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David Orentlicher

University of Nevada, Las Vegas – William S. Boyd School of Law

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THE LEGALIZATION OF PHYSICIAN ASSISTED SUICIDE: A VERY MODEST REVOLUTION

DAVID ORENTLICHER, M.D., J.D.*

INTRODUCTION

During the past two years, right-to-die law has apparently undergone a dramatic shift. Until recently, the law drew a clear distinction between the withdrawal of life-sustaining treatment¹ and physician assisted suicide.² Treatment withdrawal was permitted, indeed required, upon the patient's request, while suicide assistance was widely prohibited.³ In the past two-and-a-half years, the distinction has rapidly eroded. Although voters in Washington and California rejected referenda that

* Associate Professor of Law and Co-Director, Center for Law and Health, Indiana University School of Law-Indianapolis. A.B., Brandeis, 1977; M.D., Harvard, 1981; J.D., Harvard, 1986.

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¹ By withdrawal of life-sustaining treatment, I refer to situations in which physicians discontinue the provision of medical treatment that is necessary to sustain a patient's life. Such treatment includes ventilators, feeding tubes, cardiopulmonary resuscitation (CPR), surgery, antibiotics, blood transfusions and any other health care. To be precise, life-sustaining treatment may be withdrawn or withheld.

² By physician-assisted suicide, I refer primarily to situations in which physicians provide patients with a lethal dose of a drug, and the patients take the drug immediately or at a later date to end their lives. Physician-assisted suicide would also cover situations in which a physician provides a patient with some other death-causing agent that the patient uses to commit suicide. Dr. Jack Kevorkian has used carbon monoxide to assist the suicides of most of his patients.

³ See 2 ALAN MEISEL, *THE RIGHT TO DIE* 450-57 (2d ed. 1995); Choice In Dying, Inc., *State Laws Regarding Assisted Suicide*, 1995 RIGHT-TO-DIE LAW DIG. 40, 56.

would have legalized assisted suicide in 1991⁴ and 1992,⁵ respectively, voters in Oregon enacted the first statute in the United States authorizing assisted suicide in November 1994.⁶ The Michigan Supreme Court held in December 1994 that Dr. Jack Kevorkian could be criminally prosecuted for assisting patients with suicide,⁷ but, in the spring of 1996, two juries acquitted him of charges in four cases⁸; no further charges have been brought even though he assisted his twenty-eighth suicide while on trial⁹ and has assisted several more suicides since then.¹⁰ Finally, and most strikingly, the United States Courts of Appeals for the Ninth¹¹ and Second¹² Circuits recognized a constitutional right to assisted suicide for the first time in March and April 1996, respectively. As the law abandons the distinction between withdrawing life-sustaining treatment and assisting suicide, it *seems* that the law is undergoing a profound change.¹³

This reading of the law is mistaken, however. Rather than a shift in the law, we are seeing the further development of the principles that have driven right-to-die law since the *Quinlan* case¹⁴ in 1976. For the same reasons that the law drew a distinction between treatment withdrawal and suicide assistance in the past, the law is now eliminating that distinction.

⁴ See Jane Gross, *Voters Turn Down Mercy Killing Idea*, N.Y. TIMES, Nov. 7, 1991, at B16.

⁵ See Sandi Dolbee, *Right-to-Die Measure Rejected by State Voters; Lack of Safeguards a Major Factor, Opponents Believed*, SAN DIEGO UNION-TRIB., Nov. 4, 1992, at A3.

⁶ Oregon Death with Dignity Act, 1995 OR. LAWS ch. 3 (codified at OR. REV. STAT. § 127.800 (1996)); see Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483 (1995) (discussing implications of Oregon statute). The statute has been under a federal court injunction and therefore has not yet gone into effect. See *Lee v. Oregon*, 891 F. Supp. 1439 (D. Or. 1995).

⁷ *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).

⁸ See Jack Lessenberry, *Jury Acquits Kevorkian in Common-Law Case*, N.Y. TIMES, May 15, 1996, at A14; Tamar Lewin, *Ruling Sharpens Assisted-Suicide Debate*, N.Y. TIMES, Mar. 8, 1996, at A14.

⁹ See *Kevorkian Back at Trial as Talk of Detroit Is of Another Suicide*, N.Y. TIMES, May 10, 1996, at A16.

¹⁰ See *Dr. Kevorkian Helps in Woman's Suicide, 3d Case in 9 Days*, N.Y. TIMES, June 21, 1996, at A18; *Kevorkian Held Briefly After 2d Suicide in Day*, N.Y. TIMES, Aug. 23, 1996, at A15; Jack Lessenberry, *New Official in Quandary on Trying Kevorkian*, N.Y. TIMES, Nov. 10, 1996, at A21. Indeed, Richard Thompson, the prosecutor who brought the unsuccessful charges, was voted out of office in a "primary election that was widely seen as a referendum on his handling of the issue of assisted suicide." *Prosecutor of Kevorkian Loses Re-election Bid*, N.Y. TIMES, Aug. 8, 1996, at A23.

¹¹ *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc) *cert. granted subnom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

¹² *Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996).

¹³ According to two commentators, for example, efforts to gain recognition of a right to assisted suicide are "efforts . . . not only to transform the law, but also to transform society." Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 523 (1995).

¹⁴ *In re Quinlan*, 355 A.2d 647 (N.J. 1976) (finding right to refuse life-sustaining treatment in case involving permanently unconscious 21-year-old woman whose parents wanted to have her ventilator withdrawn).

I will argue that physician assisted suicide has been prohibited not because it is meaningfully different from withdrawal of life-sustaining treatment, but because the distinction between suicide assistance and treatment withdrawal served as a useful proxy for distinguishing between morally acceptable and morally unacceptable decisions by patients to end their lives. Society commonly implements its principles through generally valid rules rather than through case-by-case determinations, recognizing that the rules will not fit every case perfectly but also recognizing the infeasibility of case-by-case determinations. The distinction between suicide assistance and treatment withdrawal is an example of rule-based decisionmaking that, in the view of the public and the courts, was an effective way to ensure that patients could end their lives only when they were morally justified in doing so.

Now, however, the distinction between physician assisted suicide and withdrawal of life-sustaining treatment has lost its utility as a moral proxy. With recent advances in medical treatment, there are many patients desiring assisted suicide whose wishes to end their lives are morally justified—in society's view. The distinction between assisted suicide and withdrawal of treatment no longer does a good job of sorting morally valid from morally invalid requests by patients to end their lives. Accordingly, the distinction is being replaced—and may continue to be replaced—by new proxy distinctions that allow for physician assisted suicide in limited situations.

It is not my intent to argue that physician assisted suicide is, or is not, justified; much has already been written as to whether there ought to be a constitutional¹⁵ or statutory¹⁶ right to assisted suicide. Rather, my aim is to explain *why* the law is beginning to recognize a right of

¹⁵ See, e.g., Chopko & Moses, *supra* note 13, at 545–78 (arguing against constitutional right); Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203 (1991) (arguing against constitutional right); Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 HASTINGS CONST. L.Q. 799 (1994) (arguing against constitutional right); Robert A. Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View from Without and Within*, 21 HASTINGS CONST. L.Q. 777 (1994) (arguing in favor of constitutional right); Symposium, *Physician-Assisted Suicide*, 35 DUQ. L. REV. 1 (1996); Kathryn L. Tucker & David J. Burman, *Physician Aid in Dying: A Humane Option, a Constitutionally Protected Choice*, 18 U. PUGET SOUND L. REV. 495 (1995) (arguing in favor of constitutional right).

¹⁶ See, e.g., Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996) (proposing model statute to legalize assisted suicide); Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1 (1996) (arguing against statutory right); Franklin Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119 (1994) (arguing in favor of statutory right); Julia Pugliese, Note, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HASTINGS L.J. 1291, 1324–29 (1993) (proposing a statutory approach to legalizing assisted suicide).

patients to physician assisted suicide after a long history of denying such a right and, in particular, why the law has recognized a right to assisted suicide only for terminally ill persons.¹⁷ Whatever one thinks about a right to assisted suicide, the law is starting to acknowledge such a right, and it is critical to understand the factors that are driving this change in the law.¹⁸

In Part I, I will demonstrate that the law's distinction between suicide assistance and treatment withdrawal cannot be explained by any of the traditional moral arguments used to distinguish the two acts. In Part II, I will show how the distinction previously served a useful proxy role for the moral concerns that underlie right-to-die law and how that proxy role has become outdated. In Part III, I will discuss how the recognition of a right to assisted suicide for terminally ill persons brings right-to-die law back into congruence with its underlying moral concerns. In Part IV, I will consider the likelihood that the law will further expand the right-to-die to include assisted suicide for patients who are not terminally ill and/or to include euthanasia.

I. THE ABSENCE OF A MEANINGFUL DIFFERENCE BETWEEN ASSISTED SUICIDE AND WITHDRAWAL OF TREATMENT

The distinction between treatment withdrawal and suicide assistance has generally been justified by courts and scholars on the ground that there is an important moral difference between the two acts.

¹⁷ See *Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir. 1996) (en banc); *Quill*, 80 F.3d at 731; see also OR. REV. STAT. § 2.01 (Supp. 1996). The *Compassion in Dying* court found a Fourteenth Amendment substantive due process right to assisted suicide for terminally ill persons by relying on the United States Supreme Court's recognition of constitutional protection for "intimate and personal choices" that are "central to personal dignity and autonomy," *Compassion in Dying*, 79 F.3d at 813 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)), and on the Supreme Court's recognition of "a liberty interest in hastening one's own death" in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) (recognizing constitutional right to refuse life-sustaining treatment). *Compassion in Dying*, 79 F.3d at 816. The *Quill* court rejected a substantive due process right to assisted suicide, *Quill*, 80 F.3d at 723-25, and instead found a denial of equal protection under the Fourteenth Amendment when a state permits terminally ill persons "to hasten their deaths" by refusing life-sustaining treatment but forbids other terminally ill persons "to hasten death by self-administering prescribed drugs" when those other persons are similarly situated except for not being dependent on life-sustaining treatment. *Id.* at 729.

