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Abstract

In a famous 1958 article, Yale Kamisar brilliantly examined the hazards of abuse and of slippery slope extensions that subsequently, for 46 years, served to thwart legalization of physician-assisted death (PAD). This paper shows that during the same period law and culture have effectively accepted a variety of ways for stricken people to hasten death, with physicians involved in diverse roles. Those ways include rejection of nutrition and hydration, terminal sedation, administration of risky analgesics, and withholding or withdrawal of medical life support.

If these existing lawful modes of hastening death were widely acknowledged, the pressure to legalize voluntary active euthanasia and assisted suicide would diminish. These modes secure a relatively tranquil death after a maximum period of approximately 10 days lingering in an insentient state. At the same time, I contend, these lawful modes of hastening death are so akin to suicide and euthanasia as to render anomalous the present ostensible prohibitions of physician-assisted death. Perhaps it is time to acknowledge that not all forms of assisted suicide and active euthanasia are criminal and unethical.

And what about Yale Kamisar's projections of abuse and distasteful extensions of voluntary medical decisionmaking? The 46 years of safe utilization of the above modes of hastening death belie the projection that PAD would ineluctably be abused. At the same time, current surrogate decisionmaking about end-of-life issues affecting now-incompetent patients tends to confirm Kamisar's predictions about extensions of PAD to the chronically afflicted (as opposed to the terminally ill) and to incompetent patients. The thesis of this paper, though, is that these extensions, rather than being alarming, are a salutary part of making death with dignity a genuine possibility for fatally stricken persons.

ON KAMISAR, KILLING, AND THE FUTURE OF PHYSICIAN-ASSISTED DEATH

*Norman L. Cantor**

Tens — perhaps hundreds — of thousands of trees could have been spared over the last forty-five years had opponents of physician-assisted death only been content to let Yale Kamisar be their exclusive spokesperson. Their movement would have lost no significant substance or persuasive force, for Kamisar's 1958 article — *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*[1] — presaged the shape and content of the subsequent forty-five year debate over legalizing physician-assisted death ("PAD").[2] Kamisar's article preceded by years the development of a whole jurisprudence relating to the withholding/withdrawing of life-sustaining medical treatment ("LSMT") and the administration of pain-relief substances alleviating physical suffering while risking accelerated death.[3] That article demonstrated remarkable prescience and intellectual honesty while shaping the content of opposition to PAD.

Kamisar continued to participate in the debate for decades thereafter,[4] always exhibiting remarkable intellectual honesty and

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1. 42 MINN. L. REV. 969 (1958) [hereinafter Kamisar, *Non-Religious Views*].

2. Some sources carefully differentiate between assisted suicide and euthanasia on the basis that assisted suicide is less subject to abuse because the suicide herself rather than a physician performs the final lethal act. An emphasis on physician-assisted suicide surfaced primarily in the 1990s. Kamisar's 1958 piece preceded the shift in emphasis to assisted suicide, and he originally preferred the term physician-assisted death ("PAD") to cover both assisted suicide and euthanasia. I, too, will primarily refer to PAD because there are so many common issues touching assisted suicide and euthanasia. Where appropriate, I will refer specifically to physician-assisted suicide ("PAS") or voluntary active euthanasia ("VAE").

3. That jurisprudence is generally traced to In re *Quinlan*, 355 A.2d 647 (N.J. 1976). *See generally* Norman L. Cantor, *Twenty-five Years after* Quinlan*: A Review of the Jurisprudence of Death and Dying*, 29 J. L. MED. & ETHICS 182 (2001) [hereinafter Cantor, *Twenty-five Years after* Quinlan].

4. Yale Kamisar, *Active v. Passive Euthanasia: Why Keep the Distinction?*, TRIAL, Mar. 1993, at 32 [hereinafter Kamisar, *Active v. Passive Euthanasia*]; Yale Kamisar, *Against Assisted Suicide — Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735 (1995) [hereinafter Kamisar, *Against Assisted Suicide*]; Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CENTER REP., May-June 1993, at 32 [hereinafter Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*]; Yale Kamisar, *On the*

insight. Kamisar's special insights started with his prediction about the legal status of a physician's withholding of LSMT. Years before cases addressing this issue emerged, he correctly anticipated that a physician's failure to provide LSMT might be treated as homicide by omission in light of a physician's affirmative fiduciary duty to the patient.[5] He also foresaw that the fiduciary obligation would not rigidly dictate maintenance of medical life support in the face of a competent patient's request to withhold or withdraw LSMT. Later, he correctly forecast that the Supreme Court would refuse to find assistance in suicide to be a fundamental liberty and would instead leave regulation of physician-assisted suicide ("PAS") to the states.[6]

Kamisar established his unwavering honesty with his 1958 concession that PAD could be morally correct. He boldly stated that he would "hate to have to argue" the moral case against PAD for an irremediably stricken patient suffering intolerably and expressing a fixed and considered desire to die.[7] Kamisar also conceded that a physician's cooperation with a patient's rejection of LSMT was morally equivalent to PAD, at least where the cooperating physician intended to bring about death. For him, no moral difference existed between pulling a plug and providing a poison or giving a fatal injection. "As a matter of logic," he wrote, the analogy between PAD and ending LSMT was appealing.[8] He believed that neither form of hastening death — withdrawal of LSMT or PAD — was intrinsically immoral.[9] (All this doesn't mean that Kamisar thought that the legal

Meaning and Impact of the Physician-Assisted Suicide Cases, 82 MINN. L. REV. 895 (1998) [hereinafter Kamisar, *On the Meaning and Impact*]; Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, *in* EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES 225 (John Keown ed., 1995) [hereinafter Kamisar, *PAS: The Last Bridge*]; Yale Kamisar, *Physician Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121 (1998) [hereinafter Kamisar, *PAS: The Problems Presented*]; Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide — And Why These Reasons Are Not Convincing*, 12 ISSUES IN L. & MED. 113 (1996) [hereinafter Kamisar, *The Reasons So Many People Support PAS*]; Yale Kamisar, *The 'Right to Die': On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481 (1996) [hereinafter Kamisar, *The 'Right to Die'*]; Yale Kamisar, *The Rise and Fall of the 'Right' to Assisted Suicide*, *in* THE CASE AGAINST ASSISTED SUICIDE, 69 (Kathleen Foley & Herbert Hendin eds., 2002) [hereinafter Kamisar, *The Rise and Fall of the 'Right' to Assisted Suicide*]; Yale Kamisar, *When Is There a Constitutional "Right to Die"? When is There* No *Constitutional "Right to Live"?*, 25 GA. L. REV. 1203 (1991).

5. Kamisar, *Non-Religious Views*, *supra* note 1, at 982-83 n.41.

6. Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 124-25.

7. Kamisar, *Non-Religious Views*, *supra* note 1, at 975.

8. Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, *supra* note 4, at 35 (emphasis in original).

9. *E.g.*, Kamisar, *Active v. Passive Euthanasia*, *supra* note 4, at 35. He agreed with Joseph Fletcher that " '[a] deliberate act of omission, when death is the goal . . . is morally the same [as] a deliberate act of commission.' " *Id.* at 36 (alteration in original) (quoting Joseph Fletcher, Remarks at the Seventh Annual Euthanasia Conference (Dec. 7, 1974), at 5, 8).

handling of PAD and removal of LSMT ought to be identical. His ultimate position will be examined in more detail below in the section on "Killing versus Letting Die").

Kamisar was also appropriately skeptical about hinging legal prohibition on a physician's state of mind or specific intent in the context of end-of-life decisionmaking.[10] He observed that a physician-actor's motives run a gamut, are sometimes mixed, and are almost always difficult to identify.[11] (He could not have anticipated that some later commentators would try to distinguish medical practices like removal of life support and administration of potentially fatal analgesics from PAD primarily on the basis of physicians' intentions). That skepticism about specific intent later helped him resolve for himself the tension between PAD and administration of risky analgesics.[12]

Kamisar showed remarkable prescience in identifying the "practical issues" that would ultimately form the crux of the dispute over legalization of PAD. For him, the benefit of PAD was expeditious relief from prolonged suffering.[13] That important benefit, however, had to be considered together with several other factors. The need for PAD depended on availability of alternative means of mitigating suffering like palliative or analgesic techniques as well as alternative legal means to hasten the death of a suffering patient.[14] The possible benefits of PAD had to be weighed against certain "utilitarian obstacles"[15] — abuse of vulnerable patients in the administration of PAD and unsavory extensions of PAD beyond the realm of voluntary active euthanasia of competent patients nearing the end of a painful dying process. These predicted abuses would take the form of "unwilling or manipulated death[s] of the most vulnerable members of society."[16] Some abuse would flow from medical mistake in diagnosis or mistake in assessing the competence of patients seeking PAD. Kamisar wondered how stricken patients facing terrible stress, pain, or effects of narcotic analgesics could possibly make careful, considered judgments about PAD.[17] Clinicians might also needlessly make PAD

10. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 255-56 n.80.

11. Kamisar, *Non-Religious Views*, *supra* note 1, at 980.

12. *See infra* notes 217-219 and accompanying text.

13. Kamisar, *Non-Religious Views*, *supra* note 1, at 1008.

14. *Id*. at 1005-07. He noted the emergence of palliative medicine and the fact that competent persons are normally able to commit suicide without legal penalty. *Id*. at 1009-11.

15. *Id*. at 974.

16. Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 116 (quoting Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on* Roe*,* Casey*, and the Right to Die*, 44 AM U. L. REV. 803, 807 (1995)).

17. Kamisar, *Non-Religious Views*, *supra* note 1, at 976-77, 985-87.

an attractive option by failing to perceive treatable depression or by under-treating pain.[18] Stricken patients would be susceptible to subtle pressures that might coerce them into agreeing to PAD. Those pressures might come from surrounding family facing the emotional and financial burdens of a deathwatch or from health-care providers burdened with caretaking tasks.[19] Or the patient's own consciousness of surrounding people bearing burdens of caretaking might generate pressure to seek PAD.[20]

Another hazard troubled Kamisar from the start: his conviction that legalization of voluntary PAD would inexorably result in unsavory extensions. Proponents of euthanasia (as well as later proponents of PAS) pushed only for legalization of PAD for competent patients facing a terminal illness. Kamisar perceived these ostensibly limited objectives as a strategic move to cultivate public opinion and insert a legal wedge leading to further extensions.[21] He was most wary of a slippery slope leading to nonvoluntary euthanasia, remarking in 1958: "Miss Voluntary Euthanasia is not likely to be going it alone for very long."[22] He recounted the horrific progression of what the Nazis had deemed mercy killing and recounted how some American proponents of euthanasia had wanted to euthanize mentally disabled persons and other "social detritus."[23] He worried about the medical fate of " 'the drooling, helpless, disoriented old man or the doubly incontinent old woman lying log-like in bed.' "[24] Kamisar concluded that, on balance, the potential abuses of voluntary PAD combined with extensions to "far more objectionable practices," outweighed the utility of PAD in relieving the suffering of some patients who genuinely did want to die.[25]

Kamisar's 1958 article, *Some Non-Religious Views*, has had an amazing impact over the last forty-five years. It may not have been cited as often as the classic article by Warren and Brandeis on the right to privacy,[26] but it was probably more successful in accomplishing its

18. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 243; Kamisar, *PAS: The Problems Presented*, *supra* note 4, at 1132; Yale Kamisar, *An Unraveling of Morality*, N.Y. TIMES, Nov. 5, 1991, at A25.

19. Kamisar, *Non-Religious Views*, *supra* note 1, at 990.

20. *Id.* at 990-91. Later, this possibility of altruistic or guilty impulses prompting choice of PAD became known as creation of a duty to die — patient perception of choosing death as "the 'right' thing to do." Kamisar, *PAS: The Problems Presented*, *supra* note 4, at 1134-35.

21. Kamisar, *Non-Religious Views*, *supra* note 1, at 1016-17.

22. *Id*. at 1031.

23. *Id*. at 1019, 1031-35.

24. *Id*. at 1026 (quoting Banks, *Euthanasia*, 26 BULL. N.Y. ACAD. MED. 297, 305 (1950)).

25. *Id*. at 1042.

26. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193 (1890) (generally considered the most cited law review article ever).

objectives.[27] Kamisar's article, with its emphasis on "utilitarian obstacles" to PAD, has not only framed the discourse over the last forty-five years, but also successfully influenced the outcome of the debate. Subsequent commentators have followed Kamisar's format by focusing on the practical consequences of legalization rather than intrinsic immorality.[28] The New York State Task Force on Life and the Law, probably the most comprehensive examination of PAD ever done, relied on the consequentialist arguments first articulated by Kamisar.[29] Successful opponents of state voter initiatives to legalize PAD have uniformly focused on the asserted hazards of abuse and lack of procedural safeguards.[30]

The impact of Yale Kamisar's opposition to PAD is undisputable. The harder question is whether, in light of post-1958 developments, Kamisar pushed in the right direction. Kamisar's initial posture preceded a number of developments: a) new and improved medical technologies capable of sustaining lives well beyond the point that many people would desire; b) evolution of jurisprudence and medical ethics governing the withholding and withdrawal of LSMT; c) sophisticated palliative care techniques, especially drugs capable of both mitigating pain and hastening death; d) a shift in typical causes of death from virulent diseases to slower, progressive conditions carrying the prospect of lingering in a gravely debilitated state; e) changes in the nature and financing of the doctor-patient relationship away from a long-term relationship rendered on a fee-for-service basis and toward managed care carrying disincentives for expensive medical interventions; and f) acceptance of voluntary euthanasia or assisted suicide in the Netherlands, Belgium, Germany, Switzerland, and Oregon. Those developments prompt this reexamination of PAD

27. The Warren-Brandeis article, with its emphasis on private control over public image and the insulation of personal life from public view, found a more responsive audience in Europe than it did in America. *See* James Q. Whitman, *The Two Western Cultures of Privacy: Dignity Versus Liberty*, 113 YALE L.J. 1151 (2004). Whitman asserts that the right to privacy as envisioned by Warren and Brandeis "amounts to little in American practice today." *Id*. at 1204.

28. *E.g.*, Felicia Cohn & Joanne Lynn, *Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide*, *in* THE CASE AGAINST ASSISTED SUICIDE 238 (Kathleen Foley & Herbert Hendin eds., 2002); Carl H. Coleman, *The New York State Task Force on Life and the Law: Why It Concluded Physician-Assisted Suicide Should Not be Legalized*, 12 ST. JOHN'S J. LEGAL COMMENT. 647, 650-51 (1997); Robert I. Misbin, *Physicians' Aid in Dying*, 325 NEW ENG. J. MED. 1307, 1309 (1991). Other commentators, including John Arras, Dan Callahan, and David Pratt have opposed legalization of PAD primarily because of the hazards of abuse.

29. N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 117-48 (1994).

30. This was true in California, Washington, Michigan, and Maine where the initiatives lost, as well as in Oregon where the initiative got voter approval. David J. Mayo & Martin Gunderson, *Vitalism Revitalized: Vulnerable Populations, Prejudice, and Physician-Assisted Death*, HASTINGS CENTER REP., Jul-Aug. 2002, at 14, 15.

forty-five years after Kamisar's landmark piece. I will argue that, while prohibitions on PAS and voluntary euthanasia ostensibly prevail, a variety of lawful means of hastening death exist that render the legal prohibitions of PAD anomalous.

Part I considers the theoretical tensions between the prevailing ban on PAD and the jurisprudence authorizing rejection of life support and administration of risky analgesics. How sound is the prevailing distinction between killing and letting die? And how convincing is the claim that any benefit from PAD would be outweighed by accompanying risks of abuse? Part II reflects on the ultimate bounds of legalization of PAD. Are the envisioned extensions of voluntary patient choice inevitable and, if so, are they as objectionable as portrayed? Finally, Part III reexamines opposition to any legalization of PAD in the light of existing lawful means of hastening death. I argue that existing commentary on PAD misconceives the moving force behind the legalization movement as compassion (relief of suffering) rather than provision of medical handling that allows fatally afflicted people to preserve their personal visions of a dignified death. Autonomy, constructive preference,[31] and dignity are the crucial objects. And those objects point to avoidance of a lingering, severely debilitated dying process as patients' primary concern.

Kamisar's position opposing PAS and VAE may hold up as a matter of legal formality. Ironically, that is so only because law and medical mores have found ways to circumvent those prohibitions and to allow various means of hastening death. American law and culture have in essence accepted various forms of physician-assisted suicide or euthanasia and perhaps it is time to acknowledge that fact.

