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# AGING POPULATIONS AND PHYSICIAN AID IN DYING: THE EVOLUTION OF STATE GOVERNMENT POLICY

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As state governments respond to the needs of their aging populations, an issue of particular concern is health care at the end of life. With the many advances in public health and medical treatment—as well as in education, wealth, and other socioeconomic metrics<sup>1</sup>—Americans are living much longer lives. But many Americans also face prolonged illness at the end of life that can result in great suffering. Often the suffering can be relieved with good palliative care, but for some Americans continued life becomes intolerable.

As a result, there has been increased interest in a right for terminally ill individuals to hasten the dying process by taking a lethal dose of prescription medication (i.e., by “physician aid in dying,” commonly described as “physician-assisted suicide”<sup>2</sup>). The existence of such a right has been litigated in the U.S. Supreme Court<sup>3</sup> and state supreme courts,<sup>4</sup> debated in state legislatures, and addressed in ballot proposals at the state level. Voters in Oregon and Washington have legalized aid in dying by public referendum,<sup>5</sup> legislators in Vermont have done so by statutory enactment,<sup>6</sup> and justices in Montana<sup>7</sup> and a trial court in New

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1. Indeed, these socioeconomic factors may play a much bigger role in health than does health care. David Orentlicher, *The Future of The Affordable Care Act: Protecting Economic Health More than Physical Health?*, 51 HOUS. L. REV. 1057, 1067 (2014).

2. I prefer physician aid in dying over physician-assisted suicide to reflect the fact that death hastening action by a competent, terminally ill person is different from the death hastening action by other persons, especially by otherwise healthy people who suffer from a mental depression. See, e.g., *Patients' Rights to Self-Determination at the End of Life*, AM. PUB. HEALTH ASSOC. (Oct. 28, 2008), available at <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1372> (dissuading use of term “physician-assisted suicide”). If someone other than a mentally competent, terminally ill patient died from a lethal prescription, I would describe that as physician-assisted suicide.

I do not include euthanasia in my definition of physician aid in dying. That is, if a physician injected a terminally ill patient with a lethal drug, I would view that as an example of euthanasia rather than as an example of physician aid in dying.

3. *Glucksberg v. Washington*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

4. *Sampson v. State*, 31 P.3d 88 (Alaska 2001); *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997); *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

5. OR. REV. STAT. §§ 127.800-127.897 (2014); WASH. REV. CODE § 70.245 (2014).

6. VT. STAT. ANN. tit. 18, §§ 5281-5292 (2014) (LexisNexis).

7. *Baxter*, 224 P.3d at 1215.

Mexico<sup>8</sup> have done so by court holding.

In this Article, I discuss the trend toward legalization of physician aid in dying and what it tells us about societal morality regarding medical decisions at the end of life.

## I. BACKGROUND

For many years, the law drew a sharp distinction between physician-assisted suicide and the withdrawal of life-sustaining treatment.<sup>9</sup> All patients could refuse medical care, while no one could obtain a prescription for a lethal dose of drugs.<sup>10</sup>

Thus, for example, people could (and still can) refuse ventilators, kidney dialysis, surgery, or artificial nutrition and hydration, even though they could die without the treatment. Moreover, the right could be exercised not only by the terminally ill, but also by people who could expect with treatment to live for decades with a high quality of life.<sup>11</sup> All medical treatments have side effects as well as benefits, and the law leaves it to the individual to decide whether the benefits are sufficient to outweigh the harms of treatment.<sup>12</sup> In other words, quality of life is just as important as length of life, and people should be able to take into account both quality and length of life in making their medical decisions.<sup>13</sup>

On the other hand, no matter how sick a person became, no matter how terminal their disease, and no matter how great their suffering, there was no right to obtain a prescription for a lethal dose of medication.<sup>14</sup> The law once drew a very bright line between treatment withdrawal, which was permitted,<sup>15</sup> and suicide assistance, which was prohibited.<sup>16</sup>

In recent years, this sharp distinction between withdrawal of treatment and assisted suicide has begun to erode. Oregon became the first state to legalize aid

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8. Opposition to Defendant's Motion to Dismiss, *Morris v. Brandenburg*, No. D-202-cv-2012-02909 (2d Jud. Dist. N.M. Jan. 13, 2014) (opinion available at <http://www.aclu-nm.org/wp-content/uploads/2012/03/Morris-v.-NM.pdf>).

