of ethics is based on Philosophy, discussions in ethics are wont to degenerate into abstract theoretical considerations. Not only can this be uncomfortable to those schooled in the scientific method, it can also be far removed from, and thus irrelevant to the concrete problems involved in the care of patients. It is noteworthy that some of the most acclaimed medical ethicists have absolutely no background in clinical medicine. It has been noted that, *"the insights brought by physicians to the humanistic dimensions of clinical medicine are essential components of bioethics that cannot be adequately handled by distant philosophers unfamiliar with the realities of clinical practice"*. Finally, some clinicians feel that medical ethics is unnecessary, and that sound clinical judgement should suffice. While extensive clinical experience and judgement may indeed allow the resolution of difficult clinical cases, this is not to say that these the field of medical ethics might be supplanted. Rather, problematic cases may be resolved utilizing the experienced clinicians' intuition, religious heritage, moral upbringing, and other influences. We do indeed make 'medical ethics' decisions, even if we are not conscious of the ethical principles we are utilizing. As one observer suggested, *"In the clinical setting, physicians generally deal with ethical issues similar to the self-reliant manner in which they deal with medical problems; they apply the best knowledge they posses..."*. In some ways this is analogous to some clinicians' opinion of statistical analysis. For example, our clinical experience allows us to assign greater or lesser significance to a particular test result in a specific situation without resorting to the arithmetic calculation of positive predictive value. The same can be said for the approach to ethical problems, where we may conceivably arrive at a similar outcome without resorting to the formal application of ethical principles. Nevertheless, an explicit understanding of medical ethics can aid in our comprehension and resolution of challenging clinical cases. We should think of medical ethics, then, as a practical discipline. Indeed, medical ethics may be defined as the systematic identification, analysis, and resolution of ethical problems associated with the care of patients. As the care of patients becomes more technically complex, the societal expectations of physicians become more restrictive, and the physician-patient relationship becomes more regulated, an understanding of medical ethics will be an increasingly important tool.

II. History

The discipline of medical ethics enjoyed a remarkable degree of continuity from the time of Hippocrates until approximately 25 years ago (Table 1). Since then, the long standing traditions that had been preserved for almost 2500 years have been challenged, attacked, and, in some cases, discarded. Some would say that these changes were inevitable. How could the teachings of Hippocrates relate to the ethical considerations of the human genome project, not to mention a host of other decidedly contemporary issues? Nevertheless, analysis of the history of medical ethics may help allay some of the confusion in its modern interpretation.

Table 1. Time Line of Medical Ethics

400	B.C.	The era of Hippocrates
100	A.D.	Roman Influence
1100		Crusades
1845		1 st AMA Ethical Code
1945		Nuremberg Trials
1948		Geneva Declaration
1960's		"Question Authority"
1961		Scribner Shunt
1975		Helsinki Declaration
1976		<i>In the matter of Quinlan</i>
1988		'Death with Dignity' Initiatives
1990		Americans with Disabilities Act
1992		Health Care Reform / Managed Care

A. Hippocrates

At first glance, it might seem anomalous that so much of the substance of medical ethics could have been derived from the work of a single, ancient physician. However, this was a unique man in a unique age. Hippocrates (460 - 370 B.C.) lived in the time period that would come to be called the 'Golden Age of Athens'. This was the age of philosophers such as Plato and Aristotle, politicians such as Pericles, playwrights such as Aristophanes and Euripides, and many notable others; *"an inclusive catalogue of human intellectual capacity"*. Hippocrates, because he was the son of an Asklepiad, was born into the practice of medicine, or 'the Art', as he would call it. He is widely credited with bringing medicine away from mysticism, refusing to attribute illness to the caprice of the various gods as his predecessors did. Rather, with his precise descriptions of disease, Hippocrates helped move medicine towards the scientific method. It has been said that *"before Hippocrates, the physician was either an associate of the priest in times of peace, or a surgeon in times of war"*. Among Hippocrates' greatest contributions was that he provided physicians with lofty ideals for their practice of 'the Art'. We are reminded of this through our recitation of the Hippocratic Oath.

As is the case with other seminal works of Hellenic antiquity (e.g. the Odyssey), there is dispute as to whether the 'Hippocratic Oath' and other writings attributed to Hippocrates are indeed the work of a single author. It has been suggested that the entire Hippocratic corpus, over 60 books, may have been contributed to by several authors over perhaps two centuries. Nevertheless, there is no dispute as to the importance of Hippocrates' works. Influenced by contemporary philosophy, the body of Hippocratic work established several important ideals for the physician. Primary among them was the idea of *Φρόνησις* (phronesis). This may be translated variously as good sense, sound judgement, high mindedness, thoughtfulness, or practical wisdom. The physician was enjoined to use *Φρόνησις* in the care of his patient. This prime objective can be dissected into two of the central principles of medical ethics: beneficence (i.e.

do some good for the patient) and non-maleficence (i.e. do not harm the patient). Although these principles are alluded to in the Hippocratic Oath (see the Appendix for the complete Oath), they are defined perhaps most clearly in Hippocrates' *Epidemics*:

"As to diseases, make a habit of two things; to benefit, or at least to do no harm".

Interestingly, although medicine and philosophy had some cross-fertilization in the time of Hippocrates, the intersection of ideas was not complete. Thus, individual patient autonomy, an idea that finds some support in the works of Plato, would remain absent from medical ethics for more than 2,000 years.

In addition to using sound judgement, physicians are also held to other standards by the Hippocratic Oath. Of particular note, abortion and physician assisted suicide are specifically proscribed (although right-to-die advocates would point out that even in antiquity, all of the tenets of the Oath may not have been universally followed). Many parts of the Oath may be best understood when it is recalled that medicine at the time was a guild. Therefore, upon entering 'the Art', one swears an oath to Apollo, the healer-god of the Hellenic Pantheon, and his offspring (i.e. Apollo's son Asclepias, and Asclepias' daughters Panacea and Hygieia). Furthermore, there are specific instructions as to one's teachers and pupils, as well as guidelines appropriate to the etiquette expected of a prudent gentleman, such as confidentiality.

B. Religious Influence

Medical ethics, with its foundation in Hippocratic tenets, was shaped by other influences over the centuries. The Romans, along with the Stoic philosophers, helped add the concepts of duty, virtue, and compassion to the physician-patient relationship. It was also during this time period, under the influence of Roman law, that the physician-patient relationship came to be seen as a fiduciary one. According to this concept, the patient entrusts his physician with the power to make decisions that are in the patient's best interest. Another contribution to medicine and medical ethics that be traced to Roman times was the hospital. While the ancient Babylonians had brought their sick to the marketplace, and the Greeks had their Asklepien temples for the sick, it was the Roman *valetudinaria* (military first aid stations) that were the proximate predecessors of modern hospitals. This is particularly relevant to medical ethics because following the conversion of Rome to Christianity, care of the sick came to be associated with religion. This was evidenced most clearly during the Crusades, when several religious orders were established in order to provide care to the injured and ailing crusaders. Following the Crusades, aid-stations, or hospitals as they would come to be called, were usually closely associated with churches. Thus, ethical issues related to the care of the sick became inexorably intertwined with religious beliefs and practices in the Judeo-Christian tradition.

Throughout the following centuries, medical ethics remained largely unchanged. For example, one of the earliest modern treatises on the subject of medical ethics was written by the English physician Thomas Percival in 1803. In keeping with the Hippocratic tradition, Percival considered beneficence and non-maleficence to be primary among all other concerns in physician-patient relationships. His writings contributed substantially to the first ethical code of the American Medical Association, which was published in 1847.

The mid-20th century is most notable as regards medical ethics for the nefarious conduct of some Nazi physicians during World War II. These actions, which were brought to light during the Nuremberg trials, provided the impetus for the WHO Geneva Declaration of 1948. While little known to many physicians, this declaration demands a very high code of conduct for physician behavior; namely, that physicians will not use their knowledge contrary to the benefit of a patient, *even under threat*. While it may be easy for us to be self-righteous about the war crimes of past generations of physicians, such a high standard is quite relevant to many current debates in medical ethics throughout the world. The WHO Geneva conference was followed by two conferences in Helsinki (1964 and 1975). The most important declaration from these meetings as regards medical ethics related to issues of informed consent.

C. The 1960's

The most striking changes in medical ethics over the past 2500 years have occurred beginning in the early 1960's. A decade of social revolution and technological advance caused the staid field of medical ethics to be radically redefined. Prior to the 1960's, medical ethics was "*solely the domain of the profession, protected from the mainstream of cultural change and framed in seemingly immutable moral principles*". Several forces in this era helped contribute to the redefinition of medical ethics.