I. ON KILLING VERSUS LETTING DIE

The prevailing legal framework in the United States differentiates sharply between physician conduct withdrawing LSMT (thereby prompting death) and conduct providing or administering a lethal substance. The patient's voluntary rejection of treatment in the former makes the physician's conduct legal, while the voluntary request to hasten death in the latter fails to legalize the physician's conduct.[32] This sharp differentiation dates to the cases from the 1960s and 1970s upholding a competent patient's prerogative to reject LSMT. Those cases insisted that doctors implementing a patient's rejection of LSMT

31. Constructive preference refers to an effort to project what a now-incompetent medical patient would want done in the circumstances now being faced. That approach is applicable to formerly competent persons who have not left clear-cut instructions regarding their own end-of-life medical choices. *See infra* notes 183-184 and accompanying text.

32. *See* Norman L. Cantor, Glucksberg, *The Putative Right to Adequate Pain Relief, and Death with Dignity*, 34 J. HEALTH L. 301, 305-07 (2001) [hereinafter Cantor, Glucksberg].

were not assisting suicide or performing euthanasia.[33] Rather, they were respecting the patient's self-determination and bodily integrity. Accordingly, withdrawal of LSMT merely allowed a natural dying process to occur while administration of a lethal substance precipitated death by unnatural means and constituted unlawful killing. Does the dichotomy hold up? Are there good reasons to honor a stricken patient's request to remove life support but not to receive a lethal substance?

A. *State of Mind*

One explanation for distinguishing removal of life support relies on the physician actor's purported state of mind when removing the LSMT. This explanation draws a normative line between intentionally killing another and merely discontinuing care.[34] According to this version, in the context of LSMT the cooperating physician's "intent is not to bring about the patient's death but to respect the patient's wishes not to be subjected to undesired treatment."[35] The accompanying assumption is that PAD inevitably entails a specific intention by the cooperating physician to bring about death. In 1997, five members of the Supreme Court accepted this distinction in rejecting physicians' and patients' claims that the different legal treatment of removal of LSMT and physician-assisted suicide was arbitrary. The opinion by Chief Justice Rehnquist noted the state-of-mind distinction as one reason to deem the divergent legal treatment rational.[36] He insisted that in removing LSMT the physician intends only to respect the patient's wishes or to cease doing degrading things to the patient while in providing a poison the physician "indubitably" intends primarily to make the patient dead.[37]

While comprehensible, the state-of-mind distinction is misguided because it largely does not reflect reality. Though some fatally stricken patients reject LSMT simply in order to avoid a burdensome medical intervention (e.g., dialysis) and thus have no intent to die, many others do intend to end their existence. These dying patients have

33. *E.g.*, Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977).

34. LEON KASS, LIFE, LIBERTY AND THE DEFENSE OF DIGNITY 207-08 (2002).

35. Cohn & Lynn, *supra* note 28, at 247. Note that the patient's own intention is assumed to be avoidance of burdensome treatment rather than a wish to die. The patient's wishes are relevant to understanding the physician's reasons for cooperating with the patient.

36. Vacco v. Quill, 521 U.S. 793 (1997).

37. *Id.* at 802. The Chief Justice's statement is a close paraphrase of Leon Kass's position as articulated in Leon R. Kass, *'I Will Give No Deadly Drug': Why Doctors Must Not Kill*, *in* THE CASE AGAINST ASSISTED SUICIDE 17, 37 (Kathleen Foley & Herbert Hendin eds., 2002).

deteriorated to an intolerable level (e.g., last stages of ALS or AIDS) and their rejection of LSMT is made with the intention of precipitating death.[38] Their object is "to allow death to occur, to end an existence that no longer benefits the patient."[39] These patients have a suicidal state of mind — a specific wish to die — when they reject LSMT. This is perhaps most obvious when patients reject mostly painless artificial nutrition and hydration ("ANH"); they are certain to die and are not seeking to avoid any burdensome discomforts associated with the ANH treatment they cease.[40]

A physician's cooperation with a suffering patient's rejection of LSMT with the intent to die accounts for the common references to withholding or withdrawing of life support as voluntary "passive euthanasia."[41] It is deemed passive because the patient is seeking relief from suffering not by means of a poison or injection, but rather by removal of life support. And it is euthanasia because, while some cooperating physicians may only be respecting the patient's prerogative to resist treatment, many others in removing LSMT share the patient's object to hasten death.[42] "Compassionate critical care clinicians may often wish that death would come quickly in the setting of withholding or withdrawing life-sustaining treatments for the sake of patients and their families . . . ."[43] Take withdrawal of ANH. As one commentator asks: "Why else, in practice, is a doctor likely to withhold/withdraw tube-feeding from a patient whose life he thinks is no longer a benefit [to the patient] except in order to put an end to that life?"[44] While some such physicians may be respecting their patients' wishes without embracing their objects to die, and others might be seeking to avoid a burdensome treatment (as where ANH might prompt aspiration pneumonia), many physicians intend to

38. Such a patient's motive for seeking death may vary. Emotional suffering, intolerable indignity, or desire to spare loved ones' additional burdens are all plausible motives. The point is that a patient rejecting LSMT often seeks death and wants to die.

39. Alexander Morgan Capron, *Death and the Court*, HASTINGS CENTER REP., Sept.-Oct. 1997, at 27-28. "[M]any patients who want treatment discontinued know that they will die without it and . . . clearly express a desire to end their suffering [by dying]." Note, *Physician-Assisted Suicide and the Right to Die With Assistance*, 105 HARV. L. REV. 2021, 2030 (1992).

40. For confirmation that death by dehydration need not be a painful or burdensome process, see *infra* notes 204-212 and accompanying text.

41. JOHN KEOWN, EUTHANASIA, ETHICS, AND PUBLIC POLICY 215 (2002).

42. Yale Kamisar, *The Right to Die?*, L. QUADRANGLE NOTES, Fall 1988, at 7.

43. Graeme M. Rocker & J. Randall Curtis, *Caring for the Dying in the Intensive Care Unit*, 290 JAMA 820, 821 (2002).

44. KEOWN, *supra* note 41, at 247. Removal of life support from a permanently unconscious patient most clearly denotes intent to hasten death. There, the physician cannot be withdrawing a burdensome mode of treatment from a patient (though in theory the physician actor might only be respecting the patient's previously articulated wishes).

hasten their patients' deaths.[45] Data from the Netherlands support the thesis that physicians removing life support often do so with this specific intention.[46]

Yale Kamisar, with characteristic intellectual honesty, always acknowledged that many removals of life support occur with the intention by both patient and physician of hastening death. He had always been "greatly troubled" by social willingness to accept this form of passive euthanasia,[47] for he understood the theoretical tension between legal authorization of removal of life support with intent to cause the patient's death and banning PAD.[48] He could not accept the notion that the patient lacked specific intent to die or that the physician only wanted to avoid burdensome treatment — especially in the context of cases where the patient's condition had stabilized and life support was being removed solely because the patient sought to die.[49] Kamisar had always been suspicious of having legality depend on the specific intent of a physician because he understood the frequent presence of mixed intentions and the difficulty of discerning actual intention in the context of end-of-life medical intervention.[50] He accepted the fact that passive euthanasia had become a fait accompli in modern medicine and only sought to confine euthanasia to those narrow bounds.[51] In other words, although Kamisar supported the distinction Chief Justice Rehnquist attempted to draw, he rejected the court's rationale that physicians who remove life support do not intend to hasten death.

The converse claim on which Rehnquist also depends — that physicians participating in PAD always intend to cause death — is also faulty, though not as obviously so. Alternative states of mind might accompany a physician's participation in PAD. Where intolerable suffering, for example, prompts a patient's request for euthanasia or assistance in suicide a cooperating physician might only intend to relieve suffering. David Orentlicher claims: "A lethal dose of a drug is

45. Douglas O. Linder, *The Other Right-to-Life Debate: When Does Fourteenth Amendment 'Life' End?*, 37 ARIZ. L. REV. 1183, 1202 (1995) ("Withdrawal of food and hydration . . . is an action *aimed* at death in a way that is not unlike the administration of a lethal injection.").

46. Henk Jochemsen, *Dutch Court Decisions on Nonvoluntary Euthanasia Critically Reviewed*, 13 ISSUES IN L. & MED. 447, 450 (1998) (reporting on a 1995 study indicating that about 10% of deaths in the Netherlands resulted from removal of LSMT with the intention to hasten death); *see also* KEOWN, *supra* note 41, at 129 (claiming that two-thirds of Dutch physicians' withdrawals of LSMT have the specific purpose of hastening death).

47. Kamisar, *The 'Right to Die,' supra* note 4, at 491.

48. *See supra* note 7 and accompanying text.

49. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 244, 255 n.80; *see supra* note 7 and accompanying text.

50. Kamisar, *Non-Religious Views*, *supra* note 1, at 980.

51. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 244.

prescribed not to kill the patient but to relieve the patient's suffering."[52] Thus, the intention only to relieve suffering (without seeking death) is at least possible. The likelihood is that the physician's intentions are mixed, for if death is the only way to relieve suffering it seems natural for the physician both to want to relieve suffering and to want the patient to die as quickly as possible. Some commentators also contend that doctors administering large doses of painkillers, knowing that the substances will cause death, may still only be intending to relieve suffering.[53] A physician's large morphine dose may be delivered with the desire to provide permanent relief (by hastening death).

Even a physician who prescribes a poison might not intend to shorten the life of a dying patient. By providing a poisonous substance, the physician may intend to give the patient control over her time of death and thereby relieve the patient's anxiety about unavoidably dying in intolerable pain. Such a physician would provide the lethal substance with the hope and intention that the patient would never use it. Indeed, George Annas has claimed that assisted suicide is legal so long as the physician supplying a lethal substance hopes that the patient won't use it.[54]

In short, the attempt to distinguish LSMT from PAD on the basis of the physician-actor's state-of-mind fails. Some withdrawals of treatment are performed with the intention of bringing about death. Conversely, some physician actions terminating a patient's life may be accompanied by an intent to end suffering rather than an intent to end life. Because of the largely indeterminate physician state of mind in these contexts (such as administration of risky analgesics),[55] the President's Commission in 1983 noted the "substantial potential for unclear or contested determinations" and concluded that making state of mind the key determinant "does not help."[56]

52. David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663, 664 (1996). As noted, Kamisar saw practical reasons for banning PAD. *See supra* notes 13-16 and accompanying text; *infra* notes 58-61 and accompanying text.

53. KASS, *supra* note 37, at 37; *see infra* notes 220-222 and accompanying text.

54. George J. Annas, *The Bell Tolls for a Constitutional Right to Physician-Assisted Suicide*, 337 NEW ENG. J. MED. 1098, 1101 (1997). I doubt that the avoidance of assisted suicide prohibitions can be so simple. A prosecutor might still seek to prove intention to assist a suicide, or the physician might be accused of reckless conduct in violation of professional standards.

55. Part of good palliative medical care is the provision of opioid analgesics that may risk hastening death. This active medical intervention hastening death evokes the image of euthanasia. Some commentators rely on the treating physician's state of mind to explain a distinction. That is a distinction that I discredit. *See infra* notes 220-224 and accompanying text.

56. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 78-82 (1983).

B. *Letting Nature Take Its Course*

Popular wisdom claims (and courts sometimes agree) that there's an important difference between PAD, which involves active intervention to hasten death, and removal of life support, which involves letting a natural disease process run its course. For example, the Michigan Supreme Court commented, in rejecting a constitutional challenge to the state's ban on physician-assisted suicide: "There is a difference between choosing a natural death summoned by an uninvited illness . . . and deliberately seeking to terminate one's life by resorting to death-inducing measures . . . ."[57] As we've just seen, the difference cannot simply be the patient's or the physician-actor's state of mind. So if both forms of causing death occur in the context of a competent dying patient who seeks relief in death, what real difference does it make whether PAD or removal of life support is used?

Yale Kamisar has never found any major distinction between PAD and LSMT. He does not dispute Joseph Fletcher's assertion that "[a] deliberate act of omission, when death is the goal . . . is morally the same [as] a deliberate act of commission."[58] For Kamisar, the differential legal treatment of PAD and LSMT is "neither perfectly neat nor perfectly logical."[59] Yet, he strongly favors continuation of the current legal framework. He regards the differential legal treatment as "a cultural and pragmatic compromise" between a societal desire to respect the wishes of seriously ill people seeking relief and a need to protect weak and vulnerable afflicted people.[60] (Recall that Kamisar's 1958 antipathy toward PAD was primarily grounded on "pragmatic" apprehensions about abuses that would flow from legalization of PAD.) He also perceives that medical practice has institutionalized the PAD/LSMT distinction.[61]

Others seek more theoretical rationales than Kamisar's practical accommodation. Causation in fact is sometimes cited as the explanation for the different legal status of PAD and rejection of LSMT. The contention is that when a physician allows nature to take its course the underlying disease process is the proximate cause of death but when active conduct such as a lethal injection accelerates

57. People v. Kevorkian, 527 N.W.2d 714, 728-29 (Mich. 1994); *see also* Washington v. Glucksberg, 49 F.3d 586, 592-93 (9th Cir. 1995) (asserting a moral distinction between letting a patient die and taking a life via a poison).

58. Kamisar, *Active v. Passive Euthanasia*, *supra* note 4, at 36 (quoting Joseph Fletcher, Remarks at the Seventh Annual Euthenasia Conference (Dec. 7, 1974), at 5, 8).

59. Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 127.

60. *Id*. at 128.

61. "The distinction between managing medical intervention and resorting to external death-causing agents has become an integral part of the medico-legal landscape." Yale Kamisar, *Law, Morality and Death*, L.A. DAILY J., Nov. 3, 1992, at 6.

death, physician action is the proximate cause.[62] This explanation is unconvincing. It's true that when LSMT is withheld or withdrawn one cause in fact of death is the underlying disease process. When a physician removes LSMT that was capable of sustaining the patient's life, however, the physician is also hastening death and the physician conduct will be considered the proximate cause of death depending on whether his or her conduct is legally justified. Suppose a physician disconnects a respirator without the consent of a competent patient and thereby precipitates the patient's untimely death. Without question, the physician's conduct removing LSMT is a proximate cause of death (even though the underlying pulmonary condition is the natural cause of death), and the physician is guilty of homicide. It is only the legal judgment that the physician has no duty to continue life support that alters the physician's legal responsibility for a killing, not the matter of causation.[63] The same is true of withholding critical life support. If the physician has a professional and legal responsibility to provide LSMT, a physician's unjustified withholding of care can also constitute an unlawful killing. Causation does not provide a helpful distinction here.

An act versus omission distinction might be asserted to explain the different treatment of PAD and removal of LSMT. But the notion that an act is more culpable than an omission fails in the context of end-of-life medical handling. First, as just noted, a physician may have a professional and legal responsibility to initiate treatment and may be guilty of homicide by omitting treatment. Second, withdrawal of life support at a patient's request (now treated legally as an omission) is unquestionably an *action* by a physician precipitating death. That action could have been treated as an unlawful killing. American law determined to treat that conduct as a lawful omission in order to respect a patient's autonomy and bodily integrity in the face of life-threatening afflictions.[64] Otherwise, physicians would have been deterred from initiating life support because of fear that the patient's condition would still deteriorate, locking the patient into an unwanted limbo.[65] In the context of end-of-life medical treatment, an active

62. *E.g.*, Cohn & Lynn, *supra* note 28, at 247.

63. Yale Kamisar has always found "unpersuasive" the attempt to say that death is caused by natural causes when a physician removes life support and hastens an actual death. Kamisar, *The 'Right to Die,' supra* note 4, at 491.

64. *See* Linda Edmondson, *A Good Death in Oklahoma*, 27 OKLA. CITY U. L. REV. 939, 942 (2002); Bernard Gert & Charles M. Culver, *Distinguishing Between Active and Passive Euthanasia*, CLINICS IN GERIATRIC MED., Feb. 1986, at 32.