9. *Legalization*, *supra* note \*, at 443.

10. *Id.*

11. To be sure, *In re Quinlan*, 355 A.2d 647 (N.J. 1976), limited the right to refuse treatment to patients with a serious medical condition, but later courts extended the right to all persons. DAVID ORENTLICHER ET AL., *BIOETHICS AND PUBLIC HEALTH LAW* 287-89 (3d ed. 2013).

12. PFIZER, *MEDICINE SAFETY AND YOU: UNDERSTANDING 'SIDE EFFECTS' 1-2* (2011) (explaining that medications have benefits and risks).

13. In some cases, refusals of treatment reflect religious belief, as when a Jehovah's Witness refuses a blood transfusion. *See, e.g., Stamford Hosp. v. Vega*, 674 A.2d 821, 824-25 (Conn. 1996).

14. *See* ALAN MEISEL, *THE RIGHT TO DIE* 450-57 (2d ed. 1995).

15. There are some exceptions to the right to refuse medical treatment, most importantly when a refusal of treatment would result in harm to other persons, as when an individual refuses treatment for tuberculosis. *See, e.g., McCormick v. Stalder*, 105 F.3d. 1059 (5th Cir. 1997).

16. *See* MEISEL, *supra* note 14, at 450-57.

in dying after approval via public referendum in November 1994.<sup>17</sup> Voters in Washington followed suit in November 2008 with approval of a Washington Death with Dignity Act<sup>18</sup> that was patterned after the Oregon Death with Dignity Act, and the Montana Supreme Court one year later cleared the way for aid in dying by holding that there was no legal prohibition in state law against the practice.<sup>19</sup> In its 2013 session, the Vermont State Legislature enacted the Patient Choice and Control at End of Life Act,<sup>20</sup> and in January 2014, a state trial court found a right to aid in dying under the New Mexico constitution.<sup>21</sup>

Note that in all five states, physicians are allowed to prescribe a lethal dose of medication only for terminally ill patients who are mentally competent (i.e., the practice of aid in dying).<sup>22</sup> All five states still prohibit as forms of physician assisted suicide the prescribing of lethal medication to persons who are not both mentally competent and terminally ill.<sup>23</sup>

With these changes in the law, it appears that we are seeing an evolution in moral and legal thinking about physician-assisted suicide. A practice that once was universally condemned is gaining gradual acceptance when limited to the terminally ill.<sup>24</sup> It seems that public views about aid in dying are going through the same kind of transition that occurred with abortion in the 1960s and 1970s and that has occurred in recent years with same sex marriage.<sup>25</sup>

That probably is not what is happening. Rather, for the same reasons that the law drew a sharp distinction between treatment withdrawal and suicide assistance, it is now relaxing the distinction.<sup>26</sup> In other words, moral views about suicide assistance are not changing, but the law is being changed to better reflect the same moral views. Over time, it has become clear that society's legal rules for

17. Constitutional challenges and legislative action delayed implementation of the Oregon Death with Dignity Act until it was reapproved by public referendum in November 1997. See OR. REV. STAT. §§ 127.800-127.897 (1995). After implementation, the act survived another legal challenge from the George W. Bush Administration. See *Gonzales v. Oregon*, 546 U.S. 243 (2006) (rejecting effort to use the federal Controlled Substances Act to override the Oregon statute).

18. WASH. REV. CODE § 70.245 (2014).

19. *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

20. VT. STAT. ANN. tit. 18 §§ 5281-92 (2014).

21. Opposition to Defendant's Motion to Dismiss, *Morris v. Brandenburg*, No. D-202-cv-2012-02909 (2d Jud. Dist. N.M. Jan. 13, 2014).

22. See *id.*; OR. REV. STAT. §§ 127.800-27.897 (2014); VT. STAT. ANN. tit. 18 §§ 5281-92 (2014) (LexisNexis); WASH. REV. CODE § 70.245 (2014); *Baxter*, 224 P.3d at 1221-22.