In 1960, in Seattle, Dr. Belding Scribner, and his colleague Dr. Wayne Quinton developed the first arteriovenous access device. Subsequent refinements in this 'Quinton-Scribner' shunt allowed, for the first time, long-term hemodialysis for patients with end stage renal disease. Although allusions to 'Pandora's Box' may be overused, it seems appropriate in this instance. While the lives of less than a dozen people could be immediately prolonged by long-term hemodialysis, literally thousands of patients were potential candidates. Faced with this rationing dilemma, the doctors involved helped establish the first 'ethics committee' to help decide which patients were the best candidates. Members of the committee selected candidates based on a variety of characteristics, including age, mental acuity, family support, criminal record, income potential, employment history, education, and access to transportation. In a very human but very politically incorrect manner, the committee selected candidates for hemodialysis that were of similar socioeconomic background to the committee members. When this was exposed in a *Life* magazine article ("The Death Committee"), the committee was rapidly disbanded.

Important technological breakthroughs in the 1960's included the development of ventilators, the introduction of Intensive Care Units, advances in transplantation, and a host of others. Many of these advances had in common the ability to sustain lives that would otherwise have ended. This ability to postpone death has engendered many of the difficult issues in medical ethics. Accompanying the dramatic advances in medical care has been a shift in public attitudes towards medicine. Many have come to feel that there is no limit to what might be achieved with the miracles of modern medicine. Finally, in addition to the developments in intervention there have been substantial developments in diagnosis. Previously, physicians' ability to diagnose illness in asymptomatic persons was limited. Since the 1960's, diagnostic ability has risen dramatically, raising a host of ethical concerns. This may be most clearly seen in the debate surrounding the human genome project.

In addition to the technological advances described, another crucial force that helped transform the concepts of medical ethics during the 1960's was the social upheaval that took place in this decade. The dramatic changes in society that occurred in the 1960's included several distinct components that contributed to the metamorphosis of medical ethics. These include:

- 1) a better informed public (due to education, and advances in telecommunications)
- 2) the increase in participatory democracy (e.g. the civil rights movement, consumerism)
- 3) the decline in communally shared values (due to a more pluralistic and diverse society)
- 4) a distrust of authority (beginning with a distrust of government, and later spreading to include all authority figures, even doctors)

Combined, these factors helped spawn the 'patient's rights' movement. There were several readily apparent sequelae of this alteration in medical ethics. For example, physicians in the halcyon days of old had frequently engaged in what has been described as 'benevolent deception' when it came to informing patients. Why tell the patient that they had a terrible disease and could die in a matter of months when this information would only devastate them?. Due in large part to the societal revolution of the 1960's and the revision of medical ethics that resulted, such medical paternalism would no longer be tolerated. (Indeed, some of our more experienced physicians may be quite surprised to learn that both the word 'paternalism' as well as the concepts associated with it have come to be viewed in a pejorative sense by modern ethicists). The age of 'physician paternalism', which lasted from the time of Hippocrates until the 1960's, would be replaced by the age of 'patient autonomy'. As an indication of this change in attitudes, a 1968 survey of physicians revealed that 88% would consider withholding a diagnosis of cancer from their patients. By 1979, in a similar survey, 98% of physicians said that they would customarily inform their patients of the diagnosis.

With the erosion in the primacy of the Hippocratic tenets, physicians have increasingly turned to two additional resources for the resolution of difficult ethical issues: legal decisions, and newer applications of ethical theory such as the four principle approach to ethics. These will be covered in subsequent sections.

D. The 1990's

Several important medical ethics issues have received increasing notice over the past few years. One of the most prominent has been the euthanasia movement. Having derived significant momentum from the patient autonomy movement alluded to above, discussion of euthanasia has progressed to the point where 'right-to-die' initiatives have already reached the ballot in 3 states. Moreover, similar initiatives are expected to be on the ballot in a dozen states next fall. Thus, euthanasia, which is discussed in more detail in subsequent sections, may be expected to remain a contentious issue in the years to come.

An ethical issue that has risen only recently in the United States, but which promises to be increasingly consequential, is the high cost of health care and the necessity for health care rationing. If the 1960's was the era when 'patient autonomy' overcame 'physician paternalism' in medical ethics thinking, then the 1990's may be the age of "bureaucratic parsimony". We have heard the figures: health care consumes approximately 14% of the GNP of the United

States, having risen from 5% over the past few decades. In contrast, most industrialized nations spend approximately 7 to 9% of their GNP on health care. Few believe the U.S. can sustain the present rate of growth in health care costs. An inevitable corollary of this is that in some fashion, health care must be rationed. This will be a unique situation in the history of American health care. Previously, any limits on health care related to 'commodity scarcity': e.g. inadequate access to health care facilities, or shortages of specific commodities such as ICU beds or organs for transplant. Now, we will be faced with 'fiscal scarcity'. Discussion of all the aspects of this important issue, which will raise myriad difficult ethical issues, is beyond the scope of the present discussion. However, rationing will be discussed as regards its potential relationship to euthanasia.

III. Ethical Theory

Consideration of ethical issues depends upon acceptance of some underlying ethical theory. A host of ethical theories have been championed as being the most relevant to contemporary medical ethics. Some date back centuries, whereas others have arisen from more recent societal influences. Pros and cons of several of the more prominent theories will be briefly considered, and their potential interpretation of the 'Debbie Case' will be discussed.

A. Utilitarian / Community Based Ethics

According to this theory, the right act is the one that produces the best overall result. This is to be determined from an impersonal perspective that gives equal weight to the interests of each affected party. The correct choice, therefore, gives the greatest good for the greatest number, as well as the least liability. Although utilitarian theory originated early in the 19th century, its most infamous rendition may have been that provided by Colorado Governor Richard Lamm. Lamm suggested that in light of the tremendous rise in health care costs, the terminally ill have "*a duty to die and get out of the way...*".

In a similar ethical theory, namely 'community based ethics', the shared goals and obligations of the community as a whole have primacy over the individual. As an example, we can consider the case of organ donation after death. In liberal ethical theories (as discussed below) the decision to donate organs must be left strictly to the individual. In contrast, according to community based ethics, the greater good of the community takes precedence. Thus, as is the case in many European countries, there is a 'presumed consent' that people would allow their organs to be used by others.

- *Pro*: Utilitarian theory would allow relatively simple resolution of hard decisions. In addition, it could be used quite effectively in conjunction with the idea that escalating health care costs require some means of rationing.

- *Con*: Which values and ideals are the most important; happiness, health, knowledge, something else? More importantly, who gets to decide?

- *The 'Debbie' case*: Utilitarian theory might suggest that the action taken in the 'Debbie' case achieved the best result, e.g. by allowing medical resources to be freed up so that they could be used by others. The action would therefore have been appropriate.

B. *Deontological Ethics*

Also called Kantian ethics after Prussian philosopher Immanuel Kant, this ethical theory is based upon standards that are often derived from religious principles (hence *Deontological*). Ethical acts must be in accordance with these categorical imperatives (e.g. thou shall not kill). Actions must be undertaken not only in accordance with, but also for the sake of these obligations.

- *Pro*: Proponents would say this theory of ethics defines the ultimate moral high ground.
- *Con*: Strict adherence to the theory may lead to conflicting obligations that cannot be resolved (e.g., thou shall not kill, versus thou shall not permit suffering)
- *The 'Debbie' case*: The action undertaken would be judged inexcusable according to this theory, and the physician culpable.

C. *Character / Virtue Based Ethics*

Following traditions of the Platonic and Aristotelian philosophies, this ethical theory assigns preeminence to virtuous character. Correct actions require not only the action itself, but also the proper motive.

- *Pro*: It might be said that in large part we do indeed judge people by the character of their actions. We expect people to have certain emotions associated with their actions.
- *Con*: Virtue, in and of itself, may not be sufficient. It may be difficult to resolve complex problems relying on virtue alone.
- *The 'Debbie' case*: Although the information provided in the case regarding the physician's motives is scant, it would appear that the action was largely unjustified.

D. *Liberal / Individualistic Ethics*

This is also referred to as 'rights based theory'. Rights are the justified claims that individuals can make upon society. Rights provide vital protection of life, liberty, and expression.

- *Pro*: 'Rights' constitute the language of many political declarations.
- *Con*: Liberal ethics may not be sufficient to deal with complex issues, e.g. the basis for rationing.
- *The 'Debbie' case*: Unclear, because the true desires of the patient are unknown. If this was clearly the patient's choice, it would be permissible; if not, the action was unjustified.

E. *Casuistry*

Casuistry, or case based ethical theory, stands in distinction to more abstract ethical theories. By stressing the importance of paradigmatic cases, it offers a concrete solution to ethical dilemmas. In this way, it is similar to legal proceedings, where the use of precedent is of great relevance.