¹⁸ My argument assumes that the relevant constitutional provisions are sufficiently indeterminate that courts could reasonably conclude either that there is or is not a constitutional right to assisted suicide. Indeed, a three-member panel of the Ninth Circuit found no constitutional right, only to be reversed by the en banc court. Compare *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995) (panel decision), with *Compassion in Dying*, 79 F.3d at 836-37 (reversing panel decision). As to statutes regarding assisted suicide, the issue is even simpler since only a majority vote of the public or a legislature is needed to define the law.

However, close examination indicates that the distinction between withdrawal and suicide rests on other grounds.

A. *Conceptual Arguments to Explain the Distinction Between Treatment Withdrawal and Suicide Assistance*

1. Physician Assisted Suicide is an Act of Killing

Perhaps the most common justification for the distinction between treatment withdrawal and suicide assistance is that suicide assistance involves an act of killing, whereas treatment withdrawal permits the patient's disease to take its natural course. This justification appears in numerous court decisions and academic writings.¹⁹ According to the New Jersey Supreme Court, for example:

Declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.²⁰

However, as the Second²¹ and Ninth²² Circuits observed, treatment withdrawal is no less a killing than suicide. If I were to enter an

¹⁹ See, e.g., NATIONAL CENTER FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 145 (2d ed. 1992) [hereinafter GUIDELINES]; Chopko & Moses, *supra* note 13, at 533-34; David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1845 (1989). The National Center for State Courts has stated:

There are significant moral and legal distinctions between letting die (including the use of medications to relieve suffering during the dying process) and killing (assisted suicide/euthanasia). In letting die, the cause of death is seen as the underlying disease process or trauma. In assisted suicide/euthanasia, the cause of death is seen as the inherently lethal action itself.

GUIDELINES, *supra*, at 145.

²⁰ *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (involving right of 84-year-old woman who was bedridden and severely demented to have feeding tube withdrawn); see also *Gray v. Romeo*, 697 F. Supp. 580, 589 (D.R.I. 1988) (addressing right of 47-year-old woman who was permanently unconscious from cerebral hemorrhage to have feeding tube withdrawn—"[T]here is an obvious distinction between deliberately ending a life by artificial means and allowing nature to take its course."); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (addressing right of 24-year-old man who was permanently unconscious from motor vehicle accident to have feeding tube withdrawn—"[T]he cause of his death will be not his refusal of care but rather his accident and his resulting medical condition."); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (addressing right of profoundly mentally retarded 67-year-old man to have chemotherapy withheld for leukemia that would respond poorly to treatment—"[T]o the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion.").

²¹ *Quill*, 80 F.3d at 730.

²² *Compassion in Dying*, 79 F.3d at 822.

intensive care unit and shut off every patient's ventilator, I would be charged with murder for every patient who died. And, it would be no defense that the patients' deaths were caused by their underlying illnesses.²³ It is of course true that I would have acted without consent, whereas withdrawal of life-sustaining treatment typically occurs with patient or proxy consent. However, whether or not there is consent does not change the *cause* of the patient's death; it only serves to *justify* the killing of the patient.²⁴

Although we could call withdrawal of life-sustaining treatment justifiable homicide, we do not do so. Calling the act "withdrawal of life-sustaining treatment" makes the act more palatable, just as concerns of palatability have led us to discard the term passive euthanasia in favor of withdrawal of life-sustaining treatment.²⁵ Nevertheless, that we use the term "withdrawal of life-sustaining treatment" rather than "justifiable homicide" does not change the causation analysis. The issue, then, is not whether assisted suicide causes death but whether it is a justifiable way to cause death.

Moreover, if causation were really the issue, assisted suicide would be less problematic morally than withdrawal of treatment. With assisted suicide, the physician has an attenuated causal role in the patient's death.²⁶ The physician may provide a lethal dose of a drug, but because the patient must self-administer the drug, the patient brings about his or her own death. Indeed, when a physician writes a prescription for a lethal dose of barbiturates that are used a few weeks or months later in a suicide, the physician has a more attenuated role in the patient's death than the physician whose discontinuation of a ventilator leads to death in minutes.

The routine use of the argument that assisted suicide involves a killing seems to reflect a failure by courts and commentators to distinguish between the act that causes a patient's death and the circum-

²³ See Dan W. Brock, *Voluntary Active Euthanasia*, 22(2) HASTINGS CENTER REP. 10, 13 (1992); Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 U. PUGET SOUND L. REV. 473, 480 (1995).

²⁴ See Brock, *supra* note 23, at 13; Note, *Physician-assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2029-30 (1992).

²⁵ Originally, withdrawal of life-sustaining treatment was generally characterized as passive euthanasia, as distinguished from active euthanasia. In active euthanasia, a physician or other person would inject a lethal drug into a patient or otherwise administer a lethal agent. See William E. May et al., *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES L. & MED. 203, 204 (1987); John A. Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 214-15 & n.16 (1975).

²⁶ See *Quill*, 80 F.3d at 729.

stances under which the act is performed. In rejecting a right to assisted suicide, the Michigan Supreme Court wrote:

We agree that persons who opt to discontinue life-sustaining medical treatment are not, in effect, committing suicide. There is a difference between choosing a natural death summoned by an uninvited illness or calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.²⁷

While there is a difference between the two situations, the important difference may lie in the fact that one person is suffering from an "uninvited illness or calamity," not that the other person is "resorting to death-inducing measures."

The Michigan court's concern about the "naturalness" of death is not helpful in distinguishing treatment withdrawal from suicide assistance. Patients who have received artificial ventilation, kidney dialysis or cancer chemotherapy for their disease are no longer able to die a "natural" death. A natural death occurs only when a person has received no treatment for her disease. Accordingly, patients who die when treatment is withdrawn also die an unnatural death. Moreover, the court is assuming that we can locate the appropriate "baseline" for the patient by looking at the patient without treatment. However, it is just as reasonable to take the patient's baseline as where the patient is with treatment. For example, I think we would want to say that, when a person has had an artificial heart valve or a cardiac pacemaker implanted, the patient is now at a new baseline in terms of her physical condition.

2. Suicide Assistance Kills the Healthy as Well as the Sick

Daniel Callahan, an eminent scholar in medical ethics, maintains that we distinguish between suicide assistance and treatment withdrawal because ceasing treatment kills only if the patient is suffering from a fatal illness, whereas assisting suicide kills both the sick and the healthy person.²⁸ Edmund Pellegrino, a distinguished physician-ethicist, has advanced a similar argument to distinguish withdrawal of life-sustaining treatment from assisted suicide; he observes that when patients are

²⁷ *People v. Kevorkian*, 527 N.W.2d 714, 728–29 (Mich. 1994).

²⁸ Daniel Callahan, *When Self-Determination Runs Amok*, 22(2) HASTINGS CENTER REP. 52, 53 (1992).

"overmastered" by disease, life-sustaining treatment serves "no beneficial purpose," and physicians "have a moral obligation to stop treatment."²⁹

These claims do not survive scrutiny. Callahan's and Pellegrino's arguments reflect the considerations that originally led society to acknowledge a right to refuse life-sustaining treatment. While that right is now well-entrenched, it was not always clear that withdrawal of treatment was permissible. Twenty years ago, Karen Quinlan's family had to obtain a landmark decision by the New Jersey Supreme Court before her ventilator could be withdrawn.³⁰ Thirteen years ago, in *Barber v. Superior Court*, two physicians were prosecuted for withdrawing life-sustaining treatment at the behest of the patient's family; the physicians needed an appellate court decision to have the murder charges vacated.³¹ At some point, society had to decide whether treatment withdrawal was an unlawful killing, and it declined to do so primarily because we think it is morally permissible to let patients die when they are hopelessly ill and have little to gain from treatment.

This justification for permitting withdrawal of life-sustaining treatment can be found in court decisions, state statutes, religious writings and academic commentaries. For example, in explaining why Elizabeth Bouvia's right to refuse artificial nutrition and hydration superseded the state's interest in preserving her life, a California court of appeals observed that Ms. Bouvia faced a life of "painful existence," that her "condition [was] irreversible" and that she had no choice but to lie "physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness."³² Similarly, the Massachusetts Supreme Judicial Court wrote:

There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended. Even if we assume that the State has an additional interest in seeing to it that individual decisions on the prolongation of life do not in any

²⁹ Edmund D. Pellegrino, *Doctors Must Not Kill*, 3 J. CLINICAL ETHICS 95, 96 (1992).

³⁰ *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

³¹ *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983) (involving right of comatose patient to have life-sustaining treatment withdrawn).

³² *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Ct. App. 1986) (involving right of 28-year-old woman afflicted with severe cerebral palsy to refuse life-sustaining treatment).

way tend to "cheapen" the value which is placed in the concept of living, . . . we believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness.³³

Living will statutes typically state that it is permissible to discontinue treatment when the treatment serves only "to prolong the dying process."³⁴ The Roman Catholic Church, in its 1980 *Declaration on Euthanasia* countenancing withdrawal of treatment, concluded:

[W]hen inevitable death is imminent in spite of the means used, it is permitted in conscience to make the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.³⁵

Norman Cantor, a leading scholar on end-of-life law, justifies withdrawal of life-sustaining treatment because the patient is "not intent on repudiating life, but on avoiding a prolonged, undignified dying process."³⁶

All of this suggests that the relevant issue is whether the person is dying and beyond help, not whether the person dies by treatment withdrawal or suicide assistance. Under this view, it should be acceptable to assist the suicide of a dying patient and unacceptable to withdraw life-sustaining treatment if a patient is not irreversibly ill.