23. *Id.*

24. MEISEL, *supra* note 14, at 450-57.

25. See Jacque Wilson, *Before and After Roe v. Wade*, CNN (Jan. 22, 2013), <http://www.cnn.com/2013/01/22/health/roe-wade-abortion-timeline/>; Andrew Flores, *Support for Same Sex Marriage is Increasing Faster than Ever Before*, WASH. POST (Mar. 14, 2014), <http://www.washingtonpost.com/blogs/monkey-cage/wp/2014/03/14/support-for-same-sex-marriage-is-increasing-faster-than-ever-before/>.

26. *Legalization*, *supra* note \*, at 444.

end-of-life care had gotten out of sync with its moral views for such care.<sup>27</sup> By allowing aid in dying through suicide assistance for terminally ill patients, society can bring the law back in line with its moral perspectives.

Why do I say that by allowing aid in dying, states can ensure that end-of-life law reflects societal morality? Hasn't ethical thinking long viewed any kind of assistance with suicide as morally very different from withdrawal of treatment? Is there not a major difference between (1) letting a person die from natural causes without artificial ventilation or other invasive medical care and (2) actively causing a patient's death with a lethal dose of drugs?

I do not believe that the usual rationales explain the fact that the law once distinguished sharply between withdrawal of treatment and suicide assistance. That is, I do not believe that the legal distinction between treatment withdrawal and assisted suicide reflected an important moral difference between the two practices. To be sure, many scholars, institutions, and lay people have seen a moral difference between treatment withdrawal and assisted suicide.<sup>28</sup> But the distinction between treatment withdrawal and assisted suicide cannot be explained by the mere difference between withdrawing and assisting. Rather, the treatment withdrawal-assisted suicide distinction provided an important legal "proxy" to sort the morally justified death from the morally unjustified death.<sup>29</sup> End-of-life law has been designed to permit patients to make life-ending choices when they are morally justified in so choosing but to prevent patients from opting to end their lives when they are not morally justified in so opting.<sup>30</sup> In other words, it is more important *why* patients want to die rather than *how* they want to die. As I will explain, it is not possible to distinguish directly between morally justified and morally unjustified deaths, so the law does so indirectly. By permitting the life-ending choice of treatment withdrawal, the law *generally* permitted morally justified choices of death.<sup>31</sup> Similarly, by prohibiting assisted suicide, the law *generally* prevented morally unjustified choices of death.<sup>32</sup> This was the proxy role of the distinction between treatment withdrawal and suicide assistance.<sup>33</sup>

Over time, however, it became clear that the distinction between treatment withdrawal and assisted suicide did not do a good enough job sorting the morally

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27. *Id.* at 475.

28. Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 303 (1996); Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89, 89 (1994); Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 310 (1996).

29. *Legalization*, *supra* note \*, at 462.

30. Norman L. Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 249-50 (1977).

31. *Legalization*, *supra* note \*, at 445.

32. *Id.*

33. *Id.*

justified death from the morally unjustified death. An absolute prohibition on suicide assistance forced many terminally ill patients to suffer intolerably through a prolonged dying process—to be denied the choice of a morally justified death.<sup>34</sup>

Hence, Oregon, Washington, Montana, Vermont, and possibly New Mexico,<sup>35</sup> have revised their end-of-life laws so their legal rules do a better job sorting between morally justified and morally unjustified deaths. In those states, the rules for treatment withdrawal, aid in dying, and physician-assisted suicide are seen as better proxies for the distinction between morally justified deaths and morally unjustified deaths.

I will continue with a discussion of legal proxies and then a discussion of what I mean by morally justified and morally unjustified deaths.

## II. LEGAL PROXIES

The law commonly distinguishes between right and wrong through legal proxies.<sup>36</sup> For example, instead of saying that people can drive at a “safe speed,” the law says that people can drive up to a specific speed limit, whether 30, 55 or 70 mph, but not at faster speeds. It does not matter that driving a few miles above the speed limit often is perfectly safe. Or consider eligibility to vote. Instead of the law saying that people can vote when they are sufficiently mature enough to cast a ballot, the law says that people can begin voting at age eighteen.<sup>37</sup> A precocious seventeen-year old who has graduated from college is not permitted to vote, while a nineteen-year old who lacks any formal education or any interest in politics is granted voting rights.<sup>38</sup> The law does not try to make case-by-case assessments about the maturity of a potential voter or the speed at which a person drives, but instead adopts a clear rule that is designed to do a generally good job of sorting between the acceptable and the unacceptable.<sup>39</sup>