65. Without a prerogative to withdraw life support, health care providers would be compelled to pump gases and liquids into moribund patients who did not want further medical intervention.

intervention resulting in death and a passive omission can be equally culpable or innocent.[66]

Another effort to justify special legal tolerance of rejection of LSMT hinges on the individual's interest in bodily integrity. Writing for the majority in a 1997 assisted-suicide case, Chief Justice Rehnquist emphasized the role of bodily integrity in accounting for the different constitutional treatment of PAD and LSMT.[67] He claimed that a patient's rejection of bodily intrusion — rather than a patient's prerogative to choose the manner and timing of death — was the key aspect of liberty that had been enshrined in the doctrine of informed consent and in the Court's respect for rejection of LSMT.[68] By contrast, he implicitly claimed PAD involves an active introduction of substances into the body, a patient interest that is supposedly less venerable and robust. That claim — that a patient's right is a negative right against bodily intrusion — seems misguided. First, the cases establishing a patient's right to reject LSMT were grounded as much in respect for autonomy (in how to respond to a medical affliction) as bodily integrity.[69] Second, common sense indicates that the key element accounting for a patient's right to reject LSMT is autonomy in how to respond to a fatal affliction rather than just control over bodily intrusions. Try a thought experiment. Suppose that a dying patient who has deteriorated to an intolerably undignified state could be kept alive by a medical treatment that involved no bodily intrusion — say by a magic extra-corporeal machine that emitted waves neither penetrating the body nor even noticeable to the patient. Does anyone doubt that the patient would be entitled to reject the magic machine? And wouldn't it be the patient's autonomy interest in choosing how to respond to a fatal affliction that accounted for the patient's prerogative?[70] In other words, the fact that letting nature take its course entails an avoidance of bodily intrusions does not account for the different treatment of PAD.

66. The fact that omission and commission can be equally culpable prompts John Keown to label legal acceptance of rejection of LSMT (even in instances when the patient seeks death) as "'morally and intellectually misshapen'." For him, such physician conduct constitutes assistance to suicide and should not be legally tolerated. KEOWN, *supra* note 41, at 236-37. Keown suggests a "radical inconsistency" when law prohibits voluntary active euthanasia while permitting "intentional killing by omission." *Id*. at 233.

67. Washington v. Glucksberg, 521 U.S. 702 (1997).

68. *Id.* at 725.

69. "Society recognizes a right to be free of unwanted physical intrusions because of the importance of *self-determination* and control over one's body." Orentlicher, *supra* note 52, at 664 (emphasis added).

70. Physicians acknowledge that self-determination underpins a patient's right to refuse LSMT. *See* Edwin P. Maynard et al., Am. Coll. of Physicians, *American College of Physicians Ethics Manual*, 117 ANNALS INTERNAL MED. 947, 952 (1992).

So far, no convincing theoretical rationale supports the legal distinction between PAD and "letting nature take its course" by withdrawing LSMT. A possible rationale is to view the prohibition of PAD as a symbolic social statement underscoring the sanctity of human life. Perhaps the prohibition reminds the citizenry that there is "something shocking in deliberately killing any human being."[71] From this perspective, the fact that a patient dies from a natural pathology when LSMT is removed seems to constitute an important difference from actions that independently cause death. Thus, American physicians have always assumed that active euthanasia is murder — on the basis that respect for the sanctity of life precludes the taking of human life.[72] Likewise, the Supreme Court of Canada cited "maintaining respect for human life" as the value that warrants a continued ban on PAD.[73] Chief Justice Rehnquist insisted that states are entitled to assert an " 'unqualified interest in the preservation of human life.' "[74]

Our societal ban on virtually all active killing does underscore the importance of human life. Exceptions to the ban are few — self-defense, defense of others, capital punishment, and just war. Western society has generally criminalized mercy killing; the object of relieving suffering has never been deemed a sufficient justification for assistance to suicide or for voluntary active euthanasia.[75] Although attempting suicide is no longer punished, the Model Penal Code criminalizes assistance to suicide on the ground that willing participation in taking the life of another offends the societal interest in the sanctity of life.[76] Thus, the ban on PAD could serve as a symbolic message about the sanctity of life.

The theory of a symbolic message underlying the ban on PAD may be sound, but the force of that symbolic communication is rather flimsy. Courts and legislatures chose to regard withdrawal of LSMT as tantamount to non-initiation of life support, i.e., as medical omission

71. PETER BYRNE, PHILOSOPHICAL AND ETHICAL PROBLEMS IN MENTAL HANDICAP 81 (2000).

72. Shai Lavi, *Euthanasia and the Changing Ethics of the Deathbed*, 4 THEORETICAL INQ. L. 729, 754 (July 2003), *at* http://www.bepress.com/til/default/vol4/iss2/art10. However, many contemporary physicians regard physician-assisted suicide as a final act of palliative care consistent with physicians' responsibility to relieve suffering. *E.g.*, Steve Heilig et al., *Physician-Hastened Death*, 166 W. J. MED. 370, 371 (1997).

73. Danuta Mendelson & Timothy Stoltzfus Jost, *A Comparative Study of the Law of Palliative Care and End-of-Life Treatment*, 31 J.L. MED. & ETHICS 130, 132 (2003).

74. Washington v. Glucksberg, 521 U.S. 702, 728 (1997) (quoting Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 282 (1997)).

75. WILLIAM L. BURDICK, THE LAW OF CRIME §§ 422, 447 (1946); Lavi, *supra* note 72, at 754.

76. MODEL PENAL CODE § 210.5 cmt. 5 (1980).

rather than medical killing.[77] The public, however, generally perceives the removal of life support as an active killing by a physician.[78]

> In 1975, the trial court in *Quinlan* regarded removal of a respirator as a form of homicide. The removal of a respirator without consent is still treated as homicide. . . . In short, disconnecting life support is, in popular consciousness, viewed as causing death (i.e., a form of killing) rather than as letting a natural death occur. This common association of withdrawal of life support with killing undermines the force of the symbolic rationale for distinguishing withdrawal of life support from PAS.[79]

Similarly, where a patient dies following the medical administration of analgesics in doses that posed a risk of hastening that patient's death, the public views the physician's action as having killed that patient.[80] They believe that the imperatives of pain control prompted the caretaker to intentionally overdose the suffering patient.[81] So while a ban on intentional killing via PAD in theory reinforces a social message about the sanctity of life, that message is already eroded in the context of death and dying by the socially accepted withdrawal of LSMT and by the public perception that administration of analgesics is a widespread technique for hastening death. It may still be arguable that legalization of PAD would undermine the sanctity of life principle. But it is more likely that PAD would do just what rejection of LSMT does — reassure fatally stricken patients that they will have some control over a painful or demeaning dying process.[82]

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77. *See supra* note 52.

78. Orentlicher, *supra* note 52, at 663 ("[T]he withdrawal of treatment is no less an act of killing than suicide.").

79. Cantor, Glucksberg, *supra* note 32, at 307 (citing *In re* Quinlan, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975)). In Japan, withdrawal of LSMT is treated as a form of euthanasia. Mendelson & Jost, *supra* note 73, at 137. *See also* Henk Jochemson, *Life-Prolonging and Life-Terminating Treatment of Severely Handicapped Newborn Babies*, 8 Issues in L. & MED. 167, 168 (1992).

80. Marcia Angell, *The Supreme Court and Physician-Assisted Suicide — The Ultimate Right*, 336 NEW ENG. J. MED. 50, 51 (1997) [hereinafter Angell, *The Supreme Court*]; Stephen A. Newman, *Euthanasia: Orchestrating 'The Last Syllable of . . . Time,'* 53 U. PITT. L. REV. 153 (1991); David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide after* Glucksberg/Quill, 9 ALB. L.J. SCI. & TECH. 161, 233 (1998); John A. Robertson, *Respect for Life in Bioethical Dilemmas — The Case of Physician-Assisted Suicide*, 45 CLEV. ST. L. REV. 329, 334 (1997); Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. TIMES, Nov. 1, 1994, at A27.

81. ROGER S. MAGNUSSON, ANGELS OF DEATH: EXPLORING THE EUTHANASIA UNDERGROUND 192-94 (2002). Indeed, some clinicians perceive no real distinction between palliative care that risks hastening death and active intervention to shorten a suffering patient's dying process. Rocker & Curtis, *supra* note 43, at 822.

82. When competent, afflicted persons are allowed to shape the medical response to their condition, autonomy is respected rather than life derogated. "[T]he value of life is desecrated not by a decision to refuse medical treatment but 'by the failure to allow a competent human being the right of choice.' " *In re* Farrell, 529 A.2d 404, 411 (N.J. 1987) (quoting *In re* Conroy, 486 A.2d 1209 (N.J. 1985)). *But see* Eric A. Johnson, *Assisted Suicide, Liberal Individualism, and Visceral Jurisprudence: A Reply to Professor Chemerinsky*, 20

David Orentlicher offers an alternative explanation for differential legal treatment of PAD and LSMT. He suggests that the ban on PAD served initially as a rough demarcation of society's moral judgment about medical intervention in the dying process — "a useful proxy for separating morally valid and morally invalid" patient requests for aid in dying.[83] Orentlicher's explanation for initial reticence toward PAD seems sound. When end-of-life medical handling surfaced as a legal issue in the 1970s, the notion of suicide — or assistance to suicide — was strongly associated with mentally deranged people seeking to escape from life circumstances. Most suicides were regarded as morally problematic, so a dichotomy between rejecting LSMT and suicide was appealing. At that time, courts were taking their first hesitant steps in marking the legality of some patients' choices to end torturous dying processes. Judges were understandably reluctant to connect rejection of LSMT with suicide. For Orentlicher, the subsequent decades of experience with end-of-life medical practices indicate that the initial legal and moral dichotomy between LSMT and PAD was misplaced. For Kamisar, the moral dichotomy may not be convincing, but the hazards of abuse which he pointed to in 1958 still warrant legal prohibition of PAD.

C. *Hazards of Abuse*

Yale Kamisar's premise in 1958 was that "practical obstacles," not morals, explain why PAD should not be legalized. Since then, forty-five years of medical practice and thirty-eight years of jurisprudence relating to end-of-life medical practices have intervened. Nonetheless, Kamisar and the vast majority of other opponents of PAD have not altered their focus on the abuses that they argue would accompany legalization of PAD.[84] They have only refined their arguments and sought to add empirical proofs drawn from the Netherlands as well as the United States.

Opponents' concerns about abuse relate primarily to the impaired mental processes of seriously ill people making decisions about the momentous matter of PAD. Psychological impediments to sound decisionmaking include depression, fatigue, frustration, anxiety, pain, nausea, alertness-dulling medications, and pressure from surrounding caregivers and family. "Patients are not ideally autonomous agents but anxious, fearful, depressed, often confused, and subject to ill-

ALASKA L. REV. 321, 323 (2003) (arguing that a patient's choice to die in a deteriorated condition offends similarly debilitated disabled persons whose lives are supposedly being deemed worthless).

83. Orentlicher, *supra* note 52, at 664-65.

84. *See supra* notes 28-29 and accompanying text.

considered and mistaken ideas."[85] Kamisar and others have added a special concern for vulnerable populations such as ethnic minorities and the aged, noting that PAD would be practiced "through the prism of social inequality and prejudice that characterize the delivery of [health care] services."[86] Some contemporary commentators insist that legalized PAD would become "a deadly license for physicians to recommend and prescribe death, free from outside scrutiny."[87]

The psychological concerns echo Kamisar's 1958 warnings, but they are reinforced by physicians' experience over the last forty-five years. Modern commentators frequently note that physicians lack training in assessing competence and that competence determinations lack established criteria and are complex and difficult for physicians to perform.[88] A similar concern goes to physicians' ability to detect and respond to clinical depression in seriously ill patients. Opponents of PAD assert that physicians tend to be untrained in and inadequate at recognizing treatable depression affecting patients' judgment.[89]

The hazard of "undue influence" upon patients considering PAD is another concern. One specter is subtle or not-so-subtle influence by physicians upon their dependent patients. The fear is that physicians might use their status and control of information to manipulate patients into agreeing to PAD.[90] One prominent observer claims that patient autonomy is "illusory" in the medical treatment context because physicians so frequently end up determining their patients' medical fates.[91] The influence of surrounding family — conflicted by their own emotional and financial interests — is another concern. The fear is that as PAD becomes routinized, surrounding health care providers will not have the time or skill to detect family exercise of undue influence. In fact, a common criticism of PAD is that various extrinsic pressures, stemming from a tacit message embodied in

85. Jeffrey Blustein, *The Family in Medical Decisionmaking*, HASTINGS CENTER REP., May 1993, at 12; *see also* Johnson, *supra* note 82, at 342-43.

86. Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 118 n.20.

87. Kass, *supra* note 37, at 25; WESLEY J. SMITH, FORCED EXIT 4-5 (1997) [hereinafter SMITH, FORCED EXIT].

88. Cohn & Lynn, *supra* note 28, at 256; Susan R. Martyn & Henry J. Bourguignon, *Now is the Moment to Reflect: Two Years of Experience with Oregon's Physician-Assisted Suicide Law*, 8 ELDER L.J. 1, 6-9, 11, 22 (2000).

89. Harvey M. Chochinov & Leonard Schwartz, *Depression and the Will to Live in the Psychological Landscape of Terminally Ill Patients*, *in* THE CASE AGAINST SUICIDE 269 (Kathleen Foley & Herbert Hendin eds., 2002); David C. Clark, *'Rational Suicide' and People with Terminal Conditions or Disabilities*, 8 ISSUES L. & MED. 147, 155-57 (1992).

90. Kamisar, *PAS: The Problems Presented*, *supra* note 4, at 1134-35; Martyn & Bourguignon, *supra* note 88, at 49-50.

91. Edmund D. Pellegrino, *Compassion is Not Enough*, *in* THE CASE AGAINST ASSISTED SUICIDE 41, 48 (Kathleen Foley & Herbert Hendin eds., 2002).

legalization of PAD, will inevitably generate a "duty to die" on the part of aged or highly debilitated medical patients.[92]

Two further concerns about abuse of PAD have surfaced only in recent decades. The first flows from the fact that financing of medical care has shifted from a fee-for-service model to a managed-care framework. The capitation payment mechanism often used by HMOs creates financial incentives to curb expensive care, and medical care in the last year of life tends to be particularly expensive.[93] Physicians' financial interests might influence them to be less aggressive in providing needed care to chronically ill and elderly patients, and then PAD looms as a temptation. The emergence of new pain-relief techniques has generated a second concern about a connection between PAD and palliative care. Supposedly, legalization of PAD might divert attention from continued development of palliative techniques or might provide a convenient substitute for loving, supportive end-of-life care.[94]

Procedural safeguards form one response to all these hazards. Proponents of PAD regularly urge protective mechanisms along the lines of the current Oregon statute governing physician-assisted suicide — patients appearing to be mentally disturbed must be referred for psychiatric examination; independent medical examination needs to confirm the treating doctor's diagnosis and assessment of competence; and a waiting period will be imposed in order to confirm the patient's wish for PAD.[95]

92. *See*, *e.g.*, Cohn & Lynn, *supra* note 28, at 241 (arguing that PAD could be perceived as a social obligation); Kamisar, *PAS: The Problems Presented*, *supra* note 4, at 1134-35 (choosing death could be perceived as "the 'right' thing to do"); Kass, *supra* note 37, at 24.

93. Steve P. Calandrillo, *Coralling Kevorkian: Regulating Physician-Assisted Suicide in America*, 7 VA. J. SOC. POL'Y & L. 41, 46, 75 (1999); Cohn & Lynn, *supra* note 28, at 239; M. Cathleen Kaveny, *Managed Care, Assisted Suicide, and Vulnerable Populations*, 73 NOTRE DAME L. REV. 1275, 1281, 1299-1300 (1998).

94. Martyn & Bourguignon, *supra* note 88, at 35, 43; Lois Shepherd, *Face to Face: A Call for Radical Responsibility in Place of Compassion*, 77 ST. JOHN'S L. REV. 445, 509-12 (2003). Marcia Angell convincingly replies: "Good comfort care and the availability of physician-assisted suicide are no more mutually exclusive than good cardiologic care and the availability of heart transplantation." Angell, *The Supreme Court*, *supra* note 80, at 51.

95. *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); Calandrillo, *supra* note 93, at 94-97; Arthur L. Caplan et al., *The Role of Guidelines in the Practice of Physician-Assisted Suicide*, 132 ANNALS INTERNAL MED. 476 (2000); Heilig et al., *supra* note 72, at 372-73. Some commentators — among them opponents of PAD — warn that procedural machinery can become so cumbersome and protracted that it no longer provides a real option for a dying person seeking relief via PAD. Yale Kamisar originally sounded this alarm. Kamisar, *Non-Religious Views*, *supra* note 1, at 979. He repeated the theme later, Yale Kamisar, *Details Doom Assisted-Suicide Measures*, N.Y. TIMES, Nov. 4, 1998, at A27, and others have adopted it. *See* James L. Underwood, *The Supreme Court's Assisted Suicide Opinions in International Perspective: Avoiding a Bureaucracy of Death*, 73 N.D. L. REV. 641, 682-83 (1997); Kathy L. Cerminara, *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, 20 J. LEGAL MED. 281, 285 (1999) (book review).