- *Pro*: Casuistry offers a practical approach to the resolution of difficult ethical cases.
- *Con*: It may fall short in relatively new areas where no paradigmatic cases exist (e.g. those with novel technology). In addition, the application of case based theory works most clearly within a homogeneous society; i.e. those who share common religious beliefs, desires, and goals. As society becomes more pluralistic, the application of casuistry may become more tenuous.
- *The 'Debbie' case*: There is little precedent to condone the actions in the case.

F. The 'Four Principle' Approach

Although not strictly an ethical theory, the so-called 'four principle' approach espoused by Beauchamp and Childress has been widely taught as a practical approach to medical ethics problems. Because of its structured approach and its practicality, it has had significant appeal to clinicians. The four clusters of principles are: 1) patient autonomy, 2) non-maleficence, 3) beneficence, and 4) distributive justice. Ethical problems might be easier to resolve by dissecting complex cases according to how the aspects of this case relate to these four principles. The principles combine tenets of Hippocratic origin (i.e. non-maleficence and beneficence) with more modern ideals and values (patient autonomy and distributive justice). The principles are presented in a suggested order of consideration, i.e. with issues of patient autonomy being the most important to consider, followed by issues of non-maleficence, etc. However, depending upon the particular circumstances of the case, any of the four principles might be the most important. Therefore, consideration of that principle would dominate in that particular instance (e.g., consideration of beneficence may be more relevant than consideration of patient autonomy in a given case).

This approach to medical ethics has been derided for some of the same reasons that explain its attraction to clinicians; it is simple, pragmatic and logical. It has been disparagingly called "principlism" by those who feel that medical ethics cannot be performed by filling out a checklist of individual principles. However, an organized approach that has been widely disseminated (and thereby validated) has considerable appeal to clinicians. The four principles, along with their most relevant components, will be discussed in detail.

1. Patient Autonomy

In distinction to the long tradition advocated by centuries of physician-philosophers, many modern ethicists assign primacy to the principle of patient autonomy. Autonomy can be translated as 'self determination', and this ideal has assumed a prominent position in the modern physician-patient relationship. Autonomy may be considered to be composed of two parts: agency (i.e. the capacity for intentional action, presumably in one's own interests), and liberty (i.e. the independence from any controlling influences). These will be considered separately.

Agency has as its most important derivative the idea of competence. It can readily be appreciated that the word competence can have distinct meanings when interpreted from a legal, medical, psychiatric, or philosophic viewpoint. In general, the criteria utilized to establish competence in different situations vary depending upon the complexity of the task required (e.g. we require different levels of competence for neurosurgeons as compared to barbers, although both work on the head). In addition, we tend to require different levels of competence depending upon how the choices involved correspond to accepted societal norms and practices (e.g. we allow patients to *agree* to life-sustaining interventions readily, whereas we tend to require extended discussion before allowing a patient to *refuse* the same interventions). If we believe that a patient is not competent, then we may act without regard to their personal choice or autonomy. Therefore, the most common ethical concern relating to agency is the determination of incompetence. As with competence, definitions of *incompetence* will vary depending upon the complexity of the situation. In order of increasing complexity, incompetence may be defined as:

- 1) inability to express or communicate a preference or choice
- 2) inability to understand the situation and its consequences
- 3) inability to understand relevant information
- 4) inability to provide a reason to explain one's actions
- 5) inability to provide a *rational* reason to explain one's actions (or lack of possession of a rational set of values and goals)
- 6) inability to reach a reasonable decision (e.g. as judged by the standard of what a reasonable person would do, consistent with their own values and in their own best interest, in similar circumstances)

Liberty has as its most important derivative the idea of informed consent. As with agency, informed consent may have slightly different meanings from a legal, medical, or organizational standpoint. Thus, risk reduction, avoidance of exploitation, and protection of personal autonomy may all be considered goals of informed consent. Problems arising from the suspension of full informed consent have recently received attention surrounding the issue of Gulf War veterans, and their 'voluntary' exposure to some vaccines and medications.

Although we speak of it as a single concept, informed consent is composed of several distinct components. These include:

- 1) competence (as discussed above)
- 2) disclosure
- 3) understanding
- 4) voluntary participation ('voluntariness')
- 5) consent

Disclosure is an idea that has undergone dramatic change in recent years. As noted above, physicians had commonly exerted their 'therapeutic privilege'; that is the intentional nondisclosure of information to the patient based on sound medical judgement that revelation would be potentially harmful. While such nondisclosure may still be practiced in extreme cases (with legal support), in most cases disclosure of all relevant information has become the standard of care. That such disclosure is desirable to patients has been borne out in numerous surveys in which physicians tend to underestimate patients' desire to know while overestimating their emotional reactions to being provided information. However, the extent of information that is 'relevant' has been an area of some controversy. Some feel that the pressure to provide complete informed consent has resulted in patients being forced into a state of information overload, where the excess of data provided only heightens confusion. This could negatively impact upon the whole process of informed consent.

Like many of the ideas of medical ethics, 'understanding' has no universally accepted definition. It typically is interpreted to include some comprehension of: 1) the diagnosis itself, 2) the prognosis associated with the diagnosis, 3) the nature and purpose of any proposed intervention, 4) alternatives to the proposed intervention, 5) anticipated risks and benefits of the intervention along with the likelihood of their occurrence, and 6) the physician's recommendation. Obviously, some patients understanding may be considered suboptimal by the

standards of others. This may be due to the patient's knowledge and education, past experience, and life situation. Interestingly, patients may choose different options when presented with similar information in dissimilar ways (e.g. if the emphasis is placed on the 40% chance of survival versus the 60% chance of death). A problem in believing a patient has real understanding occurs when they possess beliefs at variance with those of the majority (e.g. the refusal of Christian Scientists to receive medical care). As in declaring someone incompetent, it is difficult not to transfer one's own values onto others (e.g. this patient must not understand what is going on because they are refusing a necessary procedure). Finally, it must be remembered that patients do have the right to refuse having information forced upon them. Indeed, it has been suggested that as many as 60% may prefer the "...whatever you say, Doc..." approach.

Voluntariness can be defined as freedom from manipulative or coercive influence. Although some would exclude coercion from this definition, and while it is certainly true that coercion may be beneficial (if paternal), coercion may interfere with a person's status as a volunteer. One example of subtle coercion that many feel was unethical relates to the Tuskegee syphilis experiments. In that case, participants were offered a variety of benefits (e.g. meals, transportation, burial insurance) to be volunteers in the study. Thus, voluntariness can be influenced by diverse factors such as socioeconomic status, as well as the presence of psychiatric disease or intercurrent illness, drug addiction, and other concerns.

Voluntariness may perhaps be the most crucial aspect of informed consent. For example, in 1722, prisoners sentenced to be hanged at Newgate prison in London were offered amnesty if they volunteered to participate in trials of smallpox inoculation. While this may be said to be coercive, it is considered ethical by many because experiments were done only on those who volunteered. In contrast, the experiments performed by the Nazi physician Sigmund Rascher (such as the hypothermia and high altitude experiments) are universally condemned because, among other concerns, the patients did not participate voluntarily. Indeed, those experiments helped provide the impetus for the Geneva and Helsinki declarations that helped establish informed consent.

Finally, an issue that may be discussed under patient autonomy deals with surrogate decision making: How should a choice be made for a patient incapable of exerting their autonomous wishes? There are 2 basic standards for how such a decision might be made: 1) best interests (e.g. parents are usually assumed to undertake actions that would be in the best interests of their children) and 2) substituted judgement (i.e. to reach the decision that the incapacitated person would have chosen if he or she were able to choose). This will be discussed in more detail in section IV: *Medical Ethics and the Law*.

2. Non-maleficence

Most physicians remember the principle of non-maleficence in the familiar and frequently invoked Latin aphorism, "*primum non nocere*", or 'above all, do no harm'. Although sometimes attributed to Hippocrates, it appears nowhere in his writings, and its origin is obscure. Many are troubled by the hortatory nature of this maxim, and its attribution of primacy to non-

maleficence. Thus, it might be preferable to use Hippocrates' own rendition of the matter, as noted above: "*as to diseases, make a habit of two things; to benefit, or at least to do no harm*".

Several critical issues in contemporary medical ethics may be best considered under the heading of non-maleficence. One that can be particularly contentious for clinicians relates to the consideration of treatment versus non-treatment. For example, it has often been emotionally more difficult for physicians to withdraw a life-sustaining therapy that has already been begun than to withhold the same therapy. Most ethicists, with the support of legal opinion, find no difference between the two actions. Similarly, physicians may have trouble considering nutrition and hydration to be simply another example of life-sustaining medical technology. For many, the issue is emotionally charged and laden with symbolism and religious overtones. The provision of food and water has been considered the least we can do for each other as humans. Nevertheless, the courts have upheld the opinion that these interventions are no different than other technologies such as ventilators. Another distinction the courts have found nonviable is that between ordinary and extraordinary measures. Founded in Catholic theology, the distinction between ordinary and extraordinary held that extraordinary measures were those that offered no additional benefit to the patient, or that involved some minimal benefit that was outweighed by the risks. Such therapies could be withdrawn. In contrast, all other therapies could be considered ordinary, and their withdrawal would be unethical. Another contentious concept that also has its origins in Roman Catholic theology is the difference between intended versus simply foreseen effects. This is the so-called 'principle of double effect'.