Why use legal proxies if they only do a generally good job of sorting between the acceptable and the unacceptable? Should we not strive for laws that fully sort the acceptable from the unacceptable? There are good reasons for choosing legal rules with clear distinctions as proxies for society’s moral views about right and wrong. With speed limits, for example, it is important to give police officers and drivers predictable and understandable rules. If the law said that people could

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34. Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 794-96 (1989).

35. See OR. REV. STAT. §§ 127.800-127.897 (2014); VT. STAT. ANN. tit. 18, §§ 5281-5292 (2014) (LexisNexis); WASH. REV. CODE § 70.245 (2014). Appellate courts in New Mexico could reject the trial court’s holding that the state constitution recognizes a right to aid in dying. For discussion generally of New Mexico’s law, see Eric Eckholm, *New Mexico Affirms Right to “Aid in Dying,”* N.Y. TIMES (Jan 13, 2014), [http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html?\\_r=0](http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html?_r=0).

36. *Legalization*, *supra* note \*, at 466.

37. U.S. CONST. amend. XXVI.

38. *Id.* (“The right of citizens of the United States, who are eighteen years of age or older, to vote shall not be denied or abridged by the United States or by any State on account of age.”).

39. *Legalization*, *supra* note \*, at 466.

drive at any safe speed, then drivers would have to worry that they would come to different conclusions about the safety of particular speeds than would a police officer. In addition, police officers likely would come to different conclusions among themselves about the range of safe speeds, so some drivers would be at greater risk of being ticketed for speeding than would other drivers. Speed limits provide a level of certainty and fairness across different drivers that drive-at-a-safe-speed laws do not.<sup>40</sup>

Concerns about fairness can be especially important. Police officers have been known to apply traffic and other laws selectively according to the race of the driver—the “driving-while-black” problem.<sup>41</sup> The more discretion left to police officers in enforcing traffic laws, the more they can act on inappropriate biases.<sup>42</sup> Voting age rules respond to the same concern. If the law allowed people to vote when sufficiently mature, then we would have to worry about the partisan affiliations of voting clerks and voters. A Democratic clerk might be quick to certify the eligibility of Democrats to vote and slow to certify the eligibility of Republicans to vote, while Republican clerks might be inclined in the other direction.

End-of-life law also has relied on legal proxies. Instead of saying that people could make life-ending choices, whether treatment withdrawal or suicide assistance, as long as they had a morally justified reason for doing so, the law allowed treatment withdrawal and prohibited assisted suicide. As I discuss in the next section, having such a legal proxy has protected the public from the problem of the government making inappropriate life-and-death judgments.

### III. THE MORALLY JUSTIFIED DEATH

I have said that end-of-life law is designed to distinguish between morally justified and morally unjustified choices that shorten life.<sup>43</sup> If a life-shortening choice is morally justified, it should be permitted by the law, while morally unjustified choices that shorten life should not be permitted.<sup>44</sup> The distinction between physician-assisted suicide and withdrawal of treatment was designed to distinguish between morally justified and morally unjustified deaths.<sup>45</sup>

#### *A. The Distinction between Physician-Assisted Suicide and the Withdrawal of Life-Sustaining Medical Treatment*

Commonly, people have said that withdrawals of treatment are morally

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40. For these and other reasons, a Montana court found a safe speed law unconstitutional. *State v. Stanko*, 974 P.2d 1132 (Mont. 1998).

41. David A. Harris, *The Stories, the Statistics, and the Law: Why “Driving While Black” Matters*, 84 MINN. L. REV. 265 (1999).

42. *Id.* at 302.

43. *Legalization*, *supra* note \*, at 463-464.

44. *Id.*

45. *Id.*

justified and assisted suicides are not morally justified.<sup>46</sup> In this view, anyone can have unwanted medical treatment discontinued, even if death might result from the withdrawal. On the other hand, no one should be able to choose to end his or her life by swallowing a lethal dose of prescription medication. In other words, *how* life is shortened is morally—and therefore, legally—determinative.