One concern about building elaborate procedural protections into a PAD scheme is fear of a backlash seeking to impose onerous procedural protections upon medical cessation of LSMT.[96] The implication from this fear of backlash is that current procedures regarding end-of-life medical decisions are working adequately and shouldn't be saddled with stringent procedures. That assessment seems sound. Death and dying jurisprudence and medical experience of the last thirty-eight years indicate that current procedures are adequate to protect competent patients' end-of-life decisions about LSMT. Those procedures generally involve an attending physician's assessment of competence, a psychiatric consult when competence is in doubt, informed consent including presentation of all options, efforts to dissuade a patient from any ill-considered decision, and ultimate implementation of the patient's chosen course. That informal process has worked reasonably well in preventing premature termination of life, so it would indeed be unfortunate if a backlash effect made those processes more cumbersome. Even minor changes might be obstructive of sound practice. In New Jersey, for example, physicians vigorously objected to a regulation by the Board of Medical Examiners that mandated two independent physicians' involvement before an attending physician could honor a competent patient's choice to end life support.[97]

All the concern about abusive practices raises an important issue about the relation between the numerous dangers associated with PAD and American experience regarding rejection of LSMT by competent medical patients. Every cited hazard of PAD exists as well in the context of rejection of LSMT — medical uncertainty both in assessing capacity to consent and in making an accurate prognosis;[98] the possible insidious effect upon decisionmaking from psychosocial factors like depression, anxiety, helplessness, and frustration;[99] the hazard of undue influence upon the patient's decision by physicians, or medical staff, or family members conflicted by their own interests in the medical decision; the hazard that sick persons will be influenced by

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Some people first demand onerous procedural protections and then argue that any protective system would be unwieldy and unusable — a Catch-22 situation.

96. Annas, *supra* note 54, at 1101; Kamisar, *The 'Right to Die,' supra* note 4, at 495; Susan M. Wolf, *Honoring Broader Directives*, HASTINGS CENTER REP., Sept.-Oct. 1991, at 58.

97. Their agitation prompted repeal of the offending regulation. Joseph C. D'Oronzio, *The Infamous* Farrell *Footnote: Public Policy as the Smile of the Cheshire Cat*, 9 CAMBRIDGE Q. HEALTHCARE ETHICS 568 (2000).

98. Clark, *supra* note 89, at 152 (recounting how people commit suicide in the mistaken belief that they are fatally ill).

99. Chochinov & Schwartz, *supra* note 89, at 262-64; Mark D. Sullivan et al., *Should Psychiatrists Serve as Gatekeepers for Physician-Assisted Suicide?* HASTINGS CENTER REP., July 1998, at 24, 27-29.

a "duty to die" when they become dependent upon others in an expensive or emotionally burdensome way;[100] the hazard that ignorance or carelessness will cause health-care providers to provide inadequate palliative care and thus prompt premature invocation of PAD; the hazard of disproportionate impact on minority patients either because of latent prejudice or economic disadvantage; the hazard that financial incentives will impel physicians — in order to avoid expensive end-of-life medical care — to influence patients to hasten death. Most of these dangers of abuse long predate PAD; they have existed ever since competent patients and their physicians began to manage the dying process via decisions about medical interventions and pain-relief techniques.[101] Indeed, manipulation of vulnerable patients is a potential problem accompanying any serious medical intervention for which informed consent is required. Think open-heart surgery.

Think dialysis as a locus of "hazards" accompanying rejection of LSMT. Cessation of dialysis (and ensuing death from renal failure) is an option adopted by thousands of patients each year.[102] Nephrologists therefore recognize and cope with the typical difficulties attendant to critical medical procedures — assessment of mental competence, prognosis with and without further treatment, projection of quality of life with and without treatment, screening for serious depression or other emotional distortions of judgment, and prevention of undue influence by people close to the patient.[103]

Again, rejection of LSMT poses hazards for patients (just as PAD does). Yet despite thousands of deaths per day associated with medical management of the dying process, medical services for dying patients have been remarkably free of widespread abuse in the sense of premature terminations of human lives.[104] Abuses do surface at times

100. KEOWN, *supra* note 41, at 276-77; Alister Browne, *Assisted Suicide and Active Voluntary Euthanasia*, 2 CAN. J. L. & JURISPRUDENCE 35, 46 (1989); Martin Gunderson & David J. Mayo, *Altruism and Physician Assisted Death*, 18 J. MED. & PHIL. 281, 286-88 (1993). Note that family pressures are acute in some other medical contexts, such as organ transplants to relatives. Carl H. Fellner & John R. Marshall, *Kidney Donors — The Myth of Informed Consent*, 126 AM. J. PSYCHIATRY 1245, 1248 (1970).

101. Nor am I the only commentator who points out that the risks of abuse are just as great in the context of LSMT as in PAD. Others have noted that PAD would not introduce "any *additional* risks to patients who may already opt to cut short a fate they view as worse than death." Mayo & Gunderson, *supra* note 30, at 14, 18; Orentlicher, *supra* note 52, at 664.

102. Lewis M. Cohen et al., *Practical Considerations in Dialysis Withdrawal*, 289 JAMA 2113 (2003).

103. *Id*. at 2115-17.

104. Occasionally, reports surface about medical personnel who became pathological serial killers. *See* Mary Jo Patterson, *Similar Clues Emerge on a Trail of Death*, NEWARK STAR LEDGER, Jan. 14, 2004, at 1.

involving termination of life-support,[105] but the more prevalent hazard for fatally stricken patients still seems to be unwanted over-treatment and excessive prolongation of the dying process rather than premature hastening of death.[106] Disproportionate impacts on minorities do not appear in termination-of-life studies,[107] a fact perhaps attributable to those patients' suspicions regarding white-dominated medical establishments.[108] Nor do data support the contention that PAD would disproportionately impact poor people. The reasons for that are uncertain. In the Netherlands, a national health-care system makes all forms of medical support available to all citizens. In Oregon, the elaborate process for securing PAS may make that process accessible only to patients who are relatively affluent. Or perhaps poor persons are more tenacious in clinging to life than the effete middle class who are more sensitive to indignity? Or poor persons might be more suspicious of the medical establishment and hence more unwilling to trust physicians who would cooperate in PAD. The absence of any assured ultimate recourse to PAD may actually prompt some fatally stricken people to seek to hasten death prematurely, fearing that otherwise they will be trapped in a degenerative spiral.[109]

For the most part, opponents of PAD ignore the fact that removal of life support from competent patients poses no risks markedly different in kind from PAD. They ignore that cessation of LSMT — seldom subjected to formal processes — has an approximately thirty-five year history with relatively few signs of abuse. When opponents of PAD do pay attention to the comparative risks from LSMT and PAD, they doggedly insist that while the era of LSMT has been surprisingly free of abuse, PAD would be much more hazardous.[110] One of their

105. For an anecdote of suspicious pressure being employed (by the younger girlfriend of an eighty-one year-old, wealthy patient), see John La Puma & David L. Schiedermayer, *The Bookie, the Girlfriend, and the Vultures*, 114 ANNALS INTERNAL MED. 98 (1991); *see also* Douglas O. Linder, *The Other Right-to-Life Debate: When Does Fourteenth Amendment 'Life' End?*, 37 ARIZ. L. REV. 1182, 1187 (1995) (providing a survey indicating physicians terminating life support over objections of family).

106. *E.g.*, Edmondson, *supra* note 64, at 940; *see also* Support Study, Howard Brody et al., *Withdrawing Intensive Life Sustaining Treatment*, 336 NEW ENG. J. MED. 652 (1997).

107. Cohen et al., *supra* note 102, at 2116 (noting that African Americans cease dialysis at only half the rate of whites); Eric L. Krakauer et al., *Barriers to Optimum End-of-Life Care for Minority Patients*, 50 J. AM. GERIATRIC SOC'Y 182, 182-90 (2002); Peter A. Selwyn & Marshall Forstein, *Overcoming the False Dichotomy of Curative vs. Palliative Care for Late-Stage HIV/AIDS*, 290 JAMA 806, 811 (2003).

108. While African Americans may receive less resource-intensive care, they are also more insistent on continuing LSMT. LaVera Crawley et al., *Palliative and End-of-Life Care in the African-American Community*, 284 JAMA 2518, 2519 (2000); Selwyn & Forstein, *supra* note 107, at 811.

109. Newman, *supra* note 80, at 176-77.

110. *See* Martyn & Bourguignon, *supra* note 88, at 56 (claiming that the legal boundary of LSMT "has been vastly more effective at preventing abuse over a long period of time than its alternatives ever can be.")

points is simply a "quantitative distinction" — a claim that there would be a greater number of decisions involving PAD than LSMT. Rejection of life support only becomes an issue when people have physically deteriorated to a point of machine dependency while PAD, if legalized, could become an option for any suffering, competent, fatally stricken person. So there would supposedly be many more end-of-life decisions if PAD were legalized, as debilitated patients considered hastening death before becoming machine dependent.[111] But even under a legal structure allowing only LSMT, every fatally afflicted patient is probably entitled to reject oral nutrition and also decline ANH, thereby having an option to precipitate his or her own death even before becoming machine dependent.[112] Thus, an opportunity to hasten death exists for every competent, fatally stricken patient even before that person becomes machine dependent.

A more troubling claim is that PAD will be more susceptible to abuse than LSMT because of the location in which PAD is likely to transpire. Cessation of life support usually occurs in an institutional setting where the process is visible to surrounding family and teams of health-care providers. That visibility might serve as a disincentive to abusive medical practices. By contrast, "[t]he prescription of lethal medication . . . will occur most often in the privacy of a doctor's office or the patient's home, settings where effective oversight to minimize error or abuse would be more difficult, if not unrealizable."[113] This argument for resisting PAD influenced the New York Task Force on Life and the Law[114] and it has persuaded Yale Kamisar.[115]

I am not convinced that PAD is much more prone to abuse than LSMT. Cessation of LSMT has been carried out in hundreds of thousands of homes without serious allegation of abuse. While arrangements for physician-assisted suicide or active euthanasia may first be formed in the privacy of a physician's office, implementation will generally take place at home where some exposure is available. The New Jersey Supreme Court comments about end-of-life medical practice occurring within the home:

111. Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 124-25.

112. While death by dehydration may sound repulsive, the reality is that a patient rejecting ANH can die a relatively placid demise, slipping into a coma after a few days and dying in seven to fourteen days. JAMES M. HOEFLER, MANAGING DEATH 117-27 (1997); Linda Ganzini et al., *Nurses' Experiences with Hospice Patients Who Refuse Food and Fluids to Hasten Death*, 349 NEW ENG. J. MED. 359 (2003).

113. Carl H. Coleman & Tracy E. Miller, *Stemming The Tide: Assisted Suicide and the Constitution*, 23 J. L. MED. & ETHICS 389, 394 (1995); *see also* KEOWN, *supra* note 41, at 75.

114. Carl H. Coleman, *The New York State Task Force on Life and the Law: Why It Concluded Physician-Assisted Suicide Should Not Be Legalized*, 12 ST. JOHN'S J. LEGAL COMMENT. 647 (1997).

115. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 248.

> We see no reason to fear that a patient at home is more vulnerable than one in an institution. In fact, probably just the opposite is true. Presumably, the patient receiving life-sustaining treatment at home [or care involving any serious medical condition] has a caring family or friend in attendance; otherwise, institutional care would be necessary. Our common human experience teaches us that family members and close friends care most and best for a patient.[116]

In the home, presence of hospice caregivers (such as home health aides or visiting nurses) as well as surrounding family ensures a certain amount of transparency to the dying process. Even where no hospice program is involved, home health aides or family often attend seriously ill persons contemplating PAD. Interestingly, San Francisco area physicians have produced an identical protocol for a careful route to physician-assisted hastening of death whether the moribund patient is in a health care institution or at home.[117]

Removal of LSMT may seem less susceptible to mistake or pressure than PAD because some patients rejecting LSMT survive for a period after cessation of treatment. This will be true for some cancer patients, some dialysis patients, some AIDS patients, and some ALS patients. Thus, cessation of life support sometimes leaves the moribund patient alive and capable of changing his or her mind about dying. Yet in practice PAD would also furnish to the patient an opportunity to reflect and change course. For PAD, if legalized in the United States, would be accompanied by a deliberate process — independent physician confirmation of the patient's prognosis and mental state plus a mandatory waiting period during which the patient would be able to reconsider.

In short, similar hazards of abuse accompany LSMT and PAD. And it would be unthinkable to regress and impose a cumbersome decisionmaking process upon LSMT. A substantial majority of deaths in the United States are medically managed (meaning doctors facilitate an earlier death than would otherwise occur). Imposition of stringent procedural processes would disrupt the end-of-life practice of medicine — causing prolongation of the dying process for hundreds of thousands of moribund patients who have reached a point of intolerable suffering or degradation. The bottom line is that onerous procedures should not be imposed upon medical practice involving either removal of LSMT or PAD for competent, fatally stricken patients.

In my judgment, no convincing rationale supports the prevailing distinction between killing and letting die. And the most frequently voiced concern about PAD — the hazards of abuse — does not seem

116. *In re* Farrell, 529 A.2d 404, 414 (N.J. 1987).

117. Heilig et al., *supra* note 72, at 372-73. The protocol obviously anticipates that trained personnel will be present in the home setting as well as in an institution.

significantly more threatening than in the case of LSMT. That leaves another practical obstacle to legalization of PAD — the slippery slope.

II. UNSAVORY EXTENSIONS

Yale Kamisar conceded that PAD was morally justified in some instances of a dying, competent patient's irremediable pain coupled with a fixed desire to die. He nonetheless opposed legalization of PAD. He objected not only to hazards of abuse accompanying legalized hastenings of death, but also to eventual extensions of PAD to "far more objectionable practices."[118] At that time, Kamisar primarily feared extension of PAD to nonvoluntary euthanasia (for patients who were not competent to make their own medical decisions) and to involuntary euthanasia (contrary to a competent patient's wishes or to the wishes of a surrogate representing a mentally incompetent patient). He cited the not-so-remote experience of Nazi Germany where the medical establishment had been enlisted in the performance of involuntary euthanasia first upon disabled citizens and later upon disfavored ethnic and political groups. Kamisar's conviction about the inevitable extension of PAD well beyond the dying, competent patient continues to occupy him and many other opponents of PAD to this day.[119]

In the 1990s, proponents of PAD shifted gears and focused upon legalization of physician-assisted suicide — rather than active euthanasia — as an option for competent, terminally ill people who were suffering unbearably. The proponents' theory was that PAS would be more palatable to the public (and to judges and legislators) because leaving the fatal act in the hands of a competent person would make it more likely that the self-killing would be strictly voluntary.[120] Kamisar re-entered the fray and predicted that the purported boundaries would never hold up. For him, PAS would inevitably shade into voluntary active euthanasia ("VAE"). Then the practice of PAD would reach all afflicted, suffering people, including those not terminally ill. Eventually it would extend to people suffering not from illness but rather from harsh life circumstances.[121] And, of course, he

118. Kamisar, *Non-Religious Views*, *supra* note 1, at 1042.

119. *E.g.*, KEOWN, *supra* note 41, at 69-70; WESLEY J. SMITH, CULTURE OF DEATH (2000) [hereinafter SMITH, CULTURE OF DEATH]; Johnson, *supra* note 82, at 323; Kass, *supra* note 37, at 25-26.

120. Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1381-82 (1992) [hereinafter Quill et al., *Care of the Hopelessly Ill*].

121. Kamisar, *Against Assisted Suicide*, *supra* note 4, at 745-47; Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 230-33.

retained his original apprehensions about a slippery slope to nonvoluntary and involuntary euthanasia.

Slippery slopes are genuine law-making concerns. A court or legislature asked to recognize a new right understandably worries about the ultimate boundaries of the prerogative being sought. For example, in 1997, when asked to recognize a constitutional right to assistance in dying (PAS), the United States Supreme Court expressed acute concern about the bounds and implications of the right they were being asked to endorse.[122] Yet not every slippery slope argument is convincing.[123] Each feared slide warrants examination.