3. Suicide Assistance Violates the Physician's Professional Role

Leon Kass, a leading scholar of medicine and philosophy, argues that assisted suicide is fundamentally inconsistent with the physician's role as a healer.³⁷ Physicians serve patients not simply to facilitate

³³ *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425-26 (Mass. 1977).

³⁴ See, e.g., IND. CODE ANN. § 16-36-4-1(a)(2) (Michie Supp. 1996); see also CAL. HEALTH & SAFETY CODE § 7186.5 (West Supp. 1996) (allowing withdrawal of treatment if it "only prolongs the process of dying or the irreversible coma or persistent vegetative state"); FLA. STAT. ANN. § 765.303(1) (West Supp. 1997) (allowing withdrawal of treatment if it serves "only to prolong artificially the process of dying").

³⁵ THE PARK RIDGE CENTER, ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE 51 (1991).

³⁶ Norman L. Cantor, Quinlan, *Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 249-50 (1977).

³⁷ See Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, 94 PUB. INTEREST 25, 30 (1989).

patient autonomy but to provide medical treatments that make patients as well as they can become. Under this view of the physician's role, treatment that is designed to cause death is not part of the medical armamentarium and therefore must not be provided.³⁸ Moreover, if physicians began to dispense death-causing agents, patients would develop a profound distrust of the medical profession. It would no longer be clear that physicians were wholeheartedly devoted to caring for patient health³⁹ or to protecting life "in all its frailty."⁴⁰

There are three responses to this important argument against assisted suicide. First, physicians are providers of comfort as fundamentally as they are healers of illness.⁴¹ When these two roles conflict, it is not clear why the healing role should take priority over the comforting role. Indeed, if we view physicians' fundamental role as relieving discomfort or disease, with health promotion being a part of that role, then assisting suicide is not only compatible with the physician's role but quite possibly incumbent upon physicians. Under this view, what breeds mistrust toward physicians by patients is not that physicians may dispense lethal agents but that they may not do so.⁴² Patients fear that when they are suffering intolerably, they will be denied the drugs that are necessary to end their suffering.⁴³

Second, even accepting the premise that healing is the fundamental physician role, permitting assisted suicide can facilitate that role. While assisted suicide will shorten some patients' lives, it will prolong

³⁸ See Council on Ethical and Judicial Affairs, American Medical Association, *Physician Assisted Suicide*, 10 ISSUES L. & MED. 91, 93 (1994); Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139, 2139 (1988); Kass, *supra* note 37, at 30.

³⁹ See Chopko & Moses, *supra* note 13, at 527; Orentlicher, *supra* note 19, at 1845.

⁴⁰ Gaylin et al., *supra* note 38, at 2140.

⁴¹ See Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVE INTERNAL MED. 1890, 1893 (1994); Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 L. MED. & HEALTH CARE 116, 123 (1992).

⁴² See MARGARET P. BATTIN, *ETHICAL ISSUES IN SUICIDE* 206 (1995).

⁴³ See Christine K. Cassel & Diane E. Meier, *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750, 751 (1990). In a survey of adult patients, researchers found that 90.5% of the patients would consider a physician who assisted suicides to be as trustworthy as other physicians in providing care to critically ill patients. See Mark A. Graber et al., *Patients' Views About Physician Participation in Assisted Suicide and Euthanasia*, 11 J. GEN. INTERNAL MED. 71, 73 (1996) (studying 228 patients at single university-based family practice program). In another study, researchers asked relatives of deceased persons whether the decedents would have wanted their physicians to provide them with a lethal dose of pills when they were dying. In 17% of cases, the decedent would have wanted a lethal dose of pills. Importantly, in only 8% of cases did the family members report that the decedent found comfort measures inadequate. See Jay A. Jacobson et al., *Decedents' Reported Preferences for Physician-Assisted Death: A Survey of Informants Listed on Death Certificates in Utah*, 6 J. CLINICAL ETHICS 149, 153-55 (1995) (studying 37% of all adult deaths in Utah other than suicides between July and November 1992).

other patients' lives. What patients often want from the right to assisted suicide is not so much the ability to die but the knowledge that they will always have control over the timing of their death.⁴⁴ Accordingly, they may be more willing to undergo aggressive medical treatments that are painful and risky. If the treatments do not succeed but only worsen the patients' condition, the patients would be assured that they could end their suffering. Without such assurance, they might well forgo the treatments entirely.

Patient control over the timing of death may also prolong life because any feelings of ambivalence are likely to stay the patient's hand.⁴⁵ When death occurs by withdrawal of life-sustaining treatment, residual ambivalence may not deter the patient. Patients recognize that hesitation at the scheduled time of discontinuation might cause their physicians to question the sincerity of any later decision to stop treatment and therefore preclude discontinuation at a later time.⁴⁶

Finally, we cannot explain the distinction between assisted suicide and treatment withdrawal in terms of the physician's healing role because we permit physicians to act in ways that are inconsistent with healing through the withdrawal of treatment. Physicians can withdraw life-sustaining treatment when the patient will likely live for many more years and even when there is a good possibility of significant improvement in the patient's condition.⁴⁷ Yet, if physicians were guided by whether their proposed actions would serve to heal, they would not remove life-sustaining treatment from patients who could be healed. Thus, even if there is merit to the argument about the physician's healing role, it does not explain the distinction between assisted suicide and withdrawal of life-sustaining treatment.

4. If Physicians Treated Patients' Pain Appropriately, Patients Would No Longer Ask for Assisted Suicide

As opponents of assisted suicide have observed, many physicians do not treat their patients' pain aggressively enough, and greater use

⁴⁴ See Brock, *supra* note 23, at 11.

⁴⁵ See Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 NEW ENG. J. MED. 1384, 1386 (1992).

⁴⁶ A similar argument could be made about physician-assisted suicide. However, an important difference between suicide assistance and treatment withdrawal is the fact that patients can end their lives by suicide privately without the presence of a physician. See, e.g., Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 693 (1991) (describing how patient dying of leukemia ended her life alone, two days after saying goodbye to her physician).

⁴⁷ See, e.g., *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990) (recognizing right of 36-year-old

of pain medications and hospice care can alleviate a patient's desire to die.⁴⁸ Still, not all physical pain can be treated. Further, suffering comes in forms other than physical pain, whether it be the wasting of the body into little more than flesh and bones, the loss of control over bodily functions and the utter dependence on others, the unrelieved mental and physical exhaustion, or the knowledge that things will only get worse. Indeed, one of Dr. Kevorkian's patients was a physician who specialized in rehabilitative medicine and therefore had special expertise in treatments and services to relieve patient suffering.⁴⁹ Greater use of palliative care would reduce the demand for assisted suicide, but it will not eliminate the demand.⁵⁰

There is, however, an even more fundamental problem with this argument; it applies equally to patients' desires for withdrawal of life-sustaining treatment. Their pain and suffering, too, could be alleviated to a considerable extent if greater use were made of pain medications and hospice care. Indeed, this concern led the Nevada Supreme Court to recognize a state interest in "encouraging the charitable and humane care of afflicted persons" in cases involving the withdrawal of life-sustaining treatment.⁵¹ According to the court, before a patient could refuse life-sustaining treatment, the patient would have to be "fully inform[ed] . . . of the care alternatives . . . available."⁵²

5. People May Reject Burdensome Treatment but Not a Burdensome Life

Some commentators have drawn a distinction between a patient's rejecting the burdensomeness of medical treatment and a patient's rejecting the burdensomeness of life.⁵³ According to these commentators, it is permissible to decline life-sustaining medical treatment because the patient is avoiding the imposition of an external burden. With assisted suicide, the patient is avoiding life itself.

adult with serious bleeding during cesarean section to refuse blood transfusions that could restore her to good health).

⁴⁸ See Chopko & Moses, *supra* note 13, at 531-32.

⁴⁹ See Don Terry, *While Out on Bail, Kevorkian Attends a Doctor's Suicide*, N.Y. TIMES, Nov. 23, 1993, at A1.

⁵⁰ See Robert J. Miller, *Hospice Care as an Alternative to Euthanasia*, 20 L. MED. & HEALTH CARE 127, 128 (1992).

⁵¹ *McKay v. Bergstedt*, 801 P.2d 617, 628 (Nev. 1990) (involving 31-year-old man who was quadriplegic and ventilator dependent from swimming accident).

⁵² *Id.*

⁵³ See May et al., *supra* note 25, at 208.

There are two problems with this distinction. First, many permitted withdrawals of treatment represent a rejection of burdensome life rather than burdensome treatment.⁵⁴ An important example is the case of Kenneth Bergstedt, who had been rendered quadriplegic and ventilator dependent by a swimming accident.⁵⁵ In that case, the Nevada Supreme Court approved withdrawal of Mr. Bergstedt's ventilator, accepting Mr. Bergstedt's rationale that he feared that his life would become undesirable once his terminally ill father died and was no longer around to care for him.⁵⁶

Second, it is not meaningful to distinguish between the burdensomeness of treatment and the burdensomeness of life. When a person's life is dependent on medical treatment, the only life the person has is a life with the treatment; the life and the treatment are inseparable.⁵⁷ Hence, when a person with chronic kidney failure can survive only with thrice-weekly dialysis, and the person decides to refuse further dialysis because life is no longer worth living on dialysis,⁵⁸ the person is simultaneously rejecting the burdensomeness of dialysis and the burdensomeness of life. The person may still enjoy the intellectual or spiritual side of his life, but his life is the totality of his intellectual, spiritual and physical well-being, and he has come to the conclusion that the disadvantages of his physical condition outweigh the advantages of his mental condition.

