

# Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions

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*In Spring, 1996, the Ninth and Second Circuits were the first circuit courts in the country to find a constitutional prohibition against laws which make physician-assisted suicide a crime. These landmark decisions held that a competent adult suffering from a terminal illness could voluntarily seek the assistance of a physician in obtaining relief through suicide. This Essay argues that the law generated by these decisions is misguided and dangerous, as their effect is to displace the well-established line between killing and letting die. The authors argue that the new line drawn by the Ninth and Second Circuits is both untenable and dangerous, concluding that the line opens the door to involuntary euthanasia. The courts' reliance upon different clauses of the Fourteenth Amendment suggests that neither could find a definite, irrefutable constitutional basis for their decision. Instead of proposing and defending a new analysis of the constitutionality of physician-assisted suicide, the authors engage in a philosophical, moral and pragmatic discussion to establish that there are many compelling reasons to maintain the traditional line between killing and letting die.*

## INTRODUCTION

On March 6, 1996, the United States Court of Appeals for the Ninth Circuit, sitting en banc, held that competent, terminally ill, adult patients have a right, as a component of the concept of liberty protected by the Fourteenth Amendment Due Process Clause, to have the

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assistance of a physician in committing suicide.<sup>1</sup> In holding unconstitutional a Washington state law that criminalized physician-assisted suicide, the court employed language subsequently repeated in several journalistic accounts of the case: "A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent."<sup>2</sup>

On April 2, 1996, a panel of the Second Circuit similarly held unconstitutional a New York statute that criminalized physician-assisted suicide.<sup>3</sup> The court found that the state law created a distinction between two "similarly circumstanced" classes of patients:

those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.<sup>4</sup>

Recognizing that this starkly different legal treatment was not rationally related to any legitimate state interest, the court held that the New York statute violated the Fourteenth Amendment Equal Protection Clause.<sup>5</sup>

We appreciate the extensive thought and soul-searching that went into these two opinions. It is obvious that the eight judges of the majority in the Ninth Circuit<sup>6</sup> and the three-judge panel of the Second Circuit have weighed carefully the personal, social, and constitutional issues involved in reaching their decisions about physician-assisted suicide. Throughout the opinions, both courts manifested their deep awareness of the heavy responsibility of being the first circuit courts in this country to find a constitutional prohibition against laws which make physician-assisted suicide a crime. No court takes such a step lightly, and no one can read these decisions without being impressed by the care, sensitivity, and thorough research that went into each opinion.

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1. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.) (en banc) [hereinafter *Compassion in Dying*, en banc opinion], cert. granted sub nom. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996). Unless otherwise noted, all references in this Essay to the Ninth Circuit opinion are to the majority opinion of the en banc court.

2. *Id.* at 814.

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

4. *Id.* at 729.

5. *Id.* at 731.

6. On June 12, 1996, Judge O'Scannlain, joined by Judges Trott and Kleinfeld, dissented from the court's order rejecting the request for a rehearing by the full court. *Compassion in Dying v. Washington*, 85 F.3d 1440 (9th Cir.) (O'Scannlain, J., dissenting) [hereinafter *Compassion in Dying*, second dissent], cert. granted sub nom. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

Nonetheless, we are convinced that both decisions are so seriously flawed that a prompt response is essential to advance the physician-assisted suicide debate. These two circuit court opinions mark a decisive turning point in American law that must not pass unnoticed or unchallenged. We enter this debate, we hope, with the same honest, serious, and profound reflection that characterized these two opinions.<sup>7</sup> In furthering the discussion of physician-assisted suicide, we strive at least to raise some questions that all participants in the debate must confront. The issues are too important to remain shrouded in obscurity or confusion. This nation should not rush unthinkingly into the future made possible by the Ninth and Second Circuit decisions.

Despite our disagreement with these recent decisions, this Essay does not engage in a constitutional debate. The language of the Fourteenth Amendment itself is open-ended and exacts judicial interpretation. Prior Supreme Court interpretations of the Amendment may lend some credence to the constitutional arguments presented by these two decisions. The fact that the two circuit courts rely upon different clauses of the Fourteenth Amendment,<sup>8</sup> however, suggests that neither court could find a definitive, irrefutable constitutional basis in the language of the Amendment itself or in previous Supreme Court interpretations of that language. The same, of course, can be said of all fresh constitutional arguments.