A. *From Assisted Suicide to Active Euthanasia*

Kamisar had two reasons for his prediction that PAS would inevitably slide into active euthanasia. First, he doubted that it was possible to differentiate between these two modes of bringing about death. He gave examples of how the line between them might be blurred, as by a third party holding a patient in place while the patient performed an act of suicide or a third party holding a weapon while a weakened patient pulled the trigger. Second, he felt that compassion for a mentally competent but physically incapacitated person unable to perform a suicidal act would impel legalization of active third-party interventions. He envisioned third parties placing poison in the mouths of quadriplegics or injecting dying patients who simply could not, because of psychological barriers, bring themselves to perform the desired lethal act.[124]

Additional reasons support the prediction of an inexorable carryover from PAS to active euthanasia. Botched suicides provide an example. Because physicians are not skilled at killing by poisons, some instances will occur where a patient's suicide attempt fails and a physician will be called upon to administer a coup de grâce.[125] In the Netherlands, approximately 18% of assisted suicides result in serious complications or fail to work.[126] The imperative of ending suffering then leads to an alternate mode of causing death, usually a lethal injection. Further, the rationale for confining assisted death to PAS is not particularly convincing. If undue influence and subtle pressures

122. Washington v. Glucksberg, 521 U.S. 702, 785-86 (1997) (Souter, J., concurring).

123. *See* Bernard Williams, *Which Slopes are Slippery?*, *in* MORAL DILEMMAS IN MODERN MEDICINE 128, 132-34 (Michael Lockwood ed., 1985) (urging good-sense assessments of whether any slippery slide will in fact occur).

124. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 230-32; Kamisar, *The 'Right to Die,' supra* note 4, at 516.

125. Cohn & Lynn, *supra* note 28, at 249; Kaveny, *supra* note 93, at 1305.

126. N. Gregory Hamilton, *Oregon's Culture of Silence*, *in* THE CASE AGAINST ASSISTED SUICIDE 175, 189 (Kathleen Foley & Herbert Hendin eds., 2002).

upon a debilitated patient are a serious concern, why would they be averted just because the patient is persuaded to take a poison rather than to submit to an injection?

Opponents of PAD insist that PAS is merely "a strategy to introduce lethal injection or infusion and other more efficient forms of medicalized killing."[127] But whether it's part of a conspiracy to promote all forms of medical killing or not, the push toward PAS in order to relieve suffering is unlikely to avoid a slide to active euthanasia. Kamisar was right on that score. Actual practice, if not the formal legal boundaries, would likely make the predicted slide.

B. *From the Terminally Ill to the Chronically Ill*

In the middle 1990s, when advocates of PAD were litigating to establish a constitutional right to PAS, they limited the right being sought to competent, terminally ill persons[128] in the end stages of their dying processes. Kamisar saw this limitation as a temporary strategy by the "death-with-dignity" movement. If self-determination in the face of egregious suffering is the moving force behind a right to assisted death, he reasoned, how could chronically ill sufferers — who would otherwise suffer longer — be excluded?[129] Why deny a right to relief to "those with nonterminal illnesses or disabilities who might have to endure greater pain and suffering *for much longer periods*" than terminal patients who will inevitably die within weeks or months?[130] And why should dying, suffering patients, such as those with ALS or cerebral palsy or AIDS, have to wait to the final phase of their degenerative illnesses? Kamisar ridiculed the notion that government has a lesser interest than usual in preserving the lives of people who have only a short life span left.[131] Unconsented killing is usually unlawful homicide even if life is shortened by only a few minutes.[132]

127. *Id*. at 183.

128. *E.g.*, Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996); Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996). Terminally ill in that litigation context generally meant unavoidable death within a discrete period of time. That time period was often fixed at six months.

129. Kamisar, *The 'Right to Die,' supra* note 4, at 489-90.

130. Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 129.

131. Kamisar, *Against Assisted Suicide*, *supra* note 4, at 742-43. Some early cases suggested that government has a lesser interest in preserving life that can only be "briefly extended," as opposed to life of long possible duration. Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978). That notion has essentially vanished from the jurisprudence of death and dying. Pub. Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989); *In re* Peter, 529 A.2d 419, 425 (N.J. 1987).

132. *E.g.*, Edinburgh v. Oklahoma, 896 P.2d 1176, 1178 (Okla. Crim. App. 1995).

Kamisar's claim about extension of PAD to chronic illness sufferers seems (you should pardon the pun) dead-on. As he correctly notes, the same factors supporting any hastening of death — respect for autonomy in the face of affliction and compassion in the face of suffering — loom large when a stricken person faces a prolonged dying process. Think persons in the middle stages of degenerative diseases whose suffering has already reached a personally intolerable level.[133] We know that if a chronic illness sufferer comes down with pneumonia, that person has an option to reject LSMT. Must that prolonged sufferer's fate wait for the happenstance of intervening illness and dependence on medical support? The humanitarian impulse to "do the right thing" by ending suffering is a powerful force in such circumstances. For example, in jurisdictions where removal of life support is legally confined to formerly competent patients who previously articulated their wish to forgo life support in the circumstances now at hand,[134] circumventions and contrivances by medical staff are common. The medical staff either coaches the family to recall prior "instructions" from the now-incompetent patient or suddenly determines that the LSMT is actually futile and should be withdrawn.[135]

The compassionate drive to provide relief for long-term, intractably suffering patients is powerfully reflected in several contexts. The American euthanasia movement, from its inception in 1906, always sought relief for afflicted persons with intractable pain even if their lives were preservable for long periods.[136] Modern legislative proposals by death-with-dignity advocates often reflect similar solicitude for persons afflicted with intractable and unbearable long-term illnesses.[137] The Dutch system as well has shown willingness to use PAD for persons affected by non-lethal pathology causing unremitting suffering.[138] While terminal illness first provoked Dutch

133. Think fatally stricken persons whose previous medical interventions have stabilized their conditions, yet whose circumstances have become so intolerable that they now want to remove the previously installed life-sustaining equipment. *See* Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986); Georgia v. McAfee, 385 S.E.2d 651 (Ga. 1989); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

134. Conservatorship of Wendland, 28 P.3d 151 (Cal. 2001); DeGrella v. Elston, 858 S.W.2d 698 (Ky. 1993); Mack v Mack, 618 A.2d 744 (Md. 1993); *In re* Martin, 538 N.W.2d 399 (Mich. 1995); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988); *In re* Westchester County Med. Ctr., 531 N.E.2d 607 (N.Y. 1988); *In re* Edna M.F., 563 N.W.2d 485 (Wis. 1997).

135. *See* Robert N. Swidler, *Harsh State Rule on End-of-Life Care Remains in Need of Reform*, N.Y. L.J., Jan. 26, 2000, at S-4 (describing such tactics in New York State).

136. Lavi, *supra* note 72, at 756-57.

137. *See* Baron et al., *supra* note 95, at 25-34; Margaret Pabst Battin, *Euthanasia*, *in* HEALTH CARE ETHICS: AN INTRODUCTION 67 (Donald VanDeVeer & Tom Regan eds., 1987); Pratt, *supra* note 80, at 187.

138. Raphael Cohen-Almagor, *Euthanasia in the Netherlands: The Legal Framework*, 10 MICH. ST. U. DETROIT C.L. J. INT'L L. 319, 327-31 (2001).

sympathy with PAD,[139] relief of unremitting and personally intolerable suffering — regardless of the patient's potential longevity — has been the hallmark of permissible PAD both at the outset of Dutch death-and-dying jurisprudence and under their recently adopted statute.[140]

To be sure, arguments exist for confining any PAD prerogative to stages when unavoidable death is near. From a religious perspective, PAD in the final stages of a dying process poses less of " 'an arrogant usurping of the role of God.' "[141] On a secular plane, there are also reasons to confine PAD to patients facing near-term, unavoidable death. In contrast to a person facing near-term death, a person with a longer potential life span might be able to adapt and cope with the medical pathology being faced. If a person's condition is not immediately lethal, there might also be greater risk of medical error in prognosis[142] or a better prospect of a miraculous medical advance to relieve the patient's condition. The response to all these factors is that properly informed patients can weigh these elements in making autonomous medical decisions.

Society might perceive the hastening of death of a person with long prospective longevity as an immoral rebuke to sanctity-of-life principles.[143] Nonetheless, as Kamisar notes, similar arguments about the importance of longer potential longevity did not prevail over autonomous patient choice in the context of rejection of LSMT.[144] A competent patient's right to refuse treatment exists even if the patient might otherwise live a long time, perhaps even in good health.[145] The

139. JOHN GRIFFITHS ET AL., EUTHANASIA AND LAW IN THE NETHERLANDS 143 (1998).

140. Cohen-Almagor, *supra* note 138, at 327; Mendelson & Jost, *supra* note 73, at 137; Pratt, *supra* note 80, at 180; Cynthia M. Bumgardner, Comment, *Euthanasia and Physician-Assisted Suicide in the United States and the Netherlands: Paradigms Compared*, 10 IND. INT'L & COMP. L. REV. 387, 408 (2000).

141. ROBERT N. WENNBERG, TERMINAL CHOICES: EUTHANASIA, SUICIDE, AND THE RIGHT TO DIE 92-93 (1989) (quoting CHARLES CURRAN, POLITICS, MEDICINE, AND CHRISTIAN ETHICS 161-62 (1973)). For some religions, PAD would constitute intermeddling in God's dominion over life and death.

142. Some commentators are uncomfortable with the uncertainty of medical projections that patients will die within a particular time span, such as six months. Cohn & Lynn, *supra* note 28, at 243, 252-55; Martyn & Bourguignon, *supra* note 88, at 33. Yet terminal illness projections (six-month spans in particular) are commonly used in the context of state advance-directive legislation and in Medicare qualifications for hospice care. Similarly, a patient contemplating rejection of life support will always seek physicians' projections of likely life span. Does it matter if the physician's projection is wrong and the patient would actually live eight months rather than six months? Patients can be informed that any medical prognosis is inexact; that fact becomes part of the competent patient's calculus in deciding whether to accept treatment.

143. Orentlicher, *supra* note 52, at 666.

144. Kamisar, *Against Assisted Suicide*, *supra* note 4, at 741.

145. Thor v. Superior Court, 855 P.2d 375 (Cal. 1993); *In re* Peter, 529 A.2d 419, 425 (N.J. 1987).

autonomy interest of a suffering patient is just as strong when PAD is being sought as when treatment is being rejected. Moreover, any limitation to a particular life span would seem arbitrary. How close would death have to be in order for a stricken patient facing intolerable suffering to be entitled to relief? In short, Kamisar is right that any PAD prerogative could not plausibly be confined to the end stages of fatal illness.

C. *From the Chronically Ill to the Existentially Unhappy*

People can go through extreme emotional suffering unrelated to any underlying physical or mental infirmity. Various life circumstances — loss of a loved one, conviction of a shameful crime, or ruinous financial setback — have the potential to cause terrible anguish and despair. That despair, in turn, can prompt the unfortunate person to seek relief via suicide.

Yale Kamisar has always believed that legalization of PAS would ultimately lead to legalization of assistance to any ostensibly rational suicide.[146] For him, unbearable suffering is the justification for assisted suicide and such suffering extends beyond the realm of medical pathology to intolerably painful life circumstances. Just as mental anguish and an accompanying wish for death can understandably be grounded in a pathological medical condition, they can also be grounded in devastating life circumstances.[147] Kamisar and others[148] argue that compassion for suffering persons would make extension of legalized PAD to the context of existential unhappiness inevitable.

At first blush, the Dutch experience suggests that Kamisar's claim is correct, though the Dutch are still wrestling with the issue. In the Netherlands, physicians originally assumed that PAD would be confined to unbearable suffering connected to physical conditions — what the Dutch call suffering with a somatic basis.[149] In the early 1990s, however, a case arose indicating the Dutch system's tolerance for PAS grounded in mental anguish stemming from a pathological mental condition.[150] A series of traumatic events — the suicide of one son, a bitter divorce, and her last child's death from cancer — left fifty-year-

146. Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 233-35. Rational suicide would presumably be suicide based on verifiable circumstances so dismal that a choice to die seems "reasonable."

147. Glanville Williams, an initiator of the modern effort to legalize euthanasia, did not know whether PAS should be confined to painful physical disease or be extended to anyone in existential distress. Glanville Williams, *Euthanasia and the Physician*, *in* BENEFICENT EUTHANASIA 145, 165 (Marvin Kohl ed., 1975).

148. Pratt, *supra* note 80, at 165; Bumgardner, *supra* note 140, at 389.

149. GRIFFITHS ET AL., *supra* note 139, at 143-44.

150. *Id*. at 149-50, 329-37; Cohen-Almagor, *supra* note 138, at 335-39.

old Hilly Boscher suffering unbearably and seeking death. Doctor Chabot conducted thirty therapy sessions and recommended intensive grief therapy and antidepressants. Ms. Boscher declined further psychiatric intervention and persisted in her desire for assistance in suicide to end her unbearable anguish. Dr. Chabot then consulted by phone with four psychiatrists and proceeded to write a prescription for a poison that Ms. Boscher used to end her life. Dr. Chabot was convicted by a court for unlawfully assisting a suicide and also reprimanded by a medical disciplinary body. The derelictions prompting his conviction and discipline were his reliance on phone consultations and his failure to insist on further therapy for Ms. Boscher before supplying the means for suicide. Neither the court nor the professional disciplinary body required that psychic suffering justifying assisted suicide be based on a physical disorder.[151] The unbearable suffering necessary to justify PAD could apparently be based on a psychic disorder such as Ms. Bosch's pathological depression.

A subsequent case, however, signaled that the Dutch system does not authorize assistance to suicide where the person seeking assistance is merely escaping adverse life circumstances. General physical decline due to aging made eighty-six-year-old Mr. Brongersma feel that he was leading " 'a pointless and empty existence.' "[152] He sought assistance in dying to relieve his unhappiness. Dr. Sutorius provided the means and Mr. Brongersma committed suicide. Dr. Sutorius was accused of going beyond the permissible bounds of assistance to suicide, but the trial court acquitted him. In 2000, the Dutch court of appeals and the Dutch medical society both rejected the trial court's position. For them, unbearable suffering justifying assistance to suicide had to be grounded in physical or psychiatric illness rather than mere unhappiness associated with aging.[153] They drew a line between suffering stemming from medical conditions and existential suffering.[154] Not everyone in the Netherlands agrees with that line. After the Netherlands in 2001 adopted a statute authorizing PAD for "lasting and unbearable suffering," some elderly people demanded that the right to assistance in dying be extended to them even if they were just tired of life.[155] But the line between existential unhappiness

151. GRIFFITHS ET AL., *supra* note 139, at 334-35.

152. Cohen-Almagor, *supra* note 138, at 340 (quoting Tony Sheldon, *Dutch GP Cleared after Helping to End Man's 'Hopeless Existence,'* 321 BRIT MED. J. 1170, 1174 (2000)).

153. Cohen-Almagor, *supra* note 138, at 340-41. The Royal Dutch Medical Society declared that basing PAD on a person's "social decline," rather than on physical or psychiatric illness, "stretched too far" the appropriate guideline — unbearable suffering. *Id.*

154. KEOWN, *supra* note 41, at 87, 290.

155. Dec. 12, 2001 e-mail from Derek Humphrey.

and somatic bases for suffering currently appears to hold in the Netherlands.

On the question of whether legalized PAD must ultimately be extended to people anguished by life circumstances, Kamisar is probably wrong. American society has a long history of antipathy toward suicide, perhaps grounded in the stereotypical image of a deranged, spurned lover or bankrupt entrepreneur. Supporters of death with dignity did not attack all suicide laws, but rather their application to people afflicted with serious illness. Though Chief Justice Rehnquist cheated in *Washington v. Glucksberg* when he essentially treated the dying patients' claim as a generalized attack on government impediments to all suicides, he was correct that this country has never recognized a broad right to choose the time and manner of one's death. Nor has it ever recognized a broad right to freedom from suffering. Generally, people are not required to be good Samaritans to suffering strangers and injured people are expected to cover their own catastrophic losses.

The prevailing American ethic respects autonomy in the face of natural affliction,[156] not escape from unhappy life circumstances. The probable explanation is that American society draws a moral line between choosing death in the face of affliction and choosing death to escape unhappy circumstances.[157] Society deeply sympathizes with people facing fatal afflictions, especially when those people seek to avoid a demeaning dying process and especially when they are resisting bodily invasions. Society somehow deems it morally offensive for people to repudiate life just because of circumstances that might change at any moment, while it understands inability to cope with natural afflictions of the body. In upholding a competent patient's rejection of further life-sustaining respirator therapy, for example, the Nevada Supreme Court commented: "[I]f Kenneth had enjoyed sound physical health, but had viewed life as unbearably miserable because of his mental state, his liberty interest would provide no basis for asserting a right to terminate his life with or without the assistance of other persons."[158]

The superior moral status of seeking death in the face of affliction — as opposed to adverse life circumstances — is reflected in the divergent legal treatment of persons seeking to die by refusal to eat.

156. For people who have never been competent, the prevailing ethic is respect for intrinsic dignity and well-being rather than autonomy. *See* NORMAN L. CANTOR, MAKING MEDICAL DECISIONS FOR THE PROFOUNDLY MENTALLY DISABLED (forthcoming from M.I.T. Press 2005).