I will argue that *how* one dies is not so critical; rather, it has mattered much more *why* a person wants to make a life-shortening choice. The line between morally justified and morally unjustified deaths is defined not simply by the difference between treatment withdrawal and suicide assistance, but on other grounds.

Why do I reject the usual moral distinction between treatment withdrawal and assisted suicide? If we consider the usual arguments, we find that they do not really explain the law's distinction between the two practices. For example, people typically cite considerations of causation to distinguish between treatment withdrawal and suicide assistance.<sup>47</sup> Assisted suicide entails a killing, while treatment withdrawal simply lets the patient die from natural causes.<sup>48</sup> And it is true that we hold people more accountable for their actions than their omissions. The law prohibits people from throwing infants into swimming pools, but it does not require people to rescue infants who have fallen on their own into swimming pools.<sup>49</sup>

It is not surprising that arguments from causation are important. Acts that cause death *usually* are worse than omissions that are followed by death.<sup>50</sup> There is a high correlation between the act-omission distinction and the distinction between unlawful and lawful conduct.

But it is not a perfect correlation. Even though most actions that cause death should be punished by the law and most omissions that are followed by death should not be punished, we still need to ask for any particular act or omission whether it should be prohibited. Some killings are permissible, as in the case of self-defense, and some omissions are not, as in a failure to feed one's baby.<sup>51</sup> Indeed, if I were to withhold treatment by discontinuing artificial nutrition and hydration for patients without their permission or that of their families, I would be prosecuted for murder.<sup>52</sup>

Moreover, if causation really explained the distinction between treatment withdrawal and assisted suicide, we would consider withdrawal of treatment

46. *Id.* at 445.

47. *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

48. *Id.*

49. To be sure, parents or other caretakers of the infant would be held accountable, and the owner of the pool would as well if the owner had not taken proper precautions to prevent infants from falling in.

50. Tom Stacy, *Acts, Omissions, and the Necessity of Killing Innocents*, 29 AM. J. CRIM. L. 481, 514 (2002).

51. *See, e.g.*, IND. CODE § 35-41-3-2 (2014) (self-defense); *see also id.* § 31-34-1-1 (neglect of a dependent by failing to provide necessary food).

52. *See e.g., id.* § 35-42-1-1.



worse than suicide assistance.<sup>53</sup> A physician who turns off a patient's ventilator directly causes the patient's death.<sup>54</sup> When a physician writes a prescription for a lethal dose of drugs that the patient takes later at home, the physician only indirectly contributes to the patient's death.<sup>55</sup>

Many observers distinguish between treatment withdrawal and assisted suicide in terms of the physician's intentions.<sup>56</sup> When medical care is discontinued, there is no intent to kill the patient.<sup>57</sup> Rather, the physician is intending only to relieve a patient of the burdens of a medical treatment that is causing pain or other discomfort.<sup>58</sup> In fact, the physician can hope that the patient will survive the withdrawal of treatment. With assisted suicide, on the other hand, the whole purpose of writing the prescriptions is to help patients end their lives.<sup>59</sup>

While considerations of intent can distinguish treatment withdrawal from euthanasia, they do not distinguish treatment withdrawal from suicide assistance. Physicians in Oregon, Washington, Montana, Vermont, and New Mexico can write a prescription with the intent that they will relieve their patients' anxiety or other psychic suffering and genuinely hope that the patients will not take the pills or even fill the prescriptions. Indeed, after more than fifteen years of experience with aid in dying in Oregon, data indicate that about thirty-five percent of patients never take the pills after receiving their prescriptions.<sup>60</sup> The odds that a patient will survive the writing of a prescription for lethal medication are much greater than the odds that they will survive the withdrawal of a ventilator, dialysis, or artificial nutrition and hydration.<sup>61</sup>

Critics of a right to assisted suicide worry about the risks to vulnerable patients.<sup>62</sup> People may choose suicide assistance because they are depressed, because of inadequate palliative care, or out of a perceived "duty to die" to relieve their families of the burden of their care.<sup>63</sup> These risks are real, and we should

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53. See James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78, 80 (1975); Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 794-96 (1989).