According to the principle of double effect, an act that results in a certain outcome may be ethical or unethical depending upon the intentions with which it was done. A good example of this may be found in the 'Debbie' case presented above. Clearly, in this case, the intention of the resident was to end the life of the patient; an act that many would find intrinsically and absolutely wrong. However, suppose that the case was presented slightly differently. Imagine that the physician involved had stated that his objective was not to kill the patient, but to relieve her pain and suffering, and that he was going to do this by giving her as much morphine as it might take. Even though the same outcome (i.e. death) could have occurred, and indeed could have been anticipated based upon the dose of morphine administered, in this case the action would have been ethically permissible according to the principle of double effect, because the resident did not *intend* to kill her. In order for an action to be ethically acceptable, four criteria must be met: 1) the act must be good or at least morally neutral, 2) the intention is only for the good effect, even if the bad result might be expected, 3) the bad effect must not be a means to the good effect (i.e. I will relieve her pain by killing her), and 4) the good effect must outweigh the bad effect. Some ethicists are very critical of the double-effect principle. They point out the substantial difficulties inherent in discovering a person's intentions. Further, the notion of 'intention' itself can be complex and multifaceted. In addition, many refer to the difficulties with the strict application of the double-effect rule in other instances; in particular, abortion. According to an interpretation of Catholic dogma, it would be acceptable to perform a hysterectomy on a pregnant patient diagnosed with cervical cancer, because the primary goal is to remove the uterus to save her life, while the abortion is an unintended effect. However, it would not be ethically permissible to perform an abortion on a pregnant patient with severe heart

disease who might die if the pregnancy was not terminated.

As an alternative to the principle of double-effect, it has been proposed that various medical conditions may be divided into three groups: 1) those in which there is an obligation to treat, 2) those in which the decision to treat is optional, and 3) those in which there is an obligation not to treat. Included in the latter group would be conditions in which further therapy provides no additional physiologic benefit; i.e. futile conditions. The definition of what constitutes medical futility is also an area of increasing attention and controversy in medical ethics.

Finally, another distinction that may be considered under the principle of non-maleficence is that between letting someone die (e.g. a patient with a terminal illness who is not put on a ventilator as they approach respiratory failure) versus actively assisting them with their death. This is quite relevant to the debate surrounding euthanasia. Currently, although suicide has been decriminalized in all 50 states, assisted suicide is illegal in 36. As noted, euthanasia has recently been legalized in Oregon. The debate about the potential difference between allowing versus assisting someone to die has raised another concept that will be considered separately below; the so-called 'slippery slope' argument.

3. Beneficence

Beneficence, the obligation to act for the patient's overall good, is a primary tenet of the Hippocratic writings. While this obligation was previously based upon physician philanthropy and service, more modern writers have tried to assert that physicians have an obligation to act with beneficence because of the privileges that society has afforded them. Of note, the general public is not bound by a similar obligation to act with beneficence. This is illustrated by the case of Robert McFall, a patient with aplastic anemia who unsuccessfully sued his cousin in order to force him to undergo tissue typing and potentially bone marrow donation. The judge in the case ruled that although the cousin's action was morally indefensible, the law could not force someone to act with beneficence.

Although some ethicists would consider beneficence secondary to non-maleficence, there are clearly situations in which it is preeminent. For example, we accept the small but definite risk of serious untoward events associated with vaccination in order to provide greater benefit for most patients. Of course, issues such as these raise the specter of paternalism; an idea that has come to have negative connotations recently. There are two key elements to paternalism: 1) a person must act in accordance with their perception of what constitutes the best interests of their children (or charges) and 2) they intentionally override or exclude the preferences of those for whom they are undertaking the action. As noted, with the rise in preeminence of patient autonomy, most actions undertaken by physicians that seem paternalistic, such as withholding bad news, have been derided by many modern ethicists. However, even the most devout advocate of patient autonomy would agree that there are some instances in which paternalism may be justified; for example, restraining an acutely depressed patient who threatens suicide. In such instances, it might be said that the person's competence to make a decision was insufficient, because of the depression, so a paternalistic beneficent act was indeed justified. In most cases of intent to commit suicide, it is felt that such interventions are justified. One

historically interesting exception to this was the case of Barney Clark, the recipient of the Jarvik 7 artificial heart. Due to the extraordinary circumstances of his case, the patient was actually given a key so that he could turn off the compressor that powered his artificial heart if he so desired. He did not exercise this option.

4. Justice

Justice as a principle for medical ethics does not deal with legal justice, but rather distributive justice. There are several theories of distributive justice:

1. to each an equal share (socialist point of view)
2. to each according to need (e.g. the Medicare program)
3. to each according to effort ("*he who does not work, does not eat*")
4. to each according to prior contribution (e.g. Social Security)
5. to each according to merit (societal value)
6. to each according to free market value (the current status of health care in the U.S.)

Just as with the various ethical theories, there are different theories of justice. A *utilitarian* view would suggest a mixture of criteria be utilized, in an attempt to maximize health care for the greatest number. A *libertarian* view would suggest that health care should be distributed just as any other commodity, such as housing, and that each person should be allowed whatever level of health care they could achieve through their own initiative. There are two views that are more or less diametrically opposed to the utilitarian view: 1) the *egalitarian* view, which supports equal access to health care for all, and 2) the *communitarian* view, stressing the role of the community in determining health care distribution policy.

Associated with considerations of distributive justice are the influences that various external factors exert not only on this principle, but also on the other medical ethics principles (i.e. patient autonomy, non-maleficence, and beneficence). These factors include: 1) the role of the patient's religion, 2) the role of the patient's family and its dynamics, and 3) the patient's race, heritage, gender, and socioeconomic status. All of these factors may be relevant to the optimal resolution of individual medical ethics cases. In addition, additional 'external' factors that have become increasingly important and will demand substantial consideration in the near future include: 1) the goals and interests of society, 2) the escalating costs of health care, and 3) the optimal allocation of health care resources. It can readily be appreciated that it is a small leap from consideration of these issues to a related and very difficult issue; namely, health care rationing.

Discussions of health care rationing often seem as tendentious as they are complex. This is particularly true when the discussion switches from issues of rationing due to commodity scarcity (i.e. deciding which of the 6 eligible patients should be assigned the single available ICU bed) to rationing based on fiscal scarcity (i.e. what services to which patients should we discontinue in order to save money). The issues involved seem prone to pit one group against another (e.g. some younger writers have decried the fact that 12% of the American population older than 65 years of age consumes more than a third of all health care expenditures). It has also been noted that Americans have a 'schizophrenic' approach to cutting health care costs by rationing. Almost

all would agree that some sort of rationing is both necessary and desirable, but most are unwilling to restrict their own personal health care access or options. For physicians, the idea of health care rationing based on financial considerations may be particularly troublesome. Generations of physicians were trained, as stated as recently as 1984 in a *New England Journal of Medicine* opinion piece, that they were "...required to do everything they believe may benefit each patient without regard to costs or other societal considerations..".

The ethical implications of health care rationing are numerous and varied, and could be considered from sundry viewpoints. However, this issue may also be relevant to the present discussion of euthanasia. Because of concerns such as the provision of incentives to physicians to limit their patients' diagnostic and therapeutic options, many have warned that managed care has the potential to substantially impinge upon the physician-patient relationship. While placing limits on the provision of various types of health care interventions solely for economic considerations may be unethical, there could be no more outrageous example of this than euthanasia. What better way could there be to cut costs than to limit the amount of money spent on the care of the terminally ill? Recently, the statistics that support the idea of limiting access to health care at the end of life have been widely promulgated. For example, it has been noted that 27 to 30% of all Medicare expenditures each year are consumed by the 5 or 6% of beneficiaries who die during that year. While studies have contested the notion that substantial cost savings may result by health care rationing at the end of life, the idea has support among managed care proponents. Some have expressed considerable concern over this potentially nefarious collusion of managed care and euthanasia, referring to it as "managed death".

G. The Slippery Slope

As alluded to above, a recurring and important concept in medical ethics deals with the so-called 'slippery slope' of behaviors and actions. The concern is that once a particular course of action has been embarked upon, subsequent actions may inevitably follow. While the original endeavor may have seemed ethical, the ensuing actions may be both unintended as well as ethically objectionable. There is perhaps no more lucid nor compelling account of this concept than that presented by Leo Alexander, a psychiatrist, in his 1949 review of medical science under the German dictatorship prior to and during World War II. Several relevant excerpts are included.