6. Suicide Assistance Involves an *Intent* to Kill

Treatment withdrawal differs from suicide assistance, it is argued, because the intent is to remove an undesired treatment, not to kill the patient. Indeed, the patient may not die when life-sustaining treatment

⁵⁴ See Gilbert Meilaender, *On Removing Food and Water: Against the Stream*, 14(6) HASTINGS CENTER REP. 11, 13 (1984).

⁵⁵ See *Bergstedt*, 801 P.2d at 620. Bergstedt was in essentially the same medical condition as that of the actor Christopher Reeve since his equestrian accident. Bergstedt was able to read, watch television, write poetry by orally operating a computer and move around in a wheelchair. His quadriplegia was irreversible; on the other hand, he was not terminally ill. See *id.*

⁵⁶ *Id.* at 624-25.

⁵⁷ Cf. Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 867 (1992) (arguing that there is no moral difference between rejecting life-sustaining treatment that is not desired and rejecting life-sustaining treatment when continued life is not desired).

⁵⁸ In one study, researchers found that 11% of deaths in dialysis patients occurred as a result of a patient's decision to discontinue treatment. See Steven Neu & Carl M. Kjellstrand, *Stopping Long-term Dialysis: An Empirical Study of Withdrawal of Life-Supporting Treatment*, 314 NEW ENG. J. MED. 14, 15, 17-18 (1986).

is withdrawn. Despite her physicians' predictions that she would die without ventilatory support, Karen Quinlan lived for nearly a decade after her ventilator was withdrawn.⁵⁹ As one court wrote:

[P]eople who refuse life-sustaining medical treatment may not harbor a specific intent to die; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering.⁶⁰

Yet, as Dr. Kevorkian successfully argued to his juries,⁶¹ the same claim can be made about assisted suicide.⁶² Prescribing a lethal dose of a drug is done not to kill the patient but to relieve the patient's suffering. Moreover, the patient might not die. The patient might decide not to take the pills after all, might take a sublethal dose of the drug or might be revived before dying and then decide against subsequent suicide attempts.

The intent argument also fails to distinguish between treatment withdrawal and suicide assistance because many treatment withdrawals reflect an intent to die. As discussed in the previous section, patients often refuse life-sustaining treatment because they perceive their life as burdensome and they therefore want to die. When physicians discontinue the life-sustaining treatment for these patients, they are doing so to facilitate an intent to die.⁶³ It is true that the patients would want

⁵⁹ See Robert D. McFadden, *Karen Ann Quinlan, 31, Dies; Focus of '76 Right to Die Case*, N.Y. TIMES, June 12, 1985, at A1. While the *Quinlan* case is routinely cited as an example of the possibility that the patient will survive a removal of life-sustaining treatment, it is a misleading example. After Karen Quinlan's family won the right to have her ventilator discontinued, her physician and the hospital administration refused to comply with the decision of the New Jersey Supreme Court. Rather than turning off the ventilator immediately and letting Ms. Quinlan die, Ms. Quinlan's physician, Dr. Morse, spent the next five months "weaning" her from the ventilator so she could breathe on her own. See GREGORY E. PENCE, CLASSIC CASES IN MEDICAL ETHICS 16-17 (2d ed. 1995).

⁶⁰ *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (citations omitted); see also *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978) ("The testimony of Mr. Perlmutter . . . is that he really wants to live, but to do so, God and Mother Nature willing, under his own power. This basic wish to live, plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment being classified as attempted suicide.").

⁶¹ See Jack Lessenberry, *In Latest Suicide Trial, Kevorkian Asserts Duty as a Doctor*, N.Y. TIMES, May 4, 1996, at 10.

⁶² See George J. Annas, *Physician-Assisted Suicide—Michigan's Temporary Solution*, 20 OHIO N.U. L. REV. 561, 568 (1993) (defending actions of Dr. Timothy E. Quill in prescribing lethal dose of barbiturates to patient who was dying of leukemia on ground that "Quill intends to alleviate the pain and suffering of his patients' final weeks or months of life").

⁶³ Moreover, in many cases of treatment withdrawal, the physician may be harboring an independent wish to see the patient die. Nevertheless, we do not limit withdrawal of life-sustaining treatment because of that possibility. See John Arras, *News from the Circuit Courts: How Not to Think About Physician-Assisted Suicide*, BIOETHICS, July-Aug. 1996, at S171, S181.

to live if they were not suffering from their illnesses or injuries, but the same can be said for ill or injured patients who request assistance with suicide.

In any event, arguments about intent cannot simply be asserted. The law often holds people responsible for the foreseeable consequences of their acts, even if they did not intend to cause those consequences.⁶⁴ If lack of intent is to excuse physicians from causing their patients' deaths, we need an additional argument as to *why* lack of intent ought to matter. If the argument for treatment withdrawal is that patients cannot be required to stay alive if they are experiencing unacceptable suffering, then we are left with an argument that does not distinguish between treatment withdrawal and assisted suicide.

7. Suicide Assistance Implies a Positive Right

Some commentators distinguish suicide assistance on the ground that treatment refusal involves a negative right to be left alone while suicide assistance implicates a positive right to command aid. This argument mischaracterizes the nature of a right to assisted suicide. The right does not mean that patients can insist that their physicians aid in their suicides. Rather, the right requires that the state not interfere when a patient and physician voluntarily agree on a course of assisted suicide. Physicians would participate in assisted suicide only if they were willing to do so, just as physicians perform abortions only if they are willing to do so. A right to assisted suicide is thus a negative right to be left alone.⁶⁵

Still, it is argued, the distinction between treatment withdrawal and suicide assistance reflects the law's traditional protection against unwanted physical touchings.⁶⁶ Imposition of unwanted medical treatment is an unlawful battery. Denying someone the right to suicide assistance does not result in a battery of any kind and therefore does not implicate any rights that the person might have.

⁶⁴ See W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS 280-300 (5th ed. 1984).

⁶⁵ There is also the deeper point that the positive rights-negative rights distinction is not some objective phenomenon but a social construct that presupposes some earlier assignment of rights. The only reason why we can characterize the right to refuse treatment as a negative right is because we have already decided that individuals enjoy certain rights of personal autonomy. If we took the view that bodies belong to the larger community, with individuals serving a stewardship role over their bodies, then the right to refuse treatment would become a positive right. Similarly, the right to keep people off one's property is a negative right only because there was an earlier assignment of individual property rights. In a socialist state with no rights of private ownership of property, the right to keep someone else off property would be a positive right.

⁶⁶ See Scofield, *supra* note 23, at 478-79.

There are two problems with this battery argument. First, the law does not base rights in medical decision-making simply on whether a battery is involved. There are a number of circumstances in which courts and legislatures have imposed medical treatment on unwilling persons. For example, the Supreme Court has upheld the right of the state to require vaccination,⁶⁷ state courts have ordered pregnant women to accept medical treatment that would benefit their fetuses and themselves,⁶⁸ and the Supreme Court has granted authority to prisons to administer psychiatric medications to competent, mentally ill inmates who pose a danger to themselves.⁶⁹ It is not only the case that some unwanted physical touchings are permitted, it is also the case that there are rights in medical decision-making when the person is seeking, rather than rejecting, treatment. For example, individuals needing emergency medical care have a right to receive such care at hospital emergency rooms, whether or not they can pay for the care.⁷⁰

Even if we accept the fact that the right to refuse life-sustaining treatment implicates a right to be free from battery, this fact does not help us understand the distinction between treatment withdrawal and assisted suicide. Society recognizes a right to be free of unwanted touchings to ensure that individuals have control over their bodies and are able to exercise self-determination.⁷¹ Yet, a right to assisted suicide is also designed to ensure that individuals have control over their bodies and are able to exercise self-determination.⁷² We are still left with the question of why considerations of personal autonomy are more important with respect to treatment withdrawal than assisted suicide.

⁶⁷ See *Jacobson v. Massachusetts*, 197 U.S. 11, 39 (1905) (involving man's refusal of smallpox vaccine).

⁶⁸ See *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 459-60 (Ga. 1981) (involving ability of state to impose cesarean section on woman who was 39-weeks pregnant if cesarean section was needed to prevent severe bleeding that would threaten lives of her fetus and herself); *In re Jamaica Hosp.*, 491 N.Y.S.2d 898, 900 (N.Y. Sup. Ct. 1985) (involving refusal of blood transfusions by woman who was 18-weeks pregnant and who had suffered severe gastrointestinal bleeding).

⁶⁹ See *Washington v. Harper*, 494 U.S. 210, 227 (1990). These cases can be distinguished, one might argue, because the individual is a prisoner or is risking the health of a fetus or of other persons. Nevertheless, they demonstrate that the individual's right to make medical decisions turns on factors other than whether a battery has occurred.

⁷⁰ See *Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269, 1281 (E.D. Tex. 1990). One might also cite the right to abortion as an affirmative right to medical care and not a right to be free from a battery. However, the right to abortion could be described as a right to ward off the unwanted physical intrusion of a fetus.

⁷¹ See, e.g., *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) (holding that surgery without consent is unlawful assault because "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

⁷² See Note, *supra* note 24, at 2026-28.

B. *Slippery Slope Arguments to Explain the Distinction Between Treatment Withdrawal and Assisted Suicide*

1. Risks to Vulnerable Patients

Even though we might imagine some justifiable cases of assisted suicide, it is argued, there is too great a risk that vulnerable patients will end their lives involuntarily or will succumb to pressures from others to end their lives. Patients desiring assisted suicide may have impaired competence from a treatable depression, and physicians responding to requests for suicide assistance are often inadequately trained to distinguish rational requests from those driven by depression.⁷³ Patients may also have impaired competence from medication side-effects, or feel that they have a "duty to die" to spare their family the financial and emotional burden of their continued life.⁷⁴ Patients may also choose to die because they have not received the kinds of pain relief or support services that would make them willing to stay alive. At a time when physicians do not treat physical or psychological pain aggressively enough in their dying patients,⁷⁵ it would be dangerous for patients to have the option of assisted suicide. Patients might choose suicide for unrelieved pain and suffering that could, in fact, be relieved with appropriate treatment.