54. *Legalization*, *supra* note \*, at 466.

55. *Id.* at 448.

56. *Vacco v. Quill*, 521 U.S. 793, 801-02 (1997).

57. *Legalization*, *supra* note \*, at 455.

58. *Vacco*, 521 U.S. at 802.

59. *Id.*

60. Through December 31, 2013, physicians had written 1,172 prescriptions under the Death with Dignity Act, and 752 patients had taken the lethal medication (64 percent), a small number were still alive, and the rest died of their illnesses. See OREGON HEALTH AUTHORITY, PUBLIC HEALTH DIVISION, OREGON'S DEATH WITH DIGNITY ACT—2013, available at <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>.

61. David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, HASTINGS CONST. L.Q. 947, 958-59 (1997).

62. *Washington v. Glucksberg*, 521 U.S. 702, 731-32 (1997).

63. *Id.* at 782-83.

worry about them. But the risks are just as great a concern for decisions to withdraw life-sustaining medical treatment.<sup>64</sup> Patients also may refuse ventilators, dialysis, or artificial nutrition and hydration because they are depressed, have not received adequate palliative care, or feel a duty to die.

Indeed, the risk to vulnerable patients are greater for treatment withdrawal since it can occur for patients who have lost mental capacity and can no longer speak for themselves.<sup>65</sup> Family members may agree to the withdrawal of treatment in the mistaken belief that they are carrying out the wishes of the patient. The law responds to the risks of premature treatment withdrawal with various safeguards to protect vulnerable patients.<sup>66</sup> The same kinds of safeguards can be employed with suicide assistance, and in fact, they are an important part of the statutes in Oregon, Washington, and Vermont.<sup>67</sup>

Opponents of a right to assisted suicide especially worry about the effect of financial pressures on aid in dying decisions.<sup>68</sup> When physicians and hospitals face ever-increasing pressures to contain health care costs, they may too readily support or encourage their patients to choose suicide assistance. This risk is real, but as with the other risks discussed, it is also a serious risk for treatment withdrawal decisions. Assisted suicide for terminally ill persons would likely save far less money than withdrawing ventilators, dialysis, or artificial nutrition and hydration from patients who could live for many years—even decades—with continued care.

What about the Netherlands? Haven't there been abuses in that country?<sup>69</sup> There has been a good deal of controversy over practices in the Netherlands, but the controversy has arisen over the practice of euthanasia rather than suicide assistance.<sup>70</sup> The statutes in Oregon, Washington, and Vermont require physicians to report every case of aid in dying,<sup>71</sup> and there has not been evidence of significant abuse in those states. Moreover, concerns about abuse cannot distinguish suicide assistance from treatment withdrawal. Studies of treatment withdrawal in the United States have found that the practice often does not conform to ethical and legal standards that require physicians to make decisions in accordance with their patient's wishes.<sup>72</sup>

If the practice of assisted suicide is not inherently more problematic than the withdrawal of life-sustaining treatment, why has the law distinguished between

64. *Legalization*, *supra* note \*, at 459.

65. *Id.*

66. *Id.* at 459-60.

67. OR. REV. STAT. §§ 127.800-127.897 (2014); VT. STAT. ANN. tit. 18 §§ 5281-5292 (2014) (LexisNexis); WASH. REV. CODE. § 70.245 (2014).

68. *Vacco v. Quill*, 521 U.S. 793, 794 (1997).

69. For discussion of the Netherlands, see *Legalization*, *supra* note \*, at 461-62.

70. ORENTLICHER ET AL., *supra* note 11, at 372.

71. OR. REV. STAT. §§ 127.800-127.897 (2014); VT. STAT. ANN. tit. 18 §§ 5281-5292 (2014) (LexisNexis); WASH. REV. CODE. § 70.245 (2014).

72. ORENTLICHER ET AL., *supra* note 11, at 334. For discussion of other arguments made to distinguish treatment withdrawal from aid in dying, see sources cited *supra* note \*.

suicide assistance and treatment withdrawal? That is the topic for the next section of this Article.

*B. Identifying the Morally Justified Death*

End-of-life law is designed to distinguish morally justified choices that shorten life from morally unjustified choices that end life. The distinction between treatment withdrawal and suicide assistance has provided a legal proxy for sorting morally justified patient deaths from morally unjustified deaths.