In describing how the foundation for the euthanasia program and consequent actions was established, Alexander writes ...*"Even before the Nazis took charge, a propaganda barrage was directed against the traditional compassionate nineteenth-century attitudes toward the chronically ill, and for the adoption of a utilitarian point of view... Acceptance of this ideology was implanted even in the children. A widely used high-school mathematics text includes problems stated in distorted terms of the cost of caring for and rehabilitating the chronically ill and crippled. One of the problems asked, for instance, how many new housing units could be built for the amount of money it cost the state to care for the crippled, the criminal and the insane"*.

After describing the exterminations and some of the medical experiments performed on prisoners, Alexander deduces that *"Whatever proportions these crimes finally assumed, it became*

clear to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance, basic in the euthanasia movement, that there is such a thing as a life not worth lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, and the racially unwanted. But, it is important to realize that the infinitely small wedged-in lever from which the entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick".

Interestingly, the author details how a few years later, in 1941, Dutch physicians resisted the efforts of the local Reich Commissar to elicit their cooperation in similar fashion. He writes, *"Although on the surface the new order [to stratify the patients under their care] appeared not too grossly unacceptable, the Dutch physicians decided that it is the first, although slight, step away from the principle that is the most important one"*. This seems somewhat ironic, given the trailblazing efforts of contemporary Dutch physicians in the 'right to die' movement (*vide infra*).

Finally, some of Alexander's arguments concerning this 'slippery slope' are so germane to debates heard currently that they seem prescient. He writes, *"dictating bodies claim that all that is done is being done for the best of the people as a whole, and for that reason they look at health merely in terms of utility, efficiency, and productivity...This rationalistic point of view has insidiously crept into the motivation of medical effort, supplanting the old Hippocratic point of view...To be sure, American physicians are still far from the point of thinking of killing centers, but they have arrived at a danger point in thinking, at which likelihood of full rehabilitation is considered a factor that should determine the amount of time, effort and cost to be devoted to a particular type of patient. At this point Americans should remember that the enormity of a euthanasia movement is present in their own midst."*

The idea of the slippery slope may not be limited to old war-crimes. Indeed, some have pointed to the situation surrounding abortion in England as a more modern example. After rules concerning abortion were relaxed, in part to decriminalize what was already a common practice, the number of abortions rose sharply, and the indications for the procedure were sometimes bypassed.

Some feel that one means of avoiding the 'slippery slope' would be to sanction individual actions while not sanctioning the activity as a whole. This is how euthanasia is currently handled in the Netherlands, i.e. on a case by case basis. As we will, see, however, it can be argued that in that country a slide on the slippery slope may have already begun.

IV. Medical Ethics and the Law

Perhaps one of the most prominent recent trends, and one that has profoundly influenced not only medical ethics but also the entire practice of medicine, has been the expanding involvement of judicial opinion into various aspects of medical care. Although the case *"In the matter of Quinlan (NJ Supreme Court 1976; see Table 2)"* was not the first medical-legal case in the United States, it is often cited as an index case because of the succession of important legal

decisions that followed it. Such cases have helped shape our approach to difficult medical-legal problems. Many of these judgements have involved the application of various life-sustaining treatments to incompetent patients. Because the technology involved in these treatments has created situations that may have been beyond the scope of our previous medical ethics principles, some have felt the inclusion of judicial opinion to be useful. However, many physicians consider the growing role of legal decisions into patient care as intrusive, at best. At worst, it has seemed to some observers that medicine in general and physicians in particular have abdicated their traditional responsibilities by allowing this incursion of the legal profession into an area once considered sacrosanct; the physician-patient relationship. Interestingly, the courts themselves have been of split personality as regards the proper involvement of the judiciary system in medical matters. For example, in the majority opinion concerning a case appearing before the New Jersey Supreme Court it was written that the "*...courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient, and those who care about the patient*". In a different case, the Massachusetts Supreme Court affirmed the primacy of the judicial system in determining the most appropriate standards of medical intervention for these difficult dilemmas. Whatever one's opinion of the judiciary system's increasing involvement in medical decisions, the law is the law, and we must be cognizant of the law. As stated in the Latin legal aphorism, "*ignorantia legis non excusat*"; ignorance of the law does is not an excuse (for disobeying the law).

There are several points worth noting as regards the various landmark legal cases described in Table 2. Importantly, the courts have not been uniform in their judgements. In many cases, a initial ruling by a lower court has later been overturned by a higher court. In the only case of its kind to reach the United States Supreme Court to date (*In the matter of Cruzan*), the court affirmed the right of individual states to determine various important aspects of these cases. Thus, not only will the law regarding these matters vary from state to state, it also may evolve over time. A second point which becomes apparent is that there has been an evolution in the decisions reached in these cases. For example, in the *Quinlan* case, the opinion related only to the removal of artificial ventilation, which the family felt was extraordinarily intrusive. After being removed from the ventilator, Karen Ann Quinlan lived 9 more years, being sustained by hydration, nutrition, and other life-sustaining therapies that the court did not even consider. Later decisions have increasingly focused on the withdrawal of nutrition and hydration. It might be expected that in the near future that there will be several influential decisions, including some by the United States Supreme Court, regarding euthanasia and other concerns relevant to medical ethics.

Finally, although it has not yet received a judicial consideration relevant to medical ethics, the *Americans with Disabilities Act* (ADA) is included in the Table. Increasingly, this legislation has been used as a legal bludgeon, with which proponents on different sides of several important medical ethics decisions have tried to legally batter each other. For example, the federal government challenged Oregon's plan to ration Medicare using the ADA, and both pro- and anti-euthanasia forces have tried to use the ADA as a means to support their position.

Table 2. Selected Legal Decisions in Medical Ethics

<i>Case</i>	<i>Decision / Implications</i>
Schloendorff v. Society of New York Hospital (NY Appellate Court 1914).	"Every human being of adult years and sound mind has a right to determine what shall be done to his own body; and a surgeon who performs an operation without his patient's consent commits an assault" (Justice Benjamin Cardozo).
Salgo v. Stanford (CA Appellate Court 1957)	Affirmed malpractice decision against the doctors of a 55 y/o man who was paralyzed following an aortogram. The patient sued on the grounds of negligence for the doctors' failure to warn him of the potential risks of the procedure.
Tarasoff v. California State Regents (CA Supreme Court 1976)	Determined that a psychotherapist had a positive duty to break patient confidentiality and take reasonable steps to protect a third party from harm. "The protective privilege of confidentiality ends where the public peril begins" (5-4 majority opinion).
In the matter of Quinlan (NJ Supreme Court 1976)	Authorized discontinuation of life-support (ventilator) for 21 y/o patient in persistent vegetative state (PVS), based upon her constitutional right of privacy (balanced against state's interest in preservation of life) as asserted by her parents ('substituted consent'). Alluded to hospital 'ethics committees' to help resolve such problems.
Superintendent of Belchertown State School v. Saikewicz (MA Supreme Court 1977)	Affirmed decision to withhold chemotherapy from a profoundly retarded 67 y/o man with AML, based on right of privacy. Affirmed right to informed consent; allowed 'substituted judgement' (the decision the incapacitated person would make if he or she were able to choose. Also stressed role of courts in deciding such cases.
In the matter of Stovar; In the matter of Eichner (NY Appellate Court 1981)	Affirmed decision to withhold transfusion from incompetent patient with bladder cancer. Declined to use 'right to privacy' or 'substituted judgement'; relied upon 'clear and convincing evidence' that patient expressed a wish not to be maintained in PVS.

Table 2. Selected Legal Decisions in Medical Ethics (continued)

Barber v. Superior Court (CA Appellate Court 1983)	Dismissed homicide indictment against 2 attending physicians in the case. Ruled that not only may a ventilator be removed from a patient in PVS, but it is also permissible to discontinue fluids and nutrition in certain circumstances (i.e. where these treatments would be <i>extraordinary</i> rather than <i>ordinary</i>).
Bartling v. Superior Court (CA Appellate Court 1984)	Affirmed right of competent 70 y/o man with multiple serious, chronic (but not immediately life threatening) illnesses to refuse all medical treatment, even those that are life-sustaining (ventilator support). (subsequent ruling also allowed his doctors to be sued for imposing life-sustaining treatments against his surrogate's wishes).
In the matter of Conroy (NJ Supreme Court 1985)	Affirmed right of legal guardian for 84 y/o severely demented patient to have all life-sustaining treatments (including feeding tube) withdrawn. Based on 'best interest' (i.e. pain and suffering of continued existence outweigh benefits of living). Rejected earlier distinctions (active vs passive; withholding vs withdrawing; ordinary vs extraordinary; feeding vs other life-sustaining treatments)
In the matter of Jobes (NJ Supreme Court 1987)	Affirmed right of husband of 31 y/o patient in PVS to remove feeding tube based not on clear and convincing evidence of prior wishes, but based on irreversible condition.
In the matter of O'Connor (NY Appellate Court 1988)	Denied petition by the guardian of an incompetent 77 y/o patient to withdraw artificial feeding; based on grounds that patient's prior wishes had not been sufficiently specific.
In the matter of Cruzan (U.S. Supreme Court 1990)	Upheld individual states' rights to establish standards of evidence in applying 'substituted judgement' approach (specifically, Missouri's requirement of 'clear and convincing evidence' of incompetent patient's prior wishes). Affirmed "a constitutionally protected liberty interest in refusing unwanted medical treatment". Court denied distinction between food/hydration vs other therapies.
In the matter of Baby K (VA Federal District Court 1993)	Denied hospital's request to withhold ventilator care from an anencephalic child, based on tenets of American with Disabilities Act†
† Americans with Disabilities Act (1990)	<i>Enacted to "provide a clear and comprehensive national mandate to end discrimination against individuals with disabilities". Applies to government programs, employer benefits, and physician services, among others. Some ambiguity in provisions.</i>