These risks are real, but, as the Second Circuit observed,⁷⁶ they are just as real for patients who ask that their life-sustaining treatment be withdrawn. Indeed, in *State v. McAfee*,⁷⁷ a man who was left a ventilator-dependent quadriplegic after a motorcycle accident sought—and received—judicial permission to discontinue his ventilator; he never exercised his court-authorized right, however, in part because wide publicity about his case brought forth support services that made his life more worthwhile to him.⁷⁸ That kind of publicity, however, is most unusual.

Critics of assisted suicide observe that physicians may spend less time treating their dying patients if assisted suicide is an option.⁷⁹ It is

⁷³ Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 NEW ENG. J. MED. 1100, 1101 (1991).

⁷⁴ See Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23(3) HASTINGS CENTER REP. 32, 39 (1993).

⁷⁵ See JUDITH AHRONHEIM & DORON WEBER, FINAL PASSAGES: POSITIVE CHOICES FOR THE DYING AND THEIR LOVED ONES 99–114 (1992); Kathleen M. Foley, *Competent Care for the Dying Instead of Physician-Assisted Suicide*, 336 NEW ENG. J. MED. 54, 55–56 (1997).

⁷⁶ *Quill v. Vacco*, 80 F.3d 716, 730 (2d Cir. 1996).

⁷⁷ *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989).

⁷⁸ See Associated Press, *Larry McAfee, 39; Sought Right to Die*, N.Y. TIMES, Oct. 5, 1995, at D23.

⁷⁹ See Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near*

emotionally draining and time consuming to provide appropriate comfort and other care to patients who are seriously ill, and physicians often find it psychologically difficult to respond to the needs of these patients.⁸⁰ If people can choose suicide, then physicians may see less of a need to respond to their dying patients' needs. This concern is valid, but it also counsels against permitting the withdrawal of life-sustaining treatment. With the withdrawal of life-sustaining treatment as an option, physicians may also be discouraged from responding to the needs of their dying patients. In short, while these are legitimate concerns about physician assisted suicide, they do not explain the distinction between assisted suicide and the withdrawal of life-sustaining treatment.

Opponents also argue that it is too dangerous to allow assisted suicide in a health care system that is increasingly becoming dominated by managed care.⁸¹ With insurers rewarding physicians and hospitals for spending less on patients, fewer resources will be available for the kinds of supportive care needed to relieve dying patients' suffering. Patients, it is argued, will be driven to choose suicide when better care would have caused them to change their minds. Yet, resource constraints are even more likely to cause premature withdrawals of life-sustaining treatment. Patients dependent on ventilators or dialysis consume more resources than patients who are not so dependent, and patients can live many more years, even decades, while being sustained on artificial life supports. When the United States Supreme Court was deciding whether to permit the withdrawal of Nancy Cruzan's feeding tube, the costs of her care were reported to be more than \$130,000 per year,⁸² and she survived nearly eight years in her persistent vegetative state before her treatment was discontinued.⁸³

2. The Netherlands Experience

It is argued that the Netherlands experience demonstrates the reality of the slippery slope.⁸⁴ In the Netherlands, assisted suicide and

the End of Life, 267 JAMA 2229, 2232 (1992); Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevoonian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 826-28 (1995).

⁸⁰ See Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786, 1786 (1994).

⁸¹ See, e.g., Daniel P. Sulmasy, *Managed Care and Managed Death*, 155 ARCHIVES INTERNAL MED. 133 (1995); Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 DUQ. L. REV. 455 (1996).

⁸² See William Robbins, *Parents Fight for Right to Let a Daughter Die*, N.Y. TIMES, Nov. 27, 1989, at B9.

⁸³ See Andrew H. Malcolm, *Nancy Cruzan: End to Long Goodbye*, N.Y. TIMES, Dec. 29, 1990, at A8.

⁸⁴ See CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* 135-39 (1991).

euthanasia are technically illegal, but physicians can avoid prosecution by adhering to strict guidelines.⁸⁵ Leading studies have found that in about twenty-five percent of cases involving physician assisted suicide or euthanasia, the strict procedural safeguards are not satisfied.⁸⁶ This is an important concern, and it has led the Netherlands to adopt more stringent safeguards.⁸⁷

The Netherlands' experience may show that legalizing assisted suicide and euthanasia would be problematic, but we cannot explain the legal distinction in the United States between suicide assistance and treatment withdrawal by pointing to the Netherlands' experience. First, the legal distinction between suicide assistance and treatment withdrawal predates the disclosure of data in the United States about the Netherlands' experience. Second, the same problems exist in this country with treatment withdrawals. Studies have consistently shown that physicians do not comport with ethical principles when implementing treatment withdrawals.⁸⁸ In a study of living wills, physicians overrode a patient's treatment preference twenty-five percent of the time, and, in three-quarters of those overrides, the physician withheld treatment desired by the patient.⁸⁹ Similarly, another study has shown that physicians often write do-not-resuscitate orders without discussing the matter with patients who still possess decision-making capacity.⁹⁰ Abuses of policy are a serious concern, but they do not explain why this country has distinguished between suicide assistance and treatment withdrawal. If such abuses are reason enough to condemn decisions to shorten a patient's life, they should lead a person to oppose both assisted suicide and withdrawal of life-sustaining treatment, but not to oppose one and support the other.

More importantly, most of the abuse in the Netherlands involves euthanasia of persons who lack decision-making capacity at the time

⁸⁵ See Maurice A. M. de Wachter, *Euthanasia in the Netherlands*, 22(2) HASTINGS CENTER REP. 23, 23 (1992).

⁸⁶ See Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1699, 1701 (1996).

⁸⁷ See Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, Sept. 11, 1995, at A3.

⁸⁸ See David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1280-1301 (1994); SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995).

⁸⁹ See Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 884-85 (1991).

⁹⁰ See Andrew L. Evans & Baruch A. Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 JAMA 2236, 2238 (1985). A do-not-resuscitate (DNR) order means that no efforts will be made to revive a patient who suffers a cardiac arrest (i.e., the heart stops beating).

euthanasia is performed.⁹¹ While these cases involve patients who are "near death and clearly suffering grievously,"⁹² and who often had stated a preference for euthanasia before losing decision-making capacity,⁹³ they are nevertheless very troubling. Still, what they demonstrate are the risks of permitting euthanasia—not assisted suicide. With a right to assisted suicide, the patient must perform the life-ending act; accordingly, persons lacking decision-making capacity would not have their lives ended by others inappropriately.

II. THE REAL BASIS FOR THE LEGAL DISTINCTION BETWEEN SUICIDE AND WITHDRAWAL

In the preceding discussion, I have tried to demonstrate that none of the traditional moral arguments can explain why the law has treated withdrawal of treatment and assisted suicide differently. All of the traditional arguments can be met by equally valid counter-arguments. Yet, the law *has* distinguished suicide assistance from treatment withdrawal, and that distinction needs to be explained. As discussed below, I believe the distinction has rested in the fact that permitting treatment withdrawal but not permitting assisted suicide has given physicians a generally useful proxy for identifying morally valid and morally invalid requests by patients for help in ending their lives. There may be no meaningful difference between treatment withdrawal and assisted suicide, but distinguishing the two has served a very important functional role.

An example can illustrate how the distinction between suicide assistance and treatment withdrawal has served a proxy role in the law. There are two individuals, one of whom is twenty-eight years old, is despondent from a recent romantic breakup and, because of an acute asthma attack, is temporarily ventilator dependent. Other than the

⁹¹ See Johannes J.M. van Delden et al., *The Rummelink Study: Two Years Later*, 23(6) HASTINGS CENTER REP. 24, 24–25 (1993). Indeed, in some cases, the person never possessed decision making capacity. See, e.g., GOMEZ, *supra* note 84, at 83–84 (describing case of newborn with Down syndrome in which parents and physicians decided to withhold life-saving surgery needed to correct an obstruction of child's intestinal tract and then to administer large doses of sedating drug to ensure that child did not suffer). Note that Gomez's case is very close to an ethically permissible case of "double effect," in which a physician administers morphine or another drug to relieve a patient's pain, recognizing that the dose of drug needed to relieve suffering may also be a lethal dose. See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 77–82 (1983) (discussing principle of double effect).

⁹² van Delden et al., *supra* note 91, at 24.

⁹³ See van der Maas et al., *supra* note 86, at 1701.

asthma, this person is in good health. The other individual is eighty-two years old, is wracked with pain from widely metastatic cancer and has no more than a few weeks to live. Assume that both of these individuals wish to end their lives, the twenty-eight-year-old by refusing the ventilator and the eighty-two-year-old by suicide. Under current law, the twenty-eight-year-old may have the ventilator discontinued⁹⁴ while the eighty-two-year-old generally lacks a right to suicide assistance.

Yet, in terms of the reasons why we recognize a right to refuse life-sustaining treatment, it would be more justifiable for a physician to assist the eighty-two-year-old's suicide than to accede to the twenty-eight-year-old's refusal of the ventilator. As discussed, the right to refuse life-sustaining treatment arose out of a sense that hopelessly ill patients should be able to refuse treatment that provides little, if any, benefit and merely prolongs the dying process.⁹⁵ Society's interest in preserving a patient's life becomes attenuated when there is little life left to save, and treatment becomes burdensome rather than beneficial. In the same way, society's interest in preserving the life of the eighty-two-year-old becomes attenuated—the patient's remaining life is very short and overcome by severe suffering.⁹⁶ Conversely, imposing a ventilator on the twenty-eight-year-old would not result in the brief prolongation of a dying process but the long extension of a life that likely would become very much valued by the patient. If we were to decide these cases strictly on their own merits, we would probably permit physicians to assist the suicide of the eighty-two-year-old but not permit them to withdraw the ventilator from the twenty-eight-year-old.