As when proxies are used elsewhere in the law, we cannot directly sort between the wrongful and the permissible. We cannot directly distinguish between morally justified deaths and morally unjustified deaths that result from decisions about health care at the end of life. But we can generally distinguish between morally justified and morally unjustified deaths with the distinction between assisted suicide and treatment withdrawal. In the public's view, the *typical* refusal of life-sustaining treatment is morally justified while the *typical* suicide is not.<sup>73</sup>

What do I mean by a morally justified death? The right to refuse life-sustaining medical care arose out of a sense that people should be able to decline treatment when they are suffering greatly from irreversible and severe illness.<sup>74</sup> In such cases, it is thought, the burdens of continued treatment can easily outweigh the benefits, and people should not be forced to endure a prolonged and undignified dying process.<sup>75</sup> This societal sentiment runs through judicial opinions, academic commentary, and religious doctrine.<sup>76</sup> What is critical about the right to refuse life-sustaining treatment is the desire to protect seriously ill people from an intolerable death.

Of course, that concern is exactly what motivates advocates for a right to aid in dying. They too justify such a right in terms of protecting seriously ill people from an intolerable death. In the *Glucksberg* aid in dying case before the U.S. Supreme Court, for example, one of the plaintiffs was terminally ill from widely metastatic cancer and experienced constant pain, which could be relieved only partially by medication.<sup>77</sup> She also suffered from bed sores, nausea, vomiting, and other debilitating symptoms.<sup>78</sup>

Or consider the example of a patient dependent on kidney dialysis for survival who decides to refuse further dialysis. That patient elects to have a life-sustaining treatment withdrawn, and death will follow within a few weeks. Suppose that after several days, the patient begins to experience intolerable suffering. The patient does not want dialysis restarted, but asks for a lethal dose of medication to avoid a prolonged dying process. If the goal of end-of-life law

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73. *Legalization*, *supra* note \*, at 464.

74. *Id.* at 450-51.

75. Cantor, *supra* note 30, at 249-50.

76. ORENTLICHER, *supra* note \*, at 32-33, 65-66.

77. *Compassion in Dying v. Washington*, 79 F.3d 790, 794 (9th Cir. 1996).

78. *Id.*

is to prevent people from suffering greatly from a prolonged dying process, why allow the withdrawal of treatment but not the aid in dying? Denying aid in dying only prolongs the dialysis patient's suffering.

However, a right to suicide assistance could easily lead to many morally unjustified deaths. Many people want to end their lives with a lethal dose of medication when they are not dying from cancer or other severe and untreatable illnesses. A depressed college student might choose a lethal dose of drugs when psychiatric care could address the depression. A broad right to aid in dying would not limit death-causing choices to patients with a morally justified choice of death.

Of course, the same can be said about a broad right to withdrawal of treatment. Not all persons who refuse medical treatment are doing so to avoid a prolonged and undignified dying process.

Inasmuch as morally justified deaths could occur through either withdrawal of treatment or suicide assistance, and morally unjustified deaths also could occur through either practice, the law might permit both treatment withdrawals and assisted suicides when they are morally justified and prohibit both when they are not morally justified.

Under such an approach, however, someone representing the state's interest in preserving life would have to decide whether the patient's suffering is severe enough to justify either the withdrawal of treatment or the assistance in suicide.<sup>79</sup> The patient would select the life-shortening option, and some official representative would assess the patient's condition and prospects for recovery. The representative then would conclude either that (1) the patient's condition was serious enough and the suffering severe enough to justify the life-ending choice or that (2) the patient's condition was not serious enough or the suffering not severe enough to justify the ending of life.

But we do not want the state to decide when someone's quality of life is sufficiently miserable that it is permissible to choose death. That is one of the last powers we would want the state to assume. Judgments about quality of life can be made by people for themselves, but not by the government for them.