V. Euthanasia

The term euthanasia, which was coined by Sir Thomas Moore, may be translated as 'good death', 'desirable death' or 'beneficial death'. Euthanasia may be divided into passive (e.g. prescribing an overdose of pills so that a patient can end their life) and active (e.g. administering a lethal injection). In addition, active euthanasia may be voluntary (i.e. with the patient's consent; e.g. assisted-suicide), non-voluntary (without consent, but in a situation where consent is impossible), or involuntary (without consent or against a person's wishes).

A. The Law

Recently, there has been increasing debate concerning euthanasia, as the voters in Oregon passed Measure 16 (see the Appendix for a complete ballot description of 1994 Oregon Measure 16). The Oregon law allows physicians to prescribe drugs for adult Oregon residents to end their lives within certain defined situations. The law requires: 1) the patient must have a prognosis of 6 months or less to live, 2) the diagnosis and prognosis must be confirmed by the opinion of a second physician, 3) the patient must formally request the intervention twice orally and once in writing, 4) there must be a 15 day waiting period, and 4) counseling must be recommended if either physician believes that the patient has a mental disorder or impaired judgement from depression. Currently, the law has been placed on hold by U.S. District Judge Michael Hogan who said, "*surely, the first assisted-suicide law in this country deserves a considered, thoughtful, constitutional analysis*".

In related opinions last December, both the Michigan Supreme Court and a federal judge in New York upheld bans on assisted-suicide in those states. However, last spring a federal district judge in Washington State found that a previous law prohibiting assisted-suicide in that state was unconstitutional because it 'interfered with liberty and privacy interests protected by the 14th amendment'. It seems clear that at least one of these cases will make it to the U.S. Supreme Court. A definitive opinion regarding euthanasia should result from such consideration. In that regard, in the first week of March of this year, the lawyer representing Dr. Jack Kevorkian has appealed to the Supreme Court to hear his case challenging the Michigan ruling.

Based at least in part on the success of the Oregon measure, similar initiatives are presently being considered in at least 11 other states. Of note, while Oregon Measure 16 is the first assisted-suicide initiative to be successful, it was not the first attempted in the United States. In 1988, the "Humane and dignified death act" failed in California. Similarly, in 1991, Washington State Initiative # 119 failed by a 54 to 46% vote. There are several reasons that help explain the failure of these earlier measures and the passage of the Oregon measure. First, it should be noted that the margins of victory or defeat in each case have been small. Second, a critical difference between the failed measures and the Oregon measure is that while physicians in Oregon would be permitted to *prescribe* medications enabling patients to commit suicide, they may not *administer* such medications. This certainly contributed to the palatability of such a measure, because even some euthanasia supporters remain uncomfortable with physicians being the actual agents of death. However, such comfort would surely be short lived, as euthanasia proponents made no secret of their intent to challenge the constitutionality of such a restriction on the basis of the Americans with Disabilities Act. Thus, a person with a disability that

prevented them from actually taking the medications themselves, but who otherwise met the provisions of the 'right-to-die' law, would thereby be unfairly discriminated against on the basis of their disability by being denied their 'right' to suicide. Therefore, pro-euthanasia forces planned a court challenge as quickly as possible, using the ADA, in order to broaden the law so that it would permit direct physician-assistance in euthanasia. Finally, another factor that may have had some influence on the outcome of the right-to-die measures in the different states has been the opinion of organized medicine. When both the California and Washington initiatives were placed on the ballot, their respective state medical organizations (in addition to the national AMA) publicly opposed the measures. In contrast, the Oregon Medical Association, reflecting the plurality of its membership, refused to take any public stance on Measure 16. Some took this as tacit endorsement of euthanasia, and suggest that this helped sway public opinion.

B. Opinion regarding euthanasia: Public and Physician

As noted, there appears to have been an evolution of opinion, both public opinion as well as that of physicians, concerning euthanasia. Although the results of opinion polls can vary considerably based upon factors such as how the questions are framed, it does seem clear that the proportion of Americans who support assisted-suicide in certain situations has risen from about one-third to two-thirds past few decades. In addition, most patients believe that such a decision should be made by the patient and their doctor, rather than by outside forces such as the courts. While a similar proportion of physicians may also support the concept of euthanasia, fewer would be willing to actively participate in aiding a patient's death. Thus, in various surveys, as few as 6% or as many as 40% of physicians would participate in assisted suicide. One of the strongest factors underlying this discrepancy appears to be age. In general, far greater numbers of younger physicians both approve of the concept of euthanasia and would be willing to participate in it, as compared to older physicians. One of the important factors underlying this discrepancy is that younger physicians 'grew up' in the age not only of life-sustaining technologies, but also of DNR orders, advance directives, Dr. Jack Kevorkian, and other influences.

C. The Dutch Experience

Stimulated by a 1973 case in which a physician killed his terminally ill mother, the Dutch Supreme Court issued an opinion in 1984 declaring that euthanasia ("*Een Weldaad*" in Dutch) would no longer be prosecuted in certain approved circumstances. It should be noted that it is still illegal, as is stated in the current Dutch penal code: 'Anyone who takes another person's life, even at his explicit request, will be punished by imprisonment of at the most 12 years, or a fine of the fifth category'. When euthanasia occurs, the physician involved must list this as the cause of death. After the police have been notified, the district attorney must decide whether or not to prosecute, based upon whether the euthanasia was done in accordance with established criteria. These criteria include: 1) the patient's medical condition must be intolerable with no chance of improvement, 2) the patient must be rational and take the initiative by voluntarily and repeatedly requesting euthanasia, 3) the patient must be fully informed, 4) there must be no other means to relieve the suffering, and 5) two physicians must concur with the request. It has been estimated that roughly 10,000 explicit requests for euthanasia are made each year, with approximately one third being accepted.

A survey of Dutch hospital deaths in 1991 provided some of the first statistical information concerning euthanasia practices. Thirty-eight percent of hospital deaths in the survey involved some medical decision concerning the end of life. Euthanasia occurred in 2.9% of cases. Of particular note, in 0.8% of these deaths (36% of euthanasia deaths) the explicit requirements concerning euthanasia had not been met! Advocates on both sides of the issue have used the information in this study to further their claims. Anti-euthanasia forces say that this proves the 'slippery slope' argument, and that further deviation from the regulations would be inevitable. Indeed, not only have Dutch physicians been pushing for actual legalization of euthanasia, some have argued for broadening the policy to allow euthanasia to be performed on incompetent patients. Euthanasia supporters have pointed out that in the 36% of cases in which the requirements of the regulations were not strictly adhered to, the *spirit* of the law was followed. Thus, in several cases, while the patient may have been currently unable to communicate their desires in accordance with the regulations, the issue had been previously discussed.

Dutch opinion polls concerning euthanasia may shed some additional light on the issue. Approximately three-quarters of the general population supports not only euthanasia, but also involuntary euthanasia. More than 90% of economics students would support *compulsory* euthanasia if it would stimulate the economy. In contrast, more than 90% of the elderly living in nursing homes report being afraid that euthanasia would be forced upon them.

D. *Pro-euthanasia arguments*

Proponents of euthanasia and physician-assisted suicide would argue its necessity and legitimacy from several vantage points.

1. *Euthanasia is beneficent and compassionate because it relieves suffering.* Some would say that perhaps the clearest proof of this idea may be the case of Dr. Ali Khalili, the 20th of Dr. Kevorkian's 21 'patients' to date. Dr. Khalili, although he was a pain management specialist, still chose euthanasia. Some would say that this gives testament to the potential inadequacy of pain control measures.

2. *Patients should have the right to end their lives when they wish.* Indeed, determination of the circumstances of one's death may be the ultimate expression of patient autonomy.