Moreover, if the terminally ill eighty-two-year-old were the typical case of suicide, and the twenty-eight-year-old patient with asthma the typical case of treatment withdrawal, it is very likely that the law would permit assisted suicide and prohibit withdrawal of life-sustaining treatment. In such circumstances, suicides would generally occur when the patient's desire for death was morally justified, and treatment withdrawals would generally occur when the patient's desire for death was

⁹⁴ See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 300 (Cal. Ct. App. 1986) (holding that competent adult patient "has the right to refuse *any* medical treatment, even that which may save or prolong her life"); *In re Conroy*, 486 A.2d 1209, 1226 (N.J. 1985) (holding that competent patient's right to refuse life-sustaining treatment "would not be affected by her medical condition or prognosis"); David Orentlicher, *Physician-Assisted Dying: The Conflict with Fundamental Principles of American Law*, in *MEDICINE UNBOUND: THE HUMAN BODY AND THE LIMITS OF MEDICAL INTERVENTION* 256, 263–64 (Robert H. Blank & Andrea L. Bonnickson eds., 1994) ("[T]he right to refuse life-sustaining treatment is not limited by the patient's prognosis or the medical treatment being provided.").

⁹⁵ See *supra* text accompanying notes 30–36.

⁹⁶ See *Compassion in Dying v. Washington*, 79 F.3d 790, 820–21 (9th Cir. 1996) (en banc).

not morally justified. Indeed, in the few cases in which a patient has been denied the right to refuse a life-sustaining treatment, the patient typically has been a young person who could readily be restored to good health.⁹⁷ Although we think of assisted suicide as inherently worse than withdrawal of life-sustaining treatment, much of this sense reflects the fact that the typical suicide is less justifiable than the typical withdrawal of life-sustaining treatment.⁹⁸ The twenty-eight-year-old despondent person is the kind of person whom we think about when we think about suicide,⁹⁹ and the eighty-two-year-old person with metastatic cancer better fits our profile of the typical withdrawal case.

The proxy role of the distinction between suicide assistance and treatment withdrawal is illustrated by the effort of Jed Rubenfeld, a leading constitutional law scholar, to explain the distinction by applying his understanding of the right of privacy. He has argued that the right of privacy is not concerned with what acts the state is trying to prohibit but with what effects the state's prohibition has on people's lives.¹⁰⁰ According to Rubenfeld, the right of privacy seeks to protect individuals from laws that "tend to *take over* the lives of the persons involved . . . direct a life's development along a particular avenue . . . [and] inform the totality of a person's life."¹⁰¹ In applying this understanding to the withdrawal of life-sustaining treatment and suicide, Rubenfeld observes that, although it is difficult to distinguish between the *acts* of treatment withdrawal and suicide, "the two cases are utterly dissimilar . . . [w]ith regard to what is produced."¹⁰² The patient denied treatment withdrawal is forced into a "particular, . . . rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals."¹⁰³ Ruben-

⁹⁷ It is also true that these cases either were decided before the right to refuse life-sustaining treatment was established or were decided in part on the basis of other factors, including third party interests or the integrity of the criminal justice system. See, e.g., *Application of President & Dirs. of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir. 1964) (requiring 25-year-old to accept blood transfusion to treat severe blood loss from ruptured ulcer); *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 459-60 (Ga. 1981) (requiring pregnant woman to accept cesarean section if needed to prevent severe bleeding that would threaten lives of her fetus and herself); *In re Caulk*, 480 A.2d 93, 97 (N.H. 1984) (requiring 36-year-old healthy prisoner to accept forced feeding that would frustrate his efforts to starve himself to death to avoid potentially lifelong incarceration); *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670, 673 (N.J. 1971) (requiring 22-year-old to accept blood transfusion during surgery that was performed because her spleen was ruptured in automobile accident).

⁹⁸ 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).

⁹⁹ See *Compassion in Dying*, 79 F.2d at 821.

¹⁰⁰ Rubenfeld, *supra* note 98, at 783-84.

¹⁰¹ *Id.* at 784.

¹⁰² *Id.* at 795.

¹⁰³ *Id.*

feld distinguishes suicide by contrasting treatment withdrawal with the "ordinary" suicide," where a prohibition on suicide "does not, as a rule, direct lives into a particular, narrowly defined course."¹⁰⁴ Rubenfeld's explanation works only because it contrasts the typical case of withdrawal with the "ordinary" case of suicide. However, it does not work if we consider patients desiring suicide who are confined to a hospital bed and tended to by medical professionals (albeit not attached to medical machinery).

This discussion suggests that ideally we would permit some withdrawals of life-sustaining treatment and some assisted suicides but prohibit other treatment withdrawals and other assisted suicides. Each case would be judged on its own merits. In each case, a physician or someone else would decide whether the patient's decision that life is no longer worth living is a decision that society should respect.

However, it would be cumbersome and unwieldy to make that kind of individual judgment for each potential withdrawal of life-sustaining treatment and each assisted suicide. Every request for a do-not-resuscitate order would have to be individually assessed as would every refusal of a ventilator, feeding tube, dialysis, or any other life-sustaining treatment. More importantly, some representative of the state would need to have authority for deciding whether the withdrawal or the suicide should be permitted. It is not likely an authority that physicians or other persons would welcome, nor is it an authority that we would likely trust to physicians or other representatives of the state.¹⁰⁵ Judgments as to when a person's life has insufficient value is a judgment that can be made only by individuals for themselves.¹⁰⁶ Accordingly, while the right to refuse life-sustaining treatment once was viewed as existing only when society deemed a patient's prognosis as suitably dim and deemed a patient's care as particularly burdensome,¹⁰⁷ it has now become a right of virtually any patient to refuse virtually any treatment.¹⁰⁸

¹⁰⁴ *Id.*

¹⁰⁵ See Callahan, *supra* note 28, at 55.

¹⁰⁶ LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, § 15-11, at 1367-68 (2d ed. 1988) (observing that "having the state regularly make judgments about the value of a life" is "the worst kind of state paternalism"). To be sure, decisions to withdraw life-sustaining treatment are made for incompetent persons. There, however, it is generally a family member, friend or guardian who decides on the person's behalf, not someone representing the state's interests.

¹⁰⁷ See, e.g., *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) ("[T]he State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.").

¹⁰⁸ See *supra* note 94; see also George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DuQ. L. REV. 875, 876 (1996); Edward R.

Given the infeasibility of case-by-case judgments, we have relied on the "bright line" distinction between withdrawal and assisted suicide, a distinction that can be readily applied to specific cases and that has generally given the results that would have occurred if we had made individual assessments. For, in the vast majority of cases, withdrawal of life-sustaining treatment has been morally acceptable, and, at least until recently, the vast majority of assisted suicides have been morally problematic. The typical withdrawal case has involved a patient who is suffering greatly and will die shortly no matter what treatment is provided. Moreover, in such cases, the side effects of the treatment will likely outweigh the benefits. On the other hand, suicides frequently involve relatively young persons, like actress Marilyn Monroe or Clinton White House counsel Vincent Foster,¹⁰⁹ who lead seemingly productive and fulfilling lives and who could, with time and therapy, overcome their despondency and enjoy life for several more decades. In short, the distinction between withdrawal and assisted suicide has been based essentially on its usefulness as a proxy for distinguishing morally acceptable from morally unacceptable cases of physician assisted death. I am not making a normative judgment about whether this is good ethics or good law. Rather, I am making a descriptive judgment about *why* right-to-die law is as it is.¹¹⁰

Bright line rules are often used in ethics and the law. For example, all persons gain the right to vote at age eighteen. We could undertake a case-by-case assessment of adolescents to decide when they become mature enough to vote. However, it would be terribly burdensome for the government to make such judgments. Also, once we abandon bright line rules for case-by-case determination, we increase the chances of aggrievement among the public if people are treated differently than others whom they believe they are like, or of abuse by decision-makers. These are two reasons why the civil service has fixed salaries.

Society has also rejected case-by-case judgments with other kinds of health care decisions. For example, when hemodialysis was first developed to treat kidney failure there were not enough dialysis units available to treat everyone in need, and thus dialysis was rationed on a case-by-case basis. However, there was considerable discomfort with

Grant & Paul B. Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 OR. L. REV. 449, 460 (1995).

¹⁰⁹ Fifty-eight percent of all suicides in the United States in 1994 occurred among persons younger than 45 years of age. See THE WORLD ALMANAC AND BOOK OF FACTS 1996 964 (1995).

¹¹⁰ Understanding why the law has drawn the distinction between assisted suicide and withdrawal of life-sustaining treatment is critical to understanding how the law might evolve over time in response to the debate over the legalization of assisted suicide.

the decisions that were being made, particularly with the reliance by decision-makers on considerations of social class and social worth.¹¹¹ As a result, legislation was passed in 1972 that made Medicare funds available to cover kidney dialysis for virtually all patients with kidney failure.¹¹² The Oregon Health Plan has also taken a categorical approach to decision-making in its effort to ration health care for individuals covered by the plan. Under the Oregon plan, Medicaid covers fewer treatments than it did under Oregon's previous system, but it provides coverage for a much broader range of uninsured persons.¹¹³ In deciding what would be covered, the Oregon Health Services Commission ranked 696 different medical treatments in terms of benefit to patients, and the legislature approved funding for all treatments at 565 or above in the ranking.¹¹⁴ If a patient has an illness for which treatment is covered, the funding is available regardless of the particular patient's likelihood of benefitting from treatment. Variations among patients in terms of the severity of their illnesses do not affect the availability of coverage. Similarly, coverage is not affected by the presence of coexisting illnesses that may make the benefit from uncovered treatments greater than usual or the benefit from covered treatments smaller than usual.¹¹⁵ Because of the difficulties with case-by-case judgments, categorical judgments are often made instead.