If we cannot decide each request to shorten life on its own merits, we need a "proxy" rule that generally sorts between the morally justified and the morally unjustified. For many years, the distinction between treatment withdrawal and suicide assistance served that proxy role.<sup>80</sup> Treatment withdrawals could be permitted for everyone because the typical refusal of treatment involves a patient who is suffering greatly from a serious medical condition.<sup>81</sup> Suicide assistance

79. The decision maker could be a physician, a judge, or another person. Even though the decision makers need not be government employees, they would be representing the state's interest in preserving life.

80. *Legalization*, *supra* note \*, at 445.

81. Sometimes people refuse treatment that can restore them to good health, but those cases involve refusals of treatment for religious reasons. A Jehovah's Witness might decline a blood transfusion or a Christian Scientist might decline surgery. See, e.g., *Stamford Hosp. v. Vega*, 674 A.2d 821, 824-25 (Conn. 1996).

had to be prohibited for everyone because the typical suicide does not involve a patient suffering greatly from a serious medical condition.<sup>82</sup> The typical treatment withdrawal would represent a morally justified death while the typical suicide would represent a morally unjustified death. In short, we could permit morally justified deaths and prevent morally unjustified deaths with the distinction between treatment withdrawal and suicide assistance without making quality of life judgments for individual patients.

However, it became apparent that the proxy rule for end-of-life law had a serious defect. While the typical taking of a lethal dose of medication is not morally justified, the taking of a lethal dose of medication by someone who is terminally ill is not a typical case. A patient dying from cancer is very different from a despondent college student. Assisted suicide for the terminally ill—or aid in dying—still limits death-hastening choices to people who are suffering greatly from a serious medical condition. Like treatment withdrawal, aid in dying results in deaths that typically are morally justified in society's view.

Hence, a proxy rule that allows the taking of a lethal dose of medication by the terminally ill represents a refinement of the proxy distinctions in end-of-life-law so they better reflect society's views about morally justified and morally unjustified deaths. Moreover, it allows the refinement without forcing a representative of the state to make quality of life judgments for individual patients. Thus, when Oregon, Washington, Montana, Vermont, and New Mexico have recognized a right to assisted suicide, they have done so only for people with a terminal illness.<sup>83</sup> In all of those states, anyone who is terminally ill is eligible for aid in dying, while no one who is not terminally ill may choose aid in dying.<sup>84</sup> The states do not consider the degree of the patient's suffering or other measures of the patient's quality of life.<sup>85</sup> The law still relies on proxy rules for end-of-life decision making, but it employs proxy rules that do a better job sorting the morally justified death from the morally unjustified death.

### CONCLUSION

While legal recognition of a right to aid in dying is growing, its greater recognition does not reflect a change in societal views about the propriety of

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82. *Legalization*, *supra* note \*, at 462.

83. OR. REV. STAT. §§ 127.800-127.897 (2014); VT. STAT. ANN. tit. 18 §§ 5281-92 (2014) (LexisNexis); WASH. REV. CODE § 70.245 (2014); *Baxter v. State*, 224 P.3d 1211, 1221-22 (Mont. 2009); Opposition to Defendant's Motion to Dismiss, *Morris v. Brandenburg*, No. D-202-cv-2012-02909 (2d Jud. Dist. N.M. Jan. 13, 2014). See also David Orentlicher et al., *The Changing Legal Climate for Physician Aid in Dying*, 311 JAMA 1961, 1961 (2014).

84. OR. REV. STAT. §§ 127.800-127.897; VT. STAT. ANN. tit. 18 §§ 5281-92; WASH. REV. CODE § 70.245; *Baxter*, 224 P.3d at 1221-22; Opposition to Defendant's Motion to Dismiss, *Morris v. Brandenburg*, No. D-202-cv-2012-02909 (2d Jud. Dist. N.M. Jan. 13, 2014).

85. OR. REV. STAT. §§ 127.800-127.897; VT. STAT. ANN. tit. 18 §§ 5281-92; WASH. REV. CODE § 70.245; *Baxter*, 224 P.3d at 1221-22; Opposition to Defendant's Motion to Dismiss, *Morris v. Brandenburg*, No. D-202-cv-2012-02909 (2d Jud. Dist. N.M. Jan. 13, 2014).

physician-assisted suicide. We are not seeing an evolution in ethical thought. Rather, society is refining its legal rules for end-of-life law so they better reflect the public's long-standing moral views about death-hastening choices at the end of life.