Instead of proposing and defending a new analysis of the constitutionality of physician-assisted suicide, then, this Essay argues that the law generated by these decisions is both misguided and dangerous. Their effect is to displace the well-established line between killing and letting die. Prior to these decisions, American courts and legislatures universally recognized the line between killing and letting die as the point at which legal liability attaches to one's actions; actions that result in killing were punishable, and actions that allow death to proceed unhindered were not.

The Ninth and Second Circuits now seek to replace this line with a new one: one which would allow physician-assisted suicide while attempting to protect individuals from unacceptable harms, such as involuntary euthanasia. In order to maintain this line, both courts have limited the availability of physician-assisted suicide to cases in which a competent adult suffering from a terminal illness voluntarily seeks the

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7. We have previously criticized the Supreme Court for its refusal to recognize the moral and constitutional right of bonded family members to decide when to terminate medical treatment. Susan R. Martyn & Henry J. Bourguignon, *Coming to Terms with Death: The Cruzan Case*, 42 HASTINGS LJ. 817 (1991).

8. The Ninth Circuit bases its analysis on the liberty interest protected by the Due Process Clause, while the Second Circuit's decision rests upon an Equal Protection Clause analysis. See *supra* notes 1, 5 and accompanying text.

assistance of a physician in obtaining relief through suicide. It is the courts' hope that these factors—competency, voluntariness, terminal illness, suffering, and physician assistance—will continue to prevent involuntary euthanasia and ensure that any given act of assisted suicide is constitutionally permitted.

We believe that the line drawn by these two courts is untenable. The sole purpose of this Essay is to drive home the many compelling reasons to maintain the traditional line between killing and letting die. Even though our analysis is philosophical, moral, and pragmatic, rather than constitutional, the constitutional ramifications of our position are clear. Our argument reveals that states have a strong, paramount interest in maintaining the time-honored distinction between letting die and killing. The reasons we identify give Washington and New York, and indeed all states, sufficiently compelling interests to override a patient's due process interest in assisted suicide, as well as a clear and substantial basis, sufficient to satisfy the Equal Protection Clause, for distinguishing between withdrawal of life-sustaining medical treatment and direct intervention to cause death.

Similarly, the arguments presented here suggest that a patient's liberty interest in physician-assisted suicide, derived by the Ninth Circuit from the Due Process Clause, is not as well defined as that court seems to believe. We argue, for example, that it can be extremely difficult to ascertain whether a patient is competent and acting voluntarily. Given these difficulties, it is not at all clear whether a patient requesting suicide is exercising a constitutional right, or merely yielding to social or financial pressures to end her life. The liberty interest identified by the Ninth Circuit, then, may not support the weight that court has given it.

For the time being, however, we leave it to others to frame these constitutional arguments. Our focus here is on the overwhelming interest states have in continuing to criminalize physician-assisted suicide. If our arguments are sound, they will point to a solid foundation to satisfy whatever test future courts might employ in conducting the constitutional analysis.

We first briefly summarize the key arguments used to support the majority opinions of the Ninth and Second Circuits. We could hardly justify our critique of these two decisions without first attempting to summarize accurately what they said. After identifying what these decisions have held, we examine more closely the traditional line rejected by these recent decisions and undertake a careful analysis of the different elements relied upon by the two courts to ensure that legalizing assisted suicide will not open the door to other forms of killing, such as involuntary euthanasia. We identify serious problems with each element of the line drawn by the courts in these recent decisions. This pragmatic

analysis reveals that the line between assisted suicide and other forms of killing is much more ambiguous and untenable than its proponents believe.

We then discuss the recent historical record of the Netherlands, which supports our claim. For the past ten years, the Dutch have relied upon essentially the same line drawn by the Ninth and Second Circuits. An examination of the Dutch people's experience with this line reveals that it has, indeed, opened the door to involuntary euthanasia. By replacing the traditional line between killing and letting die with a line comparable to the one adopted in the Netherlands, the recent circuit court opinions have taken a substantial step towards the social and legal acceptance of involuntary euthanasia.

Finally, we will argue that drawing the line between assisted