III. BREAKING DOWN THE LEGAL DISTINCTION BETWEEN ASSISTED SUICIDE AND THE WITHDRAWAL OF LIFE-SUSTAINING TREATMENT

In recent years, the usefulness of the distinction between treatment withdrawal and assisted suicide has been undermined. There are many terminally ill persons who are suffering intractably but who are not dependent on life-sustaining treatment; a flat ban on assisted suicide therefore prevents many suicides that can be justified in terms of the considerations that are used to justify withdrawal of life-sustaining treatment. If we assessed each case on its own merits, we would find a significant number of persons desiring assisted suicide who have comparable medical conditions and who have exactly the same reasons for ending their lives as patients who request discontinuation of their

¹¹¹ See Roger W. Evans et al., *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 JAMA 487, 487 (1981).

¹¹² See *id.*

¹¹³ See Robert Steinbrook & Bernard Lo, *The Oregon Medicaid Demonstration Project—Will It Provide Adequate Medical Care?*, 326 NEW ENG. J. MED. 340, 340 (1992).

¹¹⁴ See David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 54 n.21 (1996).

¹¹⁵ See Steinbrook & Lo, *supra* note 113, at 342.

life-sustaining treatment.¹¹⁶ An opinion of the Ninth Circuit describes two of these patients. The first was a plaintiff in the case:

Jane Roe is a 69-year-old retired pediatrician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. Although she tried and benefitted temporarily from various treatments including chemotherapy and radiation, she is now in the terminal phase of her disease. . . . Jane Roe has been almost completely bedridden since June of 1993 and experiences constant pain, which becomes especially sharp and severe when she moves. The only medical treatment available to her at this time is medication, which cannot fully alleviate her pain. In addition, she suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.¹¹⁷

The second was a patient of a physician-plaintiff in the case:

One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares. Patient Smith's agonies could not be relieved by medication or by the excellent nursing care he received. . . . [H]e died after having been tortured for weeks by the end-phase of his disease.¹¹⁸

Oregon's statute and the decisions of the Second and Ninth Circuits were intended to reach patients like these. By redefining the right to die to include assisted suicide for terminally ill persons, the two circuit courts and Oregon ensure that patients who are hopelessly ill and who realize little benefit from treatment are not forced to remain alive against their wishes.

Our example of the twenty-eight-year-old and eighty-two-year-old also illustrates how the distinction between treatment withdrawal and suicide assistance has broken down. What is striking about that exam-

¹¹⁶ See Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1380 (1992).

¹¹⁷ *Compassion in Dying*, 79 F.3d at 794.

¹¹⁸ *Id.* at 814.

ple is the fact that the twenty-eight-year-old is *not* a very realistic example of a withdrawal of treatment case while the eighty-two-year-old *is* a reasonable example of a patient desiring physician assisted suicide. It is very rare for relatively healthy, mentally competent young persons to simultaneously become dependent on life-sustaining treatment and so despondent that they want to end their lives. It is not so rare, however, for a mentally competent older person to become terminally ill and experience suffering that is so severe and intractable that the person requests assisted suicide. Permitting withdrawal of treatment is still a good proxy for allowing patients to end their lives when they have morally justified reasons for wanting to do so. Denying assisted suicide is no longer a good proxy for preventing patients from ending their lives when they do not have morally valid reasons for wanting to do so.

The opinions of the Second and Ninth Circuits and the language of the Oregon statute indicate that their drafters were reformulating the categories of permitted and prohibited patient dying to create better proxies for justified and unjustified cases of patient death. The decisions and the statute all retain a bright-line, categorical approach to distinguishing between permissible and impermissible patient deaths: all terminally ill patients may choose a lethal dose of medication whether or not they are suffering greatly; neither the statute nor the two decisions qualify their grant of a right to assisted suicide in terms of the patient's degree of suffering.¹¹⁹ Conversely, no non-terminally ill patients may choose to end their lives with a lethal dose of medication even if they are suffering greatly. In addition, as before, all patients who desire withdrawal of life-sustaining treatment may choose that course whether or not they are suffering greatly. With the infeasibility of case-by-case determinations, the Second and Ninth Circuits and Oregon have chosen a new proxy to distinguish between permissible and impermissible patient deaths. This new proxy essentially reflects the view that the typical case in which a terminally ill patient desires suicide is a case in which the patient's death is morally justifiable.¹²⁰

¹¹⁹ See OR. REV. STAT. § 2.01 (1996 Supp.); *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996); *Compassion in Dying*, 79 F.3d at 793-94.

¹²⁰ Commentators have observed that physicians can never be certain that a patient is terminally ill. Among patients certified for hospice coverage under Medicare as having a life expectancy of less than six months, 15% survived for more than six months. See Nicholas A. Chistakis & Jose J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 NEW ENG. J. MED. 172, 174 (1996). Accordingly, some patients may choose assisted suicide on the mistaken impression that they have only a few months to live. This is a serious concern, and it can be remedied to a large extent by limiting suicide assistance to cases in which predictions of survival can be made with a high degree of certainty. Moreover, there is still no distinction

Moreover, the statute and the court decisions reflect the sense that what is critical for purposes of the patient's right to die is the patient's condition rather than whether death comes by treatment withdrawal or suicide. According to the Second Circuit, the state has little interest "in requiring the prolongation of a life that is all but ended," in requiring "the continuation of agony when the result is imminent and inevitable" or in interfering "when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness."¹²¹ The court also found no meaningful distinction between treatment withdrawal and suicide assistance, observing that "[t]he ending of life by [withdrawal of life support] is nothing more nor less than assisted suicide."¹²² The Ninth Circuit concluded that the strength of the patient's right to hasten death is "especially" dependent on "the individual's physical condition" and is at its highest when the patient is terminally ill and wishes to hasten death "because his remaining days are an unmitigated torture."¹²³ At the same time, "the state's interest in preventing such individuals from hastening their deaths [is] of comparatively little weight, but its insistence on frustrating their wishes seems cruel indeed."¹²⁴ Accordingly, the court wrote, "we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life."¹²⁵ Indeed, the Ninth Circuit expressed doubt "that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as 'suicide.'"¹²⁶ Similarly, the Oregon statute expressly states that "[a]ctions taken in accordance with [this Act] shall not, for any purpose, constitute suicide, *assisted suicide*, mercy killing or homicide."¹²⁷

An important question is how the acquittals of Dr. Kevorkian fit into my thesis. Many of the individuals whom Kevorkian has assisted with suicide were not terminally ill, including two of the five persons for whose deaths he was prosecuted.¹²⁸ Yet, he has always escaped conviction. Kevorkian has not employed a categorical approach in

between assisted suicide and treatment withdrawal. Imprecise diagnoses are also a concern for withdrawal of treatment. Patients may refuse life-sustaining treatment because they have mistakenly been told that they are terminally ill or that they will be dependent on artificial life support for the rest of their lives.

¹²¹ *Quill*, 80 F.3d at 729-30.

¹²² *Id.* at 729.

¹²³ *Compassion in Dying*, 79 F.3d at 834.

¹²⁴ *Id.* at 821.

¹²⁵ *Id.* at 824.

¹²⁶ *Id.*

¹²⁷ OR. REV. STAT. § 3.14 (1996 Supp.) (emphasis added).

¹²⁸ See Lessenberry, *supra* note 8.

deciding whom he will assist with suicide; rather, he has engaged in the kind of case-by-case determinations that I have argued are not feasible.

Kevorkian's experience is consistent with my argument. As discussed earlier, the chief objection to case-by-case judgments is that representatives of the state ought not to be making individualized judgments as to when a person's life is of such poor quality that the life no longer need be preserved.¹²⁹ Kevorkian's case-by-case approach has been accepted because he is not acting as a representative of the state; indeed, he is viewed as an advocate of patients who feel thwarted by the state. In addition, Kevorkian's acquittals suggest that the juries believed he was employing a case-by-case approach in a reasonable manner, and that he was making appropriate judgments as to whether a person's desire for his assistance was a morally justified one. As long as Kevorkian is perceived as acting in that way, he likely will continue to escape punishment. However, if he starts to assist suicides in what are viewed as morally unjustified cases, it is likely that he will be repudiated by the public.¹³⁰

IV. IMPLICATIONS FOR FURTHER DEVELOPMENTS IN RIGHT-TO-DIE LAW

If, as I argue, recognition of a right to physician assisted suicide follows from the principles that have driven right-to-die law for the past twenty years, will we also see further extensions of the right to die, as opponents of assisted suicide predict?¹³¹

The answer to this question will depend on whether society ends up with what it considers a good proxy when it permits anyone to reject life-sustaining treatment but permits only terminally ill patients to

¹²⁹ See *supra* text accompanying notes 105–15. In situations in which the state does make individualized determinations about the value of people's lives, as with imposition of the death penalty, it does so with procedures that are very formal and very deliberate. Indeed, it has become the norm for inmates to spend a decade on death row before their execution. See Conference, *The Death Penalty in the Twenty-First Century*, 45 AM. U. L. REV. 239, 303 (1995). Categorical judgments by the state are less problematic because the public can control the content of those judgments in a way that is not possible when representatives of the state make individualized judgments.

¹³⁰ Controversy over Kevorkian's 35th case of assisted suicide demonstrates that the public will react unfavorably if it appears that the deceased individual did not have a morally justified desire for death. In this case, there are allegations that the woman chose suicide because of a treatable depression and abuse by her spouse. See *Clash in Detroit Over How Ill a Kevorkian Client Really Was*, N.Y. TIMES, Aug. 20, 1996, at A13.