3. *Physicians are the best qualified to assist patients in their death.* One of the major problems pro-euthanasia forces have found with the current Oregon law is the means by which death is to be induced; i.e. an overdose of pills, usually barbiturates. Drug overdoses may be an ineffective means of ending life, instead causing prolonged discomfort or even a persistent vegetative state. One Dutch study claimed that a quarter of patients taking lethal doses of pills lingered as long as 4 days, and in many cases lethal injections were then needed. However, while many English and American physicians may agree with the concept of physician-assisted suicide, they remain uncomfortable with the manner in which it is often effected in Holland; i.e. sedation with barbiturates followed by lethal injection of a paralyzing agent.

4. *Physicians already participate in the hastening of death.* There are two components to this

argument. First, it is already widely accepted that life-sustaining measures may be withheld or withdrawn in certain situations. Many ethicists would argue that there is no moral difference between letting die and killing in analogous circumstances (e.g. if a patient has an inoperable brain tumor that causes him to lose life-sustaining functions such as respiration, he would be allowed to die. So why should a person with a similarly inoperable tumor in some other organ be allowed to linger in pain?). The second part of this argument is that assisted-death already occurs, but it does so in secret (e.g. the 'Debbie' case). Therefore, why not bring it out into the open where it can be legislated and regulated?

5. The slippery slope will be prevented by legislation. Several guidelines for euthanasia have been published, and might serve as a model for legislation. As presented in a recent *New England Journal of Medicine* commentary, such regulations often require:

- a) an established diagnosis of an incurable disease process with severe, unrelenting suffering
- b) the physician must ensure that the suffering is not due to inadequate comfort care
- c) the patient must be competent and must clearly and repeatedly request to die
- d) the physician must ensure that the patient's judgement is not distorted (e.g. by depression)
- e) there must be a physician-patient relationship
- f) there must be consultation with another physician
- g) there must be clear documentation

6. Physicians morally opposed to the process need not participate. As with abortion, physicians will not be forced to act against their own moral and religious convictions. Euthanasia proponents do feel, however, that too many physicians consider death to be a failure on their part, rather than a natural occurrence.

7. The people want it. Surveys have supported the contention that a majority of Americans desire the option for euthanasia.

E. *Anti-euthanasia arguments*

Opponents of legalizing euthanasia use a variety of arguments to support their position.

1. Killing is wrong. An important deontological viewpoint, this idea is supported by centuries of the Judeo-Christian belief that humans are stewards, not masters of life. Accordingly, 'letting die' and 'killing' (as listed above, in pro-euthanasia argument # 4) are quite different. Thus, the proximate cause of death in the former instance is the disease process itself, whereas in the latter case it is the physician who causes the death. Although such religious-based beliefs may be 'politically incorrect' in present society, they are nonetheless prevalent. As espoused by the great humanitarian Dr. Albert Schweitzer, "*to the man who is truly ethical, all life is sacred*".

2. Physician-assisted suicide violates the basis of the physician-patient relationship. The fiduciary nature of the relationship is based upon the physician acting in the patient's best interests. Would this relationship not erode if the patient has an inkling that his or her doctor

might unilaterally decide that death is the best option? In the Netherlands it has been reported that many of the frail or handicapped elderly are afraid to go to the hospital, lest they become involuntary candidates for euthanasia.

3. *People who want to die are depressed.* It has been said that more than 90% of suicidal patients suffer from depression. In addition, we have repeatedly heard how this important psychiatric condition may be under-diagnosed among general medical patients. By analogy, it has been suggested that depression is also quite common and under-diagnosed among patients with a terminal illness. Assisted suicide could therefore deny the opportunity to intervene and potentially cure a reversible cause of poor quality of life.

4. *Legalizing euthanasia could lead to a decrease in research relating to care of the terminally ill.* Although this would be hard to prove before actual implementation, it is interesting that some of the most vocal opposition to euthanasia has come from those who provide care to the terminally ill, e.g. the 'Association for Palliative Medicine' of Great Britain and Ireland, and hospice physicians in the U.S.

5. *People would feel an obligation to die.* As debate concerning the high cost of health care and the need for health care rationing continues, some patients may see euthanasia as a means for them to be less of a financial burden. Furthermore, under managed care, the economic bottom-line appeal of euthanasia may force the issue towards broader utilization. Already, doctors have reported feeling pressure under managed care arrangements to under-diagnose and under-treat patients. It can easily be imagined that they might feel similarly pressured to limit the care of the terminally ill, and might therefore encourage euthanasia more readily.

6. *Legal controls will not be sufficient.* It has been said that those who forget history are doomed to repeat it, and this is what makes the 'slippery slope' argument so formidable. For those who doubt that the 'slippery slope' argument is valid today, euthanasia opponents would point towards the Netherlands where the implementation of euthanasia has already progressed. Furthermore, in the United States, many have flaunted the laws prohibiting the practice of assisted suicide, the most flagrant perhaps being Dr. Jack Kevorkian. It is also notable that in no case to date has there been a successful prosecution of any physician who admitted, even in journal articles, to helping a patient commit suicide (i.e. in those 36 states where this practice is illegal). If euthanasia is already occurring, and thus apparently not under absolute control at a time when it is *illegal*, how can we possibly hope to control the practice when it is legal? In addition, there may be stumbling blocks to the legal control of euthanasia. For example, most proposed laws call for some means by which the state can monitor patient records to ensure compliance, but this might violate confidentiality laws.

7. *Public opinion does not equal morality.* Just because the majority of the population are in favor of something does not mean that the actions involved are morally acceptable. Indeed, it might be argued that part of the duty of the judicial branch of government is to protect the interests of the minority against majority opinion and legislation (e.g. the debate surrounding desegregation).

VI. Conclusions

From the above discussion, perhaps the 'Debbie' case presented in the preamble may be interpreted in a more organized fashion. There are certainly aspects of the case that appear troublesome.

At the onset, it is evident the resident had no previous physician-patient relationship established with this particular patient. This makes his or her failure to obtain any consultation with another physician all the more reprehensible. Further, the resident's knowledge of and therefore insight into the case were all obtained from an apparently cursory look through the chart. It would be hard to argue that the physician acted with *'Φρόνησις'* or sound judgement.

There are several considerations of patient autonomy relevant to the case. Certainly, there was no substantive process of informed consent undertaken. The physician "told the two women I was going to give Debbie something that would let her rest and to say good-bye". For such a profound and irreversible action, however, the precise intervention planned should have been explicitly communicated to the patient beforehand. Perhaps most importantly, the patients real wishes are not known. Although she does say, "let's get this over with" one does not know exactly to what she is referring. She could easily have wanted the vomiting or the pain to be over, but not her life. Even if her statement was different, and she had specifically requested death, the circumstances of the case would make the request somewhat suspect. After all, she is suffering "unrelenting vomiting", and had "loud labored breathing" and "obviously severe air hunger". As if all of this was not enough to question her competence to make such a momentous decision, she is also on an alcohol drip. As regards the ancient Hippocratic principles of beneficence and non-maleficence, it may be argued that on account of her extremely dire condition, the actions in this case may have been beneficent. However, it would be difficult for even the most ardent euthanasia proponent to contend that the physician involved did not violate the principle of non-maleficence. Finally, for those who assign relevance to the idea of intention (as might be analyzed according to the principle of 'double effect'), it is clear in this case that the physician had no other intention than to kill the patient.

So where does this discussion of the history, principles and application of medical ethics leave us? How are we to practice medicine ethically, even as technologic advances and economic considerations result in increasingly complex clinical situations? Furthermore, how are we to interact with our patients in a climate where, as one observer noted, *"in recent years, medical practice has been regarded, at least by most lawyers and medical ethicists, primarily as an impersonal encounter between two isolated and autonomous persons - the patient and the physician - whose individual interests were to be rigorously protected from each other by rules and procedural standards"*. For guidance in this area, perhaps we should return to the beginning, and consider the words of Hippocrates. As he so succinctly yet eloquently states in his *Aphorisms*:

"Life is short, the Art long; opportunity fleeting, experience fallacious, and judgement difficult. The physician must be ready not only to do his duty himself, but also to secure the cooperation of the patient, of the attendants, and of the external circumstances".

The Hippocratic Oath

I swear by Apollo, the healer, by Asclepius, by Hygieia, by Panacea and by all the gods and goddesses, making them my witnesses, that I will fulfill this oath and this covenant to the best of my ability and judgement.

I will look upon my teacher in this Art as equal to my own parents. I will share my substance with him, and I will supply his necessities, if he should be in need. I will consider his offspring as my own brothers, and teach them this art if they want to learn it, without fee or indenture. I will impart this art by precept, by oral instruction, and all by all other means of instruction to my own sons, the sons of my teacher, and to indentured pupils, but to nobody else.

I will carry out that regimen which, according to my ability and judgement, shall be for the benefit of my patient. I will keep them from injury and harm. To none will I give a deadly drug, even if solicited, nor offer counsel to such an end. Similarly, I will not give a woman a pessary to cause abortion.