157. David Orentlicher & Lois Snyder, *Can Assisted Suicide Be Regulated?*, 11 J. CLINICAL ETHICS 358, 360 (2000); J. David Velleman, *A Right of Self-Termination?*, 109 ETHICS 606 (1999).

158. McKay v. Bergstedt, 801 P.2d 617, 625 (Nev. 1990).

Courts allow fatally afflicted medical patients to cease eating and reject ANH, but generally restrain physically healthy hunger strikers who determine to precipitate their own demise by refusing to eat.[159]

Existentially unhappy people have the means to kill themselves. Though many jurisdictions authorize physical intervention to prevent a suicide, there is rarely a legal prohibition on the act of suicide. Unhappy people can't expect society in general or the medical profession in particular to facilitate their suicidal course. Physicians have an acknowledged role and experience in diagnosing and healing illness, in relieving suffering associated with illness, and in managing the dying process for fatally afflicted persons;[160] they have no comparable expertise in relieving unhappy people suffering from life circumstances.

In sum, traditional social aversion to suicide grounded in unhappy life circumstances would likely confine legalized PAD to people whose unbearable suffering is associated with a medical affliction. This line might not be fully logical or satisfying. An unhappy elderly person merely tired of life would not be entitled to PAD, but that same person might suddenly become eligible to choose PAD following the happenstance of breaking his hip. (A similar anomaly exists regarding an existentially unhappy person whose health deteriorates, ultimately making the person dependent on medical intervention and therefore entitled to precipitate his own death.) The point here is that Kamisar's forecast — that legalized PAD must ultimately extend to all people with a rational basis for suicide — seems wrong. That error, however, by no means vitiates Kamisar's contention that PAD will yield unacceptable extensions. His most foreboding prediction is that PAD would not be confined to competent persons.

D. *From Voluntary Euthanasia to Nonvoluntary or Even Involuntary Euthanasia*

Yale Kamisar is convinced that euthanasia could never be confined to competent persons.[161] This is essentially because suffering can be just as intractable and heart-wrenching for people not competent to make their own medical decisions as for competent persons. He also foresees extension of active euthanasia to people whose existence becomes inconvenient or burdensome for those around them. As support for his predictions, he cites two phenomena — medical

159. Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 95-100 (2000).

160. By managing the dying process, I mean the physician's role in withholding or removing LSMT and providing palliative care to a moribund patient.

161. *See* Kamisar, *PAS: The Last Bridge*, *supra* note 4, at 250.

practice in the Netherlands over the last twenty-five years and existing American medical practice that allows termination of life support for permanently unconscious patients on the "pretension," he says, that such termination is fulfilling the wishes of the unconscious patient.[162] (He apparently believes that permanently unconscious persons are frequently removed from life support to suit the comfort and convenience of surrounding people rather than to fulfill the now-incompetent patient's wishes.) Kamisar's underlying premise seems to be that extension of PAD to nonvoluntary euthanasia would not only be inevitable, but also a dangerous and unsavory development.

Kamisar is almost certainly correct that the impetus to extend PAD to incompetent patients would be overwhelming. When a dying, incompetent patient has reached a point of deterioration that would prompt most competent patients to seek PAD, the impulse to extend similar "relief" to incompetent patients seems irresistible.[163] This is especially true for a formerly competent patient who previously stated that she did not want to live in such a debilitated status,[164] but it is also true for now-suffering patients who have never been competent to express their own preferences. Infants born with multiple deficits who are destined to live a short but painful existence provide one example.[165]

A similar phenomenon took place in the context of LSMT. In theory, cessation of life support could have been confined to competent patients determining their own fate. Yet most jurisdictions recognized that such a policy would be inhumane to incompetent patients, as once a patient became incompetent they would have to be preserved by medical intervention no matter how torturous or demeaning their dying process might be. Most states therefore permitted surrogate end-of-life decisions according to the projected wishes of formerly competent patients or according to the best interests of now-incompetent patients.[166]

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162. Kamisar, *Against Assisted Suicide*, *supra* note 4, at 751-52; Kamisar, *The Reasons So Many People Support PAS*, *supra* note 4, at 115.

163. To be sure, there are commentators who insist that active euthanasia could and should be confined to competent persons. *E.g.*, Bertram & Elsie Bandman, *Rights, Justice, and Euthanasia*, *in* BENEFICENT EUTHANASIA 81, 91-96 (Marvin Kohl ed., 1975); Baruch Brody, *Voluntary Euthanasia and the Law*, *in* BENEFICENT EUTHANASIA 218 (Marvin Kohl ed., 1975). Neither Kamisar nor I believe that such a limitation can be maintained.

164. "Where a patient has consistently expressed a desire for euthanasia when a certain point is reached, the doctor may feel justified in assisting the patient, even when dementia intervenes in the meantime." MAGNUSSON, *supra* note 81, at 97.

165. Tracy K. Koogler et al., *Lethal Language, Lethal Decisions*, HASTINGS CENTER REP., Mar.-Apr. 2003, at 37, 39; Mark Sklansky, *Neonatal Euthanasia: Moral Considerations and Criminal Liability*, 27 J. MED. ETHICS 5, 8 (2001); American Medical Association, Code of Ethics E-2.215, Treatment Decisions for Seriously Ill Newborns, *available at* http://www.ama-assn.org/ama/pub/category/8460.html (last updated July 22, 2002).

166. *See* Cantor, *Twenty-five Years after* Quinlan, *supra* note 3, at 191.

Experience in the Netherlands tends to confirm Kamisar's prediction about nonvoluntary euthanasia. When euthanasia was initially practiced there, the assumption was that hastening the death of anyone in the absence of an explicit, competently made request would constitute murder.[167] Dutch medical practice eventually overrode that constraint in several areas — desperately ill newborns, permanently unconscious persons, now-incompetent patients who had previously declared their wishes,[168] and now-incompetent patients in the final stages of a dying process. Ever since the Dutch began to survey euthanasia practices in the late 1980s, the data have shown that each year approximately 1000 cases of nonvoluntary euthanasia take place. Also, in approximately 1300 other cases, Dutch physicians annually administer lethal doses of analgesics to suffering, incompetent patients with the intention of ending those patients' lives.[169] The Dutch do not classify such actions as euthanasia, but such lethal actions would be deemed euthanasia in the United States.

In 1995, Dutch physicians used active euthanasia to terminate the lives of a number of infants born with multiple congenital disorders who were unavoidably dying, who did not die when medical intervention ceased, and whose pain treatment was not entirely successful.[170] In one instance, a baby girl was born with Trisomy 13, a chromosomal condition causing deformities of the heart, kidneys, and brain.[171] Her projected life span was a few months. Pain treatment did not seem fully effective and the baby was enduring side effects from pain medication. Facing their child's prospect of further deterioration and increased suffering, the parents requested and the treating physician administered a lethal injection. While many Dutch physicians would have refused to perform euthanasia in such circumstances, others were willing to provide what they perceived as humane relief. Prosecutions ensued in two cases, but the trial and appellate courts upheld the use of active euthanasia.[172] Dutch physicians have administered active euthanasia as well to permanently unconscious patients and to now-incompetent patients who previously expressed a wish to die.[173] In short, Dutch medical practice did extend

167. GRIFFITHS ET AL., *supra* note 139, at 131-33.

168. *Id*. at 96-97, 131-32.

169. *Id*. at 18; KEOWN, *supra* note 41, at 106-08; Bumgardner, *supra* note 140, at 413-14.

170. GRIFFITHS ET AL., *supra* note 139, at 124-26; KEOWN, *supra* note 41, at 119-20, 130; SMITH, CULTURE OF DEATH, *supra* note 119, at 61-63; Jochemsen, *supra* note 46, at 451-53.

171. GRIFFITHS ET AL., *supra* note 139, at 341-43.

172. *Id*. at 348-49.

173. The phenomenon of euthanasia of now-incompetent patients has surfaced in studies of covert euthanasia as practiced in the United States. *See* Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide in the United States*, 280 JAMA 507, 509, 511 (1998); Rocker & Curtis, *supra* note 43, at 821. A survey of American doctors

PAD from its origins as a purely voluntary measure to some instances of nonvoluntary active euthanasia.[174]

The Dutch experience seems to verify Kamisar's slippery-slope thesis that the slide to nonvoluntary euthanasia would in fact take place if PAD were legalized in the United States. The same compassion toward people facing unbearable suffering or personally intolerable degradation as that which prompted Dutch doctors' transition to nonvoluntary PAD would surely move American physicians in the same direction. The harder question is whether, as Kamisar asserts, the extension of PAD to nonvoluntary situations would be an unacceptable development.

According to many sources, the real danger in nonvoluntary PAD (beyond the symbolic message supposedly undermining sanctity of life as described in Part I) is unsavory physician participation in "arbitrary, unjust judgments about the worth of their patients' lives."[175] From that perspective, the real slippery slope is toward "lack of worth" judgments that will serve for "weeding out the handicapped, the old, the mentally retarded, whoever [doesn't] fit 'secular humanist' notions of the 'quality of life.' "[176] It is supposedly impossible to draw a

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frequently dealing with end-of-life cases indicated that 7% had administered lethal injections to patients and 4.4% had provided poisons for patients. Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1199 (1998). Among the 7% administering lethal injections, the physicians indicated that the patient was probably incompetent in almost 50% of the cases. But in 100% of the cases the physicians believed that the action reflected the patient's putative wishes.

174. Dutch practice, even as applied to competent patients, has often deviated from the guidelines provided by the courts for defensible PAD. For relevant data, see KEOWN, *supra* note 41, at 205-07, and Cohen-Almagor, *supra* note 138, at 319-30. While the Dutch patient seeking PAD is supposed to make persistent requests for PAD, data indicate that some physicians acted after only one request and without the requisite waiting period in making PAD available. While the cooperating physician is supposed to consult with another physician about the patient's medical and psychological condition, Dutch physicians sometimes implemented PAD without an independent consultation. When physicians were prosecuted for failing to get an independent consultation, they were acquitted, merely admonished, or given light punishment. Cohen-Almagor, *supra* note 138, at 329-30. In addition, many Dutch physicians have ignored the reporting requirements attached to PAD.

Perhaps there are cultural explanations for the Dutch medical deviations from guidelines. No physician likes what are perceived as administrative hurdles to sound medical practice. But the Dutch deviations from guidelines reflect a certain indifference to disciplinary mechanisms — an indifference that might be grounded in Dutch medical custom and tradition. Dutch physicians have certainly been free from widespread malpractice claims and from tight regulatory control. Perhaps American physicians would be more risk aversive and more compliant toward a regulatory scheme. Nonetheless, the important point is not the procedural deviations from Dutch guidelines, but rather that Dutch practice clearly slid from voluntary to non-voluntary PAD.

175. KEOWN, *supra* note 41, at 252; PETER BYRNE, PHILOSOPHICAL AND ETHICAL PROBLEMS IN MENTAL HANDICAP 81 (2000).

176. PETER G. FILENE, IN THE ARMS OF OTHERS 112 (1998) (quoting Russell Shaw, *Death of Infant Doe: Why All the Surprise?* WASH. POST, MAY 15, 1982, at A19); *see also* Cruzan v. Harmon, 760 S.W.2d 408, 420 (Mo. 1988); KEOWN, *supra* note 41, at 25, 244; SMITH, CULTURE OF DEATH, *supra* note 119, at 33-42, 65-78.

principled line that would safely guide surrogate end-of-life decisions regarding mentally incapacitated patients when no previously expressed wishes are available.[177] Nonvoluntary PAD would, then, Kamisar claimed, pose an insidious threat to vulnerable populations.

Neither American nor Dutch experience with the medical handling of mentally incompetent patients supports the envisioned scenarios. It is true that Dutch physicians participate each year in administering PAD to between one and three thousand mentally incompetent patients. Yet there has been no demonstration that these cases involve arbitrary or malevolent extermination of vulnerable, undervalued persons. A number of facts tend to dispel any such specter. In approximately 90% of these nonvoluntary cases, the patient's life is shortened by less than a week.[178] This fact tends to show that the vast majority of nonvoluntary PAD in the Netherlands relates not to elimination of inconvenient or burdensome persons, but rather to hastening death at the end stage of conditions that make the dying process particularly painful or demeaning. A significant number (perhaps 25% of the entire total of nonvoluntary deaths) involve some kind of advance instruction — that is, situations where the now-incompetent person previously expressed a wish to die under circumstances like those at hand.[179] In a majority of the cases not involving prior expressions, physicians are moved by the perception that the patients are suffering severely; that is, the judgment is being made (usually by a physician and the family of the patient together) that the patient's best interests dictate PAD.[180]

Commentators also object to what they see as a particularly wide opening for subjective judgments that certain lives are not worth preserving. They claim that some measure of nonvoluntary PAD is

177. KEOWN, *supra* note 41, at 251. Most sources concede that implementation of previously made, competent patient instructions should be permitted. Without that mechanism, an incentive would exist for competent, degenerating patients to prematurely seek to hasten death, fearful that if they slipped into incompetency their preferences about an appropriate end of life would not be honored. Interestingly, the new Dutch law has made provision for advance instructions to be implemented in the context of PAD. Cohen-Almagor, *supra* note 138, at 325.

178. GRIFFITHS ET AL., *supra* note 139, at 205-06, 225-28.

179. *Id*.; KEOWN, *supra* note 41, at 104-05.

180. KEOWN, *supra* note 41, at 104-05; Mendelson & Jost, *supra* note 73, at 138; Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1197-99 (1993). For some commentators, even egregious suffering is not a proper basis for ending a patient's existence. These commentators believe that suffering has redemptive value and that a troubled dying process challenges the expiring patient to show courage and composure. KASS, *supra* note 34, at 38; Gerald D. Coleman, *Assisted Suicide: An Ethical Perspective*, 3 Issues in L. & MED. 267, 276 (1987) (referring to suffering as "an authentic means of spiritual growth"); Lavi, *supra* note 72, at 738-40. That is small consolation for suffering mortals who have already lost their cognitive abilities or who are unable to meet the spiritual challenge of overcoming pain.

performed in the Netherlands on the rationale of patient degeneration into such a level of indignity that the patient would not want to survive in that status. The further claim is that in judging intolerable indignity the doctor substitutes her own valuation of the patient's existence for that of the patient.[181]

Yet experience in the United States, in the context of removal of LSMT from incompetent patients, indicates that intolerable indignity can be an appropriate and manageable criterion for surrogate end-of-life decisionmaking.[182] The real ethic of United States death and dying jurisprudence is to replicate what the now-incompetent patient would want done in the circumstances at hand.[183] Where patients have previously expressed their own vision of intolerable indignity, as in an advance directive rejecting LSMT under certain circumstances, they have exercised a prospective autonomy that every state respects. In the absence of prior instructions, governing standards of substituted judgment, best interests of the patient, or constructive preference come into play.[184] Constructive preference is a technique for making surrogate medical decisions on behalf of incompetent persons who have not issued prior instructions. The premise is that the vast majority of people care about indignity or quality of life in the dying process, and that — at least as to certain commonly occurring end-of-life scenarios — common preferences about intolerable levels of indignity can be objectively ascertained and used as default presumptions to guide surrogates.[185] Strong common preferences are determinable via existing surveys, typical advance directives, and knowledge based on life experience. A shared judgment about intolerable indignity accounts for the widespread practice of American courts and legislatures to permit surrogate decisions removing life support from permanently unconscious patients who have not left prior instructions to the contrary; approximately 90% of people would want to be allowed to die in those intrinsically undignified circumstances.[186] Kamisar calls this approach to shaping treatment of

181. GRIFFITHS ET AL., *supra* note 139, at 137-39; KEOWN, *supra* note 41, at 105.

182. The term originally used to describe surrogate removal of life support from incompetent patients was passive, nonvoluntary euthanasia.

183. *See* Norman L. Cantor, *The Real Ethic of Death and Dying*, 94 MICH. L. REV. 1718, 1731-35 (1996) (book review) [hereinafter Cantor, *The Real Ethic*].

184. The concept of surrogate decisionmaking according to constructive preference is spelled out in Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 RUTGERS. L. REV. 1193 (1996) [hereinafter Cantor, *Discarding Substituted Judgment*].

185. *Id.* at 1256-57; Cantor, *Twenty-five Years after* Quinlan, *supra* note 3, at 192-93.

186. For survey data about public attitudes toward permanent unconsciousness, see James Lindgren, *Death by Default*, 56 LAW AND CONTEMP. PROBS., Summer 1993, at 185,

the permanently unconscious a pretense of fulfilling patients' wishes. I call it an accurate projection of patients' likely wishes based on what a large majority of people would want done for themselves in similar circumstances. In situations where no clear majority sentiment is discernible, the customary presumption in favor of life should prevail.

These surrogate judgments are not expressions that the unconscious patient has no value or is worthless. By using medical decisionmaking standards like best interests of the patient, substituted judgment (where some evidence of the patient's treatment wishes exist), or constructive preference, surrogates seek to replicate what an incompetent patient would likely want done in the circumstances at hand.

American experience does not yield data indicating that surrogate judgments about patients' best interests or likely preferences produce arbitrary or discriminatory decisions to cease LSMT. Thousands of medically managed deaths occur each week. The outcries of vitalists and right-to-life advocates to the contrary notwithstanding,[187] any deviation from sound medical practice in end-of-life decisionmaking continues to be in the direction of excessive, unwarranted medical intervention and not premature termination of life. In sum, although voluntary PAD would indeed be extended to nonvoluntary PAD just as Kamisar projected,[188] that does not necessarily mean such an extension is as highly objectionable as Kamisar claims. Nonvoluntary PAD would be administered according to the same standards applicable to surrogate LSMT decisions for incompetent patients.

198-99, and Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-to-Die Jurisprudence*, 25 U. MICH. J.L. REFORM 133, 157-58 (1991).

187. SMITH, CULTURE OF DEATH, *supra* note 119, at 33-39; SMITH, FORCED EXIT, *supra* note 87, at 36-67; Johnson, *supra* note 82, at 323-28.

188. While I concur with the prediction that voluntary euthanasia would eventually slide to nonvoluntary euthanasia, I disagree that involuntary euthanasia is also an unavoidable development. Physician-performed involuntary euthanasia — a killing contrary to the wishes of a competent patient or the agent of an incompetent patient — is anathema in American society and is not likely to materialize if PAD were legalized. Involuntary mercy killing is an oxymoron. The Nazis branded what they did as euthanasia, but it was not. Their program was killing grounded in disdain rather than compassion. *See* WENNBERG, *supra* note 141, at 218-19; Browne, *supra* note 100, at 47; Newman, *supra* note 80, at 167-68. Even if a physician's motive for an involuntary killing were compassion, the physician's unilateral act would be unsupportable. *See* Cohen-Almagor, *supra* note 138, at 341 (describing the criminal conviction of a Dutch doctor for performing a mercy-motivated killing over the opposition of the incapacitated patient's daughter). There is ordinarily no physician's prerogative to perform any medical procedure — let alone a killing — without informed consent. In the U.S., there have been moments when elements within the pro-euthanasia movement showed signs of embracing involuntary euthanasia for the socially undesirable. Lavi, *supra* note 72, at 758-59 (describing the platform of the Euthanasia Society of America in 1938); Teresa Harvey Paredes, *The Killing Words? How the New Quality-of-Life Ethic Affects People with Severe Disabilities*, 46 SMU L. REV. 805, 821 (1992) (describing sinister bills introduced before the Florida legislature in the late 1960s and early 1970s). None of these plans ever came close to being socially accepted.

To me, that seems like a desirable result. In the context of LSMT, next of kin or appointed health-care agents tend to be cautious and hesitant in making surrogate medical decisions for fatally afflicted patients. Surrounding family and medical personnel serve as a check against abusive decisions by surrogates. Nonvoluntary, active euthanasia would be subject to the same standards and safeguards. The question, for me, is not whether PAD is appropriate, but whether it is necessary in light of existing medical approaches to alleviating the strains of the dying process.

III. IS PAD NECESSARY?

Yale Kamisar understood that while emotionally compelling cases for PAD might sometimes arise, legalization of PAD must be considered in light of various hazards of abuse and unsavory extensions associated with PAD and in light of the possibility that other modes of averting a painful death might obviate the necessity for PAD. The alternative modes he perceived in 1958 included non-medical ways of committing suicide and emerging medical techniques for providing palliative care to ease the dying process. The more attractive of these options is effective palliative care that would ease the dying process and provide an incentive for patients to continue to live. Enormous strides in palliative techniques — particularly in pain relief — have occurred since 1958. Those developments surely warrant consideration before reaching any conclusion about legalization of PAD.

Contemporary opponents of PAD stress availability of modern pain-relief methods as an antidote to the pain and discomfort of a difficult dying process.[189] Virtually all seriously ill patients can be made physically comfortable, they say, especially if deep sedation is used in intractable cases.[190] To the extent sophisticated pain relief methods are not sufficiently widespread, they urge more and better training in palliative care rather than resort to PAD. For them, *"[m]edicine in fact has a great deal to offer, right up to the end, and failure to do so demands reform, not physician-assisted suicide*."[191] Good palliative care thus seems to offer a life-affirming route and does not prolong a natural dying process.

189. *E.g.*, Nathan Cherny et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. PALLIATIVE CARE 71 (1994); Cohn & Lynn, *supra* note 28, at 244-45.

190. *See* Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death*, 154 ARCHIVES INTERNAL MED. 2039, 2041 (1994) [hereinafter Billings & Block, *Patient Requests*]; Martyn & Bourguignon, *supra* note 88, at 39 (noting that physical pain can be controlled in 98% of cases and deep sedation can be used in the remainder of cases).

191. Cohn & Lynn, *supra* note 28, at 244 (emphasis in original); *see also* Misbin, *supra* note 28, at 1311.

The notion that effective pain relief obviates the necessity for PAD runs into some major problems. Most prominently, psychological or emotional suffering, rather than physical pain, is the source of most people's desire to hasten death.[192] Anxiety, dread, and frustration associated with actual and prospective debilitation and degeneration supply a major impetus for dying patients seeking to hasten death. Psychological interventions as part of good palliative care can alleviate the emotional suffering of most of these patients, but some can't be swayed in their desire for PAD.[193] Deep sedation offers a potential haven from this intractable emotional suffering,[194] but the stupor or unconsciousness accompanying such sedation makes it a distasteful, demeaning option for some seriously ill patients.[195] When helplessness, dependence, and indignity are major sources of upset to a dying patient, the prospect of lingering under deep sedation is not very palatable. Some patients therefore decline deep sedation and medical providers are understandably unwilling to override that opposition.[196] And while patients rejecting sedation can still be provided with social and psychological support, some small number of dying patients will still prefer PAD.

The reality is that pain control and good palliative care are not full remedies for the indignity and emotional suffering that most disturb dying patients.[197] More and more data indicate that an unacceptable quality of life — usually meaning indignity associated with helplessness, loss of control, dependence, and sense of being a burden — account most for dying patients' desires to hasten death.[198] Not physical pain, but rather "the prospect of losing control and

192. Cerminara, *supra* note 95, at 288; Newman, *supra* note 80, at 181.

193. Emanuel et al., *supra* note 173, at 512 ("[P]alliative care is not necessarily an effective response to patients' request for euthanasia and PAS.").

194. Chochinov & Schwartz, *supra* note 89, at 276.

195. "Some see this 'pharmacological oblivion' as preferable to euthanasia, while others regard a drug-induced stupor in a patient who has requested release as a cruel denial of patient autonomy . . . ." MAGNUSSON, *supra* note 81, at 87. "Any protracted period of helpless, insensate lingering is anathema to people seeking a dignified passing." Cantor, *Twenty-five Years after* Quinlan, *supra* note 3, at 304.

196. When patients do reject deep sedation, complications such as fatigue, breathlessness, dyspnea, nausea, vomiting, incontinence, and helplessness may still make their conscious existence uncomfortable and undignified. Browne, *supra* note 100, at 48-49.

197. William Breitbart et al., *Depression, Hopelessness, and Desire for Hastened Death in Terminally Ill Patients with Cancer*, 284 JAMA 2907, 2910 (2000); Arthur L. Caplan et al., *The Role of Guidelines in the Practice of Physician-Assisted Suicide*, 132 ANNALS INTERNAL MED. 476, 480 (2000).

198. "Research indicates that indignity, dependency and lack of control are more important than pain in motivating the desire to die." MAGNUSSON, *supra* note 81, at 90; *see also* Calandrillo, *supra* note 93, at 61; Emanuel et al., *supra* note 173, at 509; Gunderson & Mayo, *supra* note 100, at 284-85; Johnson, *supra* note 82, at 324-25; Quill et al., *Care of the Hopelessly Ill*, *supra* note 120, at 1383.

independence and of dying in an undignified, unesthetic, . . . and existentially unacceptable condition"[199] often account for such a desire. In the Netherlands, for example, 46% of patients seeking euthanasia cite physical pain as an influencing factor while 57% cite loss of dignity and 33% mention dependence.[200] Likewise, data from Oregon's experience with legalized physician-assisted suicide support the notion that indignity is a bigger impetus than pain for patients seeking death.[201] Similar conclusions flow from a study examining the impetus for patients who seek aid in dying in jurisdictions where such aid is unlawful.[202] People care mightily about a soiled image left in the memories of loved ones when a dying process is protracted and demeaning.[203] That aversion to indignity accounts for the unwillingness of some patients to accept deep sedation as a form of relief from emotional suffering. In short, good palliative care cannot alter the will of some small number of patients to accelerate their own deaths.

There are ways of hastening death (other than traditional PAD) that have surfaced over the last decades. Do these "new" forms — only dimly imagined in 1958 — obviate the need for PAD and is their legal and moral status significantly different from PAD? The first new form of hastening death is voluntary stopping of eating and drinking ("VSED"). A patient who rejects all nutrition and hydration will expire from dehydration in ten to fourteen days, less if the patient is already weakened by an enervating medical condition. With appropriate palliative care, the VSED patient will slip into a coma within days and will not suffer during the dying process.[204] The VSED

199. Quill et al., *Care of the Hopelessly Ill*, *supra* note 120, at 1383.

200. KEOWN, *supra* note 41, at 109. *But see id.* at 127 (describing somewhat different results from a 1995 study, though 56% of patients seeking euthanasia still cite loss of dignity as a factor).

201. Bumgardner, *supra* note 140, at 400; *see also* Billings & Block, *Patient Requests*, *supra* note 190, at 2043; Joan Arehart-Treichel, *Terminally Ill Choose Fasting Over M.D.-Assisted Suicide*, PSYCHIATRIC NEWS, Jan. 16, 2004, at 15.

202. Meier et al., *supra* note 173, at 1197 (indicating that 53% of such patients are moved by loss of dignity).

203. Justice Stevens has acknowledged a dying patient's "interest in dignity, and in determining the character of the memories that will survive long after her death." Washington v. Glucksberg, 521 U.S. 702, 743 (Stevens, J., concurring) (footnote omitted). Judge Reinhardt, in his Ninth Circuit opinion later reversed by the Supreme Court, remarked:

> A competent terminally ill adult . . . has a strong liberty interest in choosing a dignified and humane death rather than being reduced . . . to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.

Compassion in Dying v. Washington, 79 F.3d 790, 814 (9th Cir. 1996).

204. *See* HOEFLER, *supra* note 112, at 112-23; Ira Byock, *Patient refusal of nutrition and hydration: Walking the ever-finer line*, 12:2 AM. J. HOSPICE & PALLIATIVE CARE (March 1995) 8, 11.

technique certainly smacks of suicide (given the patient's initiation of a purposeful course of conduct hastening death) and the health care provider's cooperation with the process smacks of assistance to suicide. Similar self-destructive conduct by physically healthy persons is usually branded as suicide. That is, in most jurisdictions an otherwise healthy hunger striker is usually viewed as attempting suicide and is deemed to be subject to unwanted but life-sustaining medical intervention.[205] Nonetheless, when a dying, debilitated patient competently decides to forgo further nutrition and hydration, neither courts nor health care providers are inclined to intervene.[206] On an emotional plane, the specter of restraining or force-feeding a dying patient is repugnant.[207] On a legal plane, the patient is invoking a traditional prerogative to resist unwanted medical invasions. Some commentators therefore call the VSED approach a "lawful variant" of rejecting LSMT.[208] Interestingly, a recent survey of nurses in Oregon suggests that more patients die there via VSED than by physician-assisted suicide.[209]

A variant of VSED is a technique called terminal sedation. Under this technique, deep sedation renders a patient unconscious or stuporous until death ensues. This usually occurs toward the end stage of a person's dying process. Terminal sedation can take several forms, some of which are clearly lawful.[210] For example, deep sedation may serve as a palliative during withdrawal of life-sustaining medical machinery in order to ease the concomitant passing. Or deep sedation may be instituted when an egregiously suffering patient is within hours or days of death — a point when it is impossible to know whether the

205. *E.g.*, *In re* Caulk, 480 A.2d 93 (N.H. 1984); Von Holden v. Chapman, 450 N.Y.S.2d 623 (N.Y. App. Div. 1982); *see* NORMAN L. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 26-28 (1987) [hereinafter CANTOR, LEGAL FRONTIERS]; *see also* KEOWN, *supra* note 41, at 229-30. In the case of prisoners initiating hunger strikes, American courts usually authorize prison authorities to intervene and salvage the patient.

206. In the few cases that have arisen, courts have upheld the prerogative of a fatally afflicted patient to resist nutrition. *See* Cantor, *Legal Frontiers, supra* note 205; Cantor & Thomas, *supra* note 159, at 110-12.

207. Stephen G. Post, *Tube Feeding and Advanced Progressive Dementia*, HASTINGS CENTER REP., Jan.-Feb. 2001, at 36, 38; Cantor, *Twenty-five Years after* Quinlan, *supra* note 3, at 184.

208. Louise A. Printz, *Terminal Dehydration, a Compassionate Treatment*, 152 ARCHIVES INTERNAL MED. 697 (1992); Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099 (1997) [hereinafter Quill et al., *A Comparison*]; Timothy E. Quill et al., *Palliative Treatments of Last Resort: Choosing the Least Harmful Alternative*, 132 ANNALS INTERNAL MED. 488, 490-91 (2000) [hereinafter Quill et al., *Choosing the Least Harmful Alternative*].

209. Arehart-Treichel, *supra* note 201.

210. For a full explication of terminal sedation and its legality, see Cantor & Thomas, *supra* note 159, at 138-51.

sedation even hastens death. Terminal sedation becomes more controversial when a dying patient capable of surviving for more than a few days consents to deep sedation in order to relieve intolerable suffering and simultaneously consents to withholding of ANH after sedation is administered. The consequence is that death will ensue within days either from dehydration or from the underlying disease.[211]

From one perspective, a physician who administers the sedation and withdraws ANH knowing that the patient will soon die appears to be assisting a suicide. Cessation of hydration then seems like a gratuitous means to hasten death, as relief of suffering is already accomplished by deep sedation. From another perspective, the terminal sedation technique is just another form of acceptable palliative care[212] — "a combination of aggressive symptom management (sedatives to treat unbearable symptoms) and withdrawal of life-sustaining therapy (fluids, nutrition, and other treatments)."[213] The legal status of terminal sedation is still unclear.[214] If it is lawful, and I think it is, one thing is sure. The physician's conduct in initiating deep sedation and then cooperating in the rejection of further medical intervention (knowing that the patient will die) looks a lot like PAD. Especially when terminal sedation is undertaken long before the underlying disease process would otherwise have taken its toll, this terminal process walks, talks, and squawks like PAD.

Another way of hastening death is to administer analgesics in sufficient dosage to accelerate death. As George Thomas and I have explained elsewhere,[215] the governing principles are found in the law of recklessness and justification. A physician is justified in incurring some risk of death in order to relieve a patient's unbearable suffering. Administering analgesics that risk death but promise relief of intense suffering is not criminal so long as reasonable alternative pain-relief methods are not available, care is taken in increasing dosages, and the dosage only *risks* causing death.[216] We maintain that the criminal law

211. Roger Magnusson describes terminal sedation as a frequent "method of choice" for end-stage AIDS patients seeking to hasten their deaths. MAGNUSSON, *supra* note 81, at 87; s*ee also supra* note 209 and accompanying text.

212. Alexander Morgan Capron, *Care of the Dying: Withholding Nutrition*, HASTINGS CENTER REP., Oct.-Nov. 1984, at 32-35.

213. Quill et al., *Choosing the Least Harmful Alternative*, *supra* note 208, at 491.

214. *See* Cantor & Thomas, *supra* note 159, at 142-50. Certainly, when used at the end-stage of disease, a cooperating physician is effectively immune from prosecution. Causation could not readily be proved, for the debilitated patient might have died because of the underlying disease process rather than the physician's actions.

215. Cantor & Thomas, *supra* note 159, at 131-39.

216. In order to avoid reckless practice, the degree of risk must be proportionate to the analgesic relief provided and the physician must have tried less-dangerous analgesics previously. CANTOR, LEGAL FRONTIERS, *supra* note 205, at 312-15. "Ethically, strong

prohibits pain relief in a dosage that a physician *knows* will kill a patient, regardless of whether the physician's motive is to relieve suffering.[217] And a person "knows" that death will ensue if death is "certain or practically certain" to follow.[218] Yale Kamisar agrees.[219]

Other sources, however, have suggested that a physician may lawfully administer pain relief in a dosage that the physician knows will cause death. Conventional wisdom claims that administration of analgesics necessary to relieve suffering is lawful, however great the risk, so long as the physician's primary intent is to relieve suffering.[220] The Supreme Court seemingly legitimized this misguided conventional wisdom about aggressive pain relief in *Washington v. Glucksberg*,[221] where five Justices suggested that a knowingly lethal pain relief dosage would be legally tolerable so long as the administering person intended to relieve suffering rather than cause death.[222] This

support exists for gradually increasing medication in terminal illness to levels that relieve pain, even if a side effect is to shorten life." Maynard et al., Am. Coll. of Physicians, *supra* note 70, at 955.

217. GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 321-22 (1957); Cantor & Thomas, *supra* note 159, at 130-32; Raymond G. Frey, *Intention, Foresight, and Killing*, *in* INTENDING DEATH 66 (Tom L. Beauchamp ed., 1996); Miller, The Mental Element in Crime §§ 14, 16.

218. KEOWN, *supra* note 41, at 27-28 (describing British precedent); Cantor & Thomas, *supra* note 159, at 131-32 (referring to Section 210.2 of the Model Penal Code).

219. Kamisar, *The 'Right to Die,' supra* note 4, at 500. For him, our analysis showing that risky analgesics are legal, but that knowingly lethal analgesics are not, helps dispel the resemblance between active euthanasia and use of risky analgesics that might hasten death.

220. That wisdom approves dangerous pain relief so long as the pain relief is necessary and the person administering the analgesics primarily intends to relieve suffering rather than to kill the patient. KASS, *supra* note 37, at 37; David Thomasma, Bioethics 13:4 at 14. The claim is that the doctrine of double effect ("DDE") can be transposed to end-of-life jurisprudence and governs the legality of risky analgesics. Yet the DDE simply does not fit in this context. *See* Timothy E. Quill et al., *The Rule of Double Effect — A Critique of Its Role in End-of-Life Decision Making*, 337 NEW ENG. J. MED. 1768 (1997). First, under DDE the actor's motivation must solely be to relieve pain. Yet such a pure motivation is seldom present when large doses of painkillers are administered. Dutch experience shows that when physicians give large doses of painkillers to egregiously suffering patients, almost 40% either explicitly intend to shorten life or partly intend to shorten life. KEOWN, *supra* note 41, at 95 (noting that mixed intention is perfectly natural when the physician knows that only death will effectively end the suffering). American experience also discloses some underground practice of physicians administering analgesics with intent to end the patient's suffering by ending the patient's life. MAGNUSSON, *supra* note 81, at 192-94; Meier et al., *supra* note 173; Robertson, *supra* note 80, at 334; Marcia Angell, *No One Trusts the Dying*, WASH. POST, July 7, 1997, at A19 [hereinafter Angell, *No One Trusts the Dying*]; Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. TIMES, Nov. 1, 1994, at 27. Second, under DDE, the licit justification (here, pain relief) must be proportionate to the supposedly unwanted, but risked evil (suppressing respiration and killing the patient). However, the criminal law says that a purpose to relieve suffering is not a sufficient justification for a killing. The bottom line is that a physician's intention to relieve suffering does not make it lawful to administer analgesics in dosage that is known to be lethal.

221. 521 U.S. 702 (1997).

222. Several parties in briefs or oral argument contended that administration of necessary pain relief would be lawful even if it would certainly cause death. Language in the

suggestion from members of the Court prompted some commentators to herald an emerging constitutional "right to be free of unnecessary pain and suffering at the end of life."[223]

But if an intolerably suffering, competent patient is in fact entitled to receive an analgesic in dosage known to be fatal, then the traditional legal prohibition of PAD has been significantly eroded. Relief of suffering has never provided an adequate justification for killing a human in Anglo-American law. Traditional criminal law simply does not let the presence of extreme suffering by the victim and a merciful motive or intention by the perpetrator serve as a legal excuse or justification for knowingly killing a person. A knowing killing has always been treated as unlawful no matter how severe the victim's suffering, how near his death, how firm his request for death, or how motivated the killer is by a desire to relieve suffering.[224] Administering a drug dosage that is known to be lethal is an unlawful killing whether the actor intends to relieve suffering, intends to cause death, or intends to cause death in order to relieve suffering. So if the administration of pain relief in dosage known to be lethal is legally protected conduct, precious little difference exists between this currently condoned form of hastening death and forms of PAD like providing a poison or injecting a lethal substance that the criminal law condemns.

Despite the tensions or inconsistency between accepted "new" ways of hastening death and the current ban on PAD, why not maintain the legal status quo concerning physician conduct toward competent patients seeking to hasten death? The status quo ostensibly offers benefits without major costs. Although both PAS and voluntary active euthanasia are unlawful, some intrepid physicians still "do the right thing" in compelling cases. These intrepid doctors know that any prosecution against them will likely be unavailing where the case truly involves a patient's consent and egregious circumstances of suffering

opinions of Justices Souter, Stevens, O'Connor, Breyer, and Ginsburg seemed to say that a suffering patient would be entitled to pain relief "as needed" even if the pain relief would certainly cause death. *Glucksberg*, 521 U.S. at 780-81 (Souter, J., concurring); *id*. at 750-52 (Stevens, J., concurring); *id*. at 736-38 (O'Connor, J., concurring); *id*. at 791 (Breyer, J., concurring). *See* Cantor, Glucksberg, *supra* note 32, at 307-09, 313.

223. Pratt, *supra* note 80, at 223. *See* Robert A. Burt, *Disorder in the Court: Physician-Assisted Suicide and the Constitution*, 82 MINN. L. REV. 965, 968 (1998); Robert A. Burt, *The Supreme Court Speaks — Not Assisted Suicide But a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997); Susan Adler Channick, *The Myth of Autonomy at the End-of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577, 606 (1999); Robertson, *supra* note 80, at 329, 338; Alexander Morgan Capron, *Death and the Court*, HASTINGS CENTER REP., Sept.-Oct. 1997, at 25, 28.

224. WILLIAMS, *supra* note 217, at 319; Cantor, Glucksberg, *supra* note 32, at 309; John Harris, The Philosophical Case Against the Philosophical Case Against Euthanasia, in Euthanasia Examined: Ethical, Clinical, and Legal Perspectives 36, 39-40 (J. Keown ed. 1995).

or indignity.[225] Of course, no physician wants the burdens of defending a criminal charge, so a physician cooperating with a request for PAD must be intrepid. Because most physicians are deterred from PAD, hazards of abuse or of unsavory extensions are minimized. And without legalization of PAD, law on the books will continue to reinforce the sanctity of life by prohibiting almost all killings, even those motivated by mercy toward suffering people. Formal law will continue to communicate its symbolic message that killing a fellow human is almost always forbidden.

It also turns out that within the status quo a variety of legal or arguably legal ways exist for a competent, suffering patient to hasten death.[226] Unassisted suicide is lawful and new methods are constantly being invented to accomplish that end in a reliable, quick, and non-messy fashion.[227] Most people are capable of killing themselves; they turn to physician assistance only because of fear of a messy botched attempt.[228] As previously described, VSED coupled with rejection of ANH offers a competent, suffering patient a relatively placid way to die within ten to fourteen days. Terminal sedation (including withholding of ANH) may be an option for an agitated or tortured patient and, as described, will ensure a peaceful death within fourteen days. Subject to certain conditions, risky analgesics are available which might end suffering either by successful palliation or by accelerating a patient's death. Moreover, the perception exists in some medical circles that a physician may administer a large dose of painkillers that the physician knows will cause death, so long as the physician primarily intends to end suffering. Finally, if a suffering patient has deteriorated to the point of machine dependence, then that patient can dictate removal of LSMT.

The status quo, though, has significant detriments. Most obvious is the capriciousness that determines whether a patient can engineer a reasonably dignified death. Despite the criminal-law prohibition, some

225. Even the brash Dr. Kevorkian was acquitted of assisting suicide three times before being convicted of homicide after flaunting a video tape of him giving a lethal injection to a patient. Adam Liptak, *Rights and Wrongs*, N.Y. TIMES, Oct. 21, 2003, at A24; s*ee also* Browne, *supra* note 100, at 37 (describing the ways in which mercy killers often avoid punishment).

226. *See supra* notes 204-223 and accompanying text.

227. *See Suicide Technologies: Exit This Way*, ECONOMIST, Dec. 6, 2001, at 69. (describing suicide methods promoted by the Nu Tech coalition, supporters of death with dignity who seek to develop painless, quick, and reliable suicide methods. Currently, they favor a face mask attached to a plastic canister which will emit sodium hydroxide [turning the air to carbon dioxide] or a plastic bag containing helium which will quickly displace air).

228. Billings & Block, *Patient Requests*, *supra* note 190, at 2040.

physicians do covertly assist in suicide.[229] But whether any particular patient has access to such a physician is largely a function of chance. Also, despite the unresolved status of analgesics in dosage known to be lethal,[230] some compassionate physicians have in practice always ended some lives with overdoses of morphine or other painkillers.[231] Again, access to such relief is a function of chance. Death-hastening practice, other than removal of life support, is "secret and unpredictable, depending more on doctors' courage and compassion than on patients' needs and wishes."[232] Do we really want a regulatory regime that " '*covertly permits some particularly compassionate and courageous physicians to violate the law in fear and trembling*' "[233] while the average suffering patient must contend with the average physician who will not accommodate even an egregiously suffering patient's wish to hasten death?

Putting capriciousness aside — and that's not an easy thing to do — what other costs attach to retaining the status quo and its prohibition of PAD? In 1958, Yale Kamisar thought that the cost of the status quo was only to allow "some cancer victim to suffer a little longer"[234] or to force some patient who didn't really want to survive to linger on "for awhile."[235] Today, the availability of probably legal methods of hastening death such as VSED and terminal sedation potentially assures that a competent patient can escape suffering via sedation and limit the period of lingering on to approximately fourteen days.[236]

The problem is that many people — myself included — would regard the days of lingering helplessly and insensately as a repulsive

229. "Many doctors *are* willing to prescribe potentially lethal painkillers, even under current restrictions, knowing that it is extremely unlikely they will ever be indicted, much less tried or convicted." Pratt, *supra* note 80, at 233.

230. *See, supra* notes 215-220 and accompanying text. George Thomas, Yale Kamisar, and I all contend that such conduct is unlawful euthanasia, but some Supreme Court justices have hinted that the practice might be a constitutionally mandated option for an intractably suffering patient. *Supra* note 222.

231. MAGNUSSON, *supra* note 81, at 88-89, 192-94, 197; J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. PALLIATIVE CARE 21 (WINTER 1996); Angell, *No One Trusts the Dying*, *supra* note 220, at A19; Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. TIMES, Nov. 1, 1984, at A27. The willingness of some British doctors to administer a humane overdose of morphine was noted in Great Britain's first debate about voluntary active euthanasia in 1936. Williams, *supra* note 147, at 146.

232. Angell, *No One Trusts the Dying*, *supra* note 220, at A19.

233. Kamisar, *PAS: The Problems Presented*, *supra* note 4, at 1126 (quoting John D. Arras, *Physician-Assisted Suicide: A Tragic View*, 13 J. CONTEMP. HEALTH & POL'Y 361, 365 (1997)) (emphasis in original).

234. Kamisar, *Some Non-Religious Views*, *supra* note 1, at 1041.

235. *Id.* at 977.

236. The assurance is only potential because, until many more patients and doctors know and accept these options, their availability will remain capricious.

dying process.[237] A formerly vital individual being maintained for days or weeks in a permanently insentient state is indeed undignified in some measure. True, the sedated or comatose person might not be aware of the demeaning state or the surrounding death watch. Still, some dying persons averse to indignity would much prefer prompt access to PAD rather than lying helplessly and insensately for days or weeks before passing.

While distasteful to some, a period of insensate lingering (usually lasting a maximum of seven to fourteen days) does not violate intrinsic human dignity. Lying in deep sedation for such a finite period does not seem nearly as inhumane or demeaning as protracted unconsciousness for months or even years. There is even a similarity between a temporary state of deep sedation and a natural dying process. "In dying patients, coma may act as a natural form of anesthesia so that the hours or days before death are devoid of pain, fear, or suffering. [This disease induced condition] allows death to occur naturally and peacefully."[238] There is, as noted, some affront to self-determination, as some people would prefer a prompt death over lingering insensate for days. Yet a modest terminal period in deep sedation is not so demeaning as to be deemed intrinsically inhumane and can even be regarded as securing "a modicum of dignity at death."[239] Some people consider it a "good or very good death" when a loved one withdraws from dialysis and lingers on for an average of eight days.[240]

Oddly, the period of lingering in an undignified state during VSED or terminal sedation might not be any longer than if PAD were legalized. Any acceptable statutory scheme for legalized PAD would include a mandatory waiting period of at least seven to fourteen days. The competent patient, therefore, might not be better off with legalized PAD — except, of course, that legalized PAD would be widely, not capriciously, available.

CONCLUSION

As a practical matter, legalized PAD would probably not offer more expeditious relief to a competent, egregiously suffering patient than currently legal modes of hastening death. And once the availability of such unorthodox yet legal modes of dying becomes

237. "Any protracted period of helpless, insensate lingering is anathema to people seeking a dignified passing." Cantor, *supra* note 32, at 304.

238. Brief of Amicus Curiae Choice in Dying at 16, Washington v. Glucksberg, 521 U.S. 702 (1997) (No. 96-110).

239. George P. Smith II, *Terminal Sedation as Palliative Care: Revalidating a Right to a Good Death*, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 382, 383 (1998).

240. For part of those eight days the patient may be conscious and then slip into a coma. Cohen et al., *supra* note 102, at 2116-17.

more widely known, the current capriciousness of end-of-life medical practice might be substantially reduced. Physicians will presumably come to understand the array of options legally available for hastening death. So maintenance of the status quo still looks like the best course, even if one believes (as I do) that legalized PAD would not prompt more abuse of vulnerable, dying patients or an erosion of medical mores. In the status quo, competent patients have ways to hasten death painlessly while society maintains its putative message that almost all killing of human beings is anathema.

My main problem is the hypocrisy of pretending that contemporary American society truly bars PAD. A doctor who pulls the plug at the patient's behest knowing that the intolerably suffering patient will promptly die is performing a legal mercy killing. (And it could not be any other way because otherwise physicians would have to continue pumping fluids and medications until the last gasp of a tortured, moribund person). A physician who acquiesces in a competent patient's election of VSED and who provides palliative care while the patient dies of dehydration is, quite properly, assisting a suicide. A physician who administers deep sedation to render a dying patient senseless, and who then acquiesces in the patient's prior decision to reject ANH is, in a meaningful sense, performing voluntary euthanasia even if it may be impossible to prove that the sedation had a causal connection to the patient's death. And while a physician whose pain-relief administration merely risks the suffering patient's death is not performing a killing, a physician who administers pain relief in a known lethal dosage *is* performing euthanasia.[241]

Forty-five years ago Yale Kamisar wrote the most eloquent, comprehensive, honest, and persuasive critique of PAD ever written.[242] Kamisar fixed the parameters of subsequent debate and his position opposing legalization of PAD has ostensibly prevailed. Assisted suicide is unlawful except in Oregon and euthanasia is everywhere forbidden in the United States. Yet Kamisar could not then have anticipated the phenomenon that alternative modes of hastening death would become acceptable — modes that belie the notion of a societal ban on PAD. Kamisar won the battle but lost the war. And so it should have been. For competent, fatally afflicted persons *should* have the option of hastening death in the face of intolerable suffering or indignity. Likewise for conscientious surrogates acting on behalf of now-incompetent, fatally stricken wards.

241. We know that even under the current legal framework such actions are not uncommon. *See supra* note 231. "The imperatives of pain control and palliation can disguise the fact that a patient is being intentionally drugged to death" via I.V. painkillers. MAGNUSSON, *supra* note 81, at 192. On the practice in the Netherlands, see Report of the Board of Trustees of the American Medical Association, *Euthanasia/Physician Assisted Suicide: Lessons in the Dutch Experience*, 10 Issues in L. & MED. 81, 85, 88 (1994).

242. Second place goes to the New York State Task Force on Life and the Law.