¹³¹ See Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 744–53 (1995) (discussing why it is likely that right to assisted suicide would be extended to include patients who are not terminally ill but suffering greatly and to include right

commit suicide with assistance. For society, a good proxy exists when the law would generally distinguish between morally acceptable and morally unacceptable decisions by patients to end their lives.¹³² In particular, we would again have a good proxy from society's perspective if the law *generally* would permit people to die when they are seriously, incurably and irreversibly ill but *generally* would not permit people to die when they are in good health or could be restored to good health.¹³³ Accordingly, if we still find that there are a substantial number of persons who should be allowed to die but are not allowed to do so, and there is a way to allow them to die without opening the door to other persons who should not be allowed to die, then the law will undergo further expansion. Conversely, if we find that permitting assisted suicide for terminally ill persons results in a large number of unjustified suicides, then the law will undergo contraction and restore the distinction between treatment withdrawal and suicide assistance.

Is it likely that we will see further expansion of the right to die? I will now consider the two most obvious areas for expansion.

A. *Permitting Euthanasia for Terminally Ill Persons*

If a terminally ill person enjoys a constitutional right to assisted suicide, must we then permit euthanasia for terminally ill persons?¹³⁴

to euthanasia); Scofield, *supra* note 23, at 483–84 (arguing that right to assisted suicide would not be limited to terminally ill patients).

¹³² See *supra* text accompanying notes 94–115.

¹³³ I emphasize that the proxies *generally* work. An unqualified right to refuse life-sustaining treatment means that otherwise healthy persons are permitted to refuse blood transfusions necessary to prevent death or serious disability. One reason why society may be willing to accept these apparent deviations from its sense of morality is that the cases generally involve a refusal of treatment based on religious reasons and therefore implicate First Amendment concerns. See, e.g., *Stamford Hosp. v. Vega*, 674 A.2d 821, 824–25 (Conn. 1996) (involving refusal of blood transfusion by Jehovah's Witness who had lost good deal of blood after delivering child vaginally); *Fosmire v. Nicoleau*, 551 N.E.2d 77, 78–79 (N.Y. 1990) (involving refusal of blood transfusion by 36-year-old Jehovah's Witness who was in good health except for loss of blood following cesarean section). In addition, while appellate courts typically recognize the right to refuse the transfusion, they often do so only after the person has received the transfusion because of an order by a lower court. See, e.g., *Vega*, 674 A.2d at 826; *In re Dubreuil*, 629 So. 2d 819, 821 (Fla. 1993); *Fosmire*, 551 N.E.2d at 79. The *Dubreuil* case is particularly striking because the Florida Supreme Court had previously held that a young woman could refuse blood transfusions even though she had minor children. *Public Health Trust v. Wons*, 541 So. 2d 96 (Fla. 1989). The only apparent difference between the *Dubreuil* and *Wons* cases was that Ms. Dubreuil was estranged from her husband while Ms. Wons was apparently living amicably with her husband. See *Dubreuil*, 629 So. 2d at 826. On the other hand, the Florida Supreme Court stated in *Wons* that "these cases demand individual attention. No blanket rule is feasible which could sufficiently cover all occasions in which this situation will arise." *Wons*, 541 So. 2d at 98.

¹³⁴ By euthanasia, I primarily refer to situations in which a physician or other person seeks

There may be terminally ill persons who are incapable of carrying out a life-ending act by themselves but who have exactly the same reasons for choosing death as other persons who can take a lethal dose of a drug. If the mechanism of ending life is not morally significant, but the justifications for ending life are morally determinative, then should there not also be a right to euthanasia?¹³⁵

However, the issue is not whether euthanasia can be distinguished from assisted suicide in principle. Rather, the issue is whether permitting euthanasia for the terminally ill is necessary to ensure a right to die for persons who are morally justified in their desire to end their life. It is unlikely that it would be necessary. Permitting euthanasia would be needed only if there are a sizeable number of terminally ill persons who are neither dependent on life-sustaining treatment nor able to self-administer a lethal dose of a drug. However, it is difficult to imagine that there are many persons who meet these conditions. Terminally ill persons who are too incapacitated to take a lethal dose of a drug are probably dependent on a life-sustaining treatment.

Indeed, the results of the referenda on assisted suicide in California and Washington also suggest that the public does not see euthanasia as necessary to ensure that patients can end their lives when they are morally justified in doing so. Both referenda would have legalized euthanasia as well as assisted suicide for terminally ill persons,¹³⁶ and both referenda were defeated by 54–46% margins.¹³⁷

B. *Permitting Assisted Suicide for Persons Who Are Not Terminally Ill*

As many proponents of assisted suicide observe, patients often experience great suffering before they become terminally ill; indeed, several of Dr. Kevorkian's patients were not terminally ill when they committed suicide with his assistance.¹³⁸ If the right-to-die reflects the individual's right to be free of inhumane suffering, then it is hard to distinguish in principle between persons who are terminally ill and those who are not.¹³⁹

to end the life of a patient by injecting the patient with a lethal dose of a drug. Euthanasia can also occur through other means, including suffocation or gunshot.

¹³⁵ See Miller et al., *supra* note 16, at 120 (proposing that physicians be allowed, under very limited circumstances, both to assist suicides and to perform euthanasia).

¹³⁶ See George J. Annas, *Death by Prescription: The Oregon Initiative*, 331 NEW ENG. J. MED. 1240, 1240 (1994).

¹³⁷ See Dolbee, *supra* note 5; Gross, *supra* note 4.

¹³⁸ See, e.g., TIMOTHY E. QUILL, *DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE* 162 (1993); Sedler, *supra* note 15, at 795.

¹³⁹ See Quill et al., *supra* note 116, at 1381.

While these points are well taken, the issue again is whether there is some categorical approach to permitting assisted suicide for persons who are not terminally ill without going too far. It would not work to permit assisted suicide for anyone who is experiencing "severe, unrelenting suffering"¹⁴⁰ because there is no objective way to measure suffering. All suicidal persons undoubtedly feel that they are experiencing severe and unrelenting suffering. If severe suffering were the criterion, then we would need physicians or someone else to make the kind of individualized judgments that we are trying to avoid.¹⁴¹

The right to assisted suicide could be extended beyond terminal illness categorically by permitting it for persons with certain severe illnesses. For example, persons with AIDS might be permitted to end their lives by assisted suicide. Similarly, persons diagnosed with amyotrophic lateral sclerosis might also be given a right to assisted suicide.¹⁴²

Whether this type of extension would occur is difficult to predict. First, it is not clear that extending the right to assisted suicide to patients who are not terminally ill would be necessary to ensure that individuals with a morally justified desire to die have the option to end their lives. Persons with AIDS or other serious diseases would enjoy a right to assisted suicide once they became terminally ill. Moreover, a person with AIDS or another disease might develop a life-threatening but treatable bacterial infection before becoming terminally ill. If death were desired, the individual could refuse treatment for the infection.

Second, it is not clear that extending the right to assisted suicide would limit assisted suicide largely to patients who have a morally justified desire to end their lives. As AIDS is becoming more treatable, for example, many persons in the early stages of AIDS may not be condemned to a life of great suffering. Requiring that the AIDS be terminal is a way to distinguish among persons with AIDS in terms of whether their desire for death is likely to be morally justified. The question, then, is whether there is some earlier, reasonably objective stage of AIDS or other diseases that is highly predictive of great suffering without hope for recovery. If there is, then it is possible that the

¹⁴⁰ *Id.*

¹⁴¹ See *supra* text accompanying notes 105–15.

¹⁴² Amyotrophic lateral sclerosis (ALS), or Lou Gehrig's disease, is a fatal degenerative disease of the nervous system that affects the nerves controlling voluntary muscle movement. The disease, whose cause is unknown, gradually leaves people unable to move their muscles. Ultimately, this means not only that they cannot move their arms or legs but also that they cannot swallow, speak intelligibly or breathe. Death usually occurs within a few years from inadequate lung function combined with a lung infection. See Robert B. Layzer, *Degenerative Diseases of the Nervous System*, in CECIL TEXTBOOK OF MEDICINE 2050, 2053–54 (J. Claude Bennett & Fred Plum eds., 20th ed. 1996).

right to assisted suicide might be extended to include persons at that earlier stage of AIDS or other diseases.

CONCLUSION

The recognition of a right to assisted suicide by Oregon and the United States Courts of Appeals for the Second and Ninth Circuits is likely to be followed by other courts and states because their new proxy for morally justified deaths reflects a widely shared sentiment. Public opinion polls have consistently demonstrated majority support for assisted suicide for terminally ill patients.¹⁴³ Physician opinion polls demonstrate the same majority support.¹⁴⁴ Moreover, when assisted suicide referenda are rejected, as in California and Washington, the vote has apparently reflected concern with the adequacy of safeguards and the scope of the referenda rather than opposition to assisted suicide for terminally ill patients *per se*.¹⁴⁵ This is not to say that public opinion provides moral justification for physician assisted suicide. Again, my argument is descriptive, not normative. As the existence of capital punishment in this country suggests, laws are driven as much by public sentiment as by moral argument.

Because of the widely shared social sentiment in favor of some role for physician assisted suicide, the United States Supreme Court's upcoming decision on the existence of a constitutional right to assisted suicide will only determine how soon a legal right to assisted suicide is established. Even if the court finds no constitutional right, laws permitting assisted suicide in limited circumstances will likely be adopted widely because such laws will once again bring society's laws more closely in line with society's moral values.

¹⁴³ See Kadish, *supra* note 57, at 860; Quill et al., *supra* note 116, at 1381.

¹⁴⁴ 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).

¹⁴⁵ See Rob Carson, *Washington's I-119*, 22(2) HASTINGS CENTER REP. 7, 9 (1992); Dolbee, *supra* note 5. The California and Washington measures both would have permitted euthanasia as well as assisted suicide. See *supra* text accompanying notes 135–36; see also Annas, *supra* note 108, at 1240.