My own life and practice I will keep guiltless and right. Into whatsoever houses I enter I will enter to help the sick and I will abstain from all intentional wrongdoing and harm, especially from abusing the bodies of man or woman, bond or free.

Whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my interview with men, if it be what should not be made public I will never divulge, holding such things unsuitable to be spoken.

Now if I carry out this oath and break it not, may I gain forever reputation among all men for my life and for my Art; but if I transgress it, may the reverse be my lot.

Measure No. 16**Measure No. 16**

Proposed by initiative petition to be voted on at the General Election, November 8, 1994.

BALLOT TITLE**16 ALLOWS TERMINALLY ILL ADULTS TO OBTAIN PRESCRIPTION FOR LETHAL DRUGS**

QUESTION: Shall law allow terminally ill adult patients voluntary informed choice to obtain physician's prescription for drugs to end life?

SUMMARY: Adopts law. Allows terminally ill adult Oregon residents voluntary informed choice to obtain physician's prescription for drugs to end life. Removes criminal penalties for qualifying physician-assisted suicide. Applies when physicians predict patient's death within 6 months. Requires:

- 15-day waiting period;
- 2 oral, 1 written request;
- second physician's opinion;
- counseling if either physician believes patient has mental disorder, impaired judgment from depression.

Person has choice whether to notify next of kin. Health care providers immune from civil, criminal liability for good faith compliance.

ESTIMATE OF FINANCIAL IMPACT: No financial effect on state or local government expenditures or revenues.

**THE OREGON
DEATH WITH DIGNITY ACT**

**SECTION 1
GENERAL PROVISIONS**

§ 1.01 DEFINITIONS

The following words and phrases, whenever used in this Act, shall have the following meanings:

- (1) "Adult" means an individual who is 18 years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (4) "Counseling" means a consultation between a state licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.
- (5) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.
- (6) "Incapable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. Capable means not incapable.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:

- (a) his or her medical diagnosis;
- (b) his or her prognosis;
- (c) the potential risks associated with taking the medication to be prescribed;
- (d) the probable result of taking the medication to be prescribed;
- (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.

(9) "Patient" means a person who is under the care of a physician.

(10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.

(11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of this Act in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.

(12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.

SECTION 2

**WRITTEN REQUEST FOR MEDICATION TO END ONE'S LIFE
IN A HUMANE AND DIGNIFIED MANNER**

§ 2.01 WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

§ 2.02 FORM OF THE WRITTEN REQUEST

(1) A valid request for medication under this Act shall be in substantially the form described in Section 6 of this Act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.

(2) One of the witnesses shall be a person who is not:

- (a) A relative of the patient by blood, marriage or adoption;
- (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
- (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.

(3) The patient's attending physician at the time the request is signed shall not be a witness.

(4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Resources by rule.

**SECTION 3
SAFEGUARDS**

§ 3.01 ATTENDING PHYSICIAN RESPONSIBILITIES

The attending physician shall:

- (1) Make the initial determination of whether a patient has a

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terminal disease, is capable, and has made the request voluntarily;

(2) Inform the patient of:

- (a) his or her medical diagnosis;
- (b) his or her prognosis;
- (c) the potential risks associated with taking the medication to be prescribed;
- (d) the probable result of taking the medication to be prescribed;
- (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.

(3) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;

(4) Refer the patient for counseling if appropriate pursuant to Section 3.03;

(5) Request that the patient notify next of kin;

(6) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to Section 3.06;

(7) Verify, immediately prior to writing the prescription for medication under this Act, that the patient is making an informed decision;

(8) Fulfill the medical record documentation requirements of Section 3.09;

(9) Ensure that all appropriate steps are carried out in accordance with this Act prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.

§ 3.02 CONSULTING PHYSICIAN CONFIRMATION

Before a patient is qualified under this Act, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

§ 3.03 COUNSELING REFERRAL

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

§ 3.04 INFORMED DECISION

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in Section 1.01(7). Immediately prior to writing a prescription for medication under this Act, the attending physician shall verify that the patient is making an informed decision.

§ 3.05 FAMILY NOTIFICATION

The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

§ 3.06 WRITTEN AND ORAL REQUESTS

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less

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than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

§ 3.07 RIGHT TO RESCIND REQUEST

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

§ 3.08 WAITING PERIODS

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under this Act. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under this Act.

§ 3.09 MEDICAL RECORD DOCUMENTATION REQUIREMENTS

The following shall be documented or filed in the patient's medical record:

(1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;

(2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;

(3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;

(4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;

(5) A report of the outcome and determinations made during counseling, if performed;

(6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to Section 3.06; and

(7) A note by the attending physician indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

§ 3.10 RESIDENCY REQUIREMENT

Only requests made by Oregon residents, under this Act, shall be granted.

§ 3.11 REPORTING REQUIREMENTS

(1) The Health Division shall annually review a sample of records maintained pursuant to this Act.

(2) The Health Division shall make rules to facilitate the collection of information regarding compliance with this Act. The information collected shall not be a public record and may not be made available for inspection by the public.

(3) The Health Division shall generate and make available to the public an annual statistical report of information collected under Section 3.11(2) of this Act.

§ 3.12 EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS AND STATUTES

(1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.

(2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

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§ 3.13 INSURANCE OR ANNUITY POLICIES

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified patient's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

§ 3.14 CONSTRUCTION OF ACT

Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

SECTION 4 IMMUNITIES AND LIABILITIES

§ 4.01 IMMUNITIES

Except as provided in Section 4.02:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this Act.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this Act, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

§ 4.02 LIABILITIES

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in this Act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act.

SECTION 5 SEVERABILITY

§ 5.01 SEVERABILITY

Any section of this Act being held invalid as to any person or circumstance shall not affect the application of any other section of this Act which can be given full effect without the invalid section or application.

SECTION 6 FORM OF THE REQUEST

§ 6.01 FORM OF THE REQUEST

A request for a medication as authorized by this act shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) Is personally known to us or has provided proof of identity;

(b) Signed this request in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Is not a patient for whom either of us is attending physician.

Witness 1/Date

Witness 2/Date

NOTE: One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Measure No. 16**Measure No. 16****EXPLANATORY STATEMENT**

This measure would allow an informed and capable adult resident of Oregon, who is terminally ill and within six months of death, to voluntarily request a prescription for medication to take his or her life. The measure allows a physician to prescribe a lethal dose of medication when conditions of the measure are met. The physician and others may be present if the medication is taken.

The process begins when the patient makes the request of his or her physician, who shall:

- Determine if the patient is terminally ill, is capable of making health care decisions, and has made the request voluntarily.
- Inform the patient of his or her diagnosis and prognosis; the risks and results of taking the medication; and alternatives, including comfort care, hospice care, and pain control.
- Ask that the patient notify next of kin, but not deny the request if the patient declines or is unable to notify next of kin.
- Inform the patient that he or she has an opportunity to rescind the request at any time, in any manner.
- Refer the patient for counseling, if appropriate.
- Refer the patient to a consulting physician.

A consulting physician, who is qualified by specialty or experience, must confirm the diagnosis and determine that the patient is capable and acting voluntarily.

If either physician believes that the patient might be suffering from a psychiatric or psychological disorder, or from depression causing impaired judgment, the physician must refer the patient to a licensed psychiatrist or psychologist for counseling. The psychiatrist or psychologist must determine that the patient does not suffer from such a disorder before medication may be prescribed.

The measure requires two oral and one written requests. The written request requires two witnesses attesting that the patient is acting voluntarily. At least one witness must not be a relative or heir of the patient.

At least fifteen days must pass from the time of the initial oral request and 48 hours must pass from the time of the written request before the prescription may be written.

Before writing the prescription, the attending physician must again verify the patient is making a voluntary and informed request, and offer the patient the opportunity to rescind the request.

Additional provisions of the measure are:

- Participating physicians must be licensed in Oregon.
- The physician must document in the patient's medical record that all requirements have been met. The State Health Division must review samples of those records and make statistical reports available to the public.
- Those who comply with the requirements of the measure are protected from prosecution and professional discipline.
- Any physician or health care provider may decline to participate.

This measure does not authorize lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this measure shall not constitute suicide, assisted suicide, mercy killing or homicide, under the law.

Anyone coercing or exerting undue influence on a patient to request medication, or altering or forging a request for medication, is guilty of a Class A felony.

Committee Members:

Barbara Coombs Lee
Eli Stutsman
Pat McCormick*
William E. Petty, M.D.*
Mitzi Naucier

Appointed by:

Chief Petitioners
Chief Petitioners
Secretary of State
Secretary of State
Members of the Committee

* Member dissents (does not concur with explanatory statement)

(This committee was appointed to provide an impartial explanation of the ballot measure pursuant to ORS 251.215.)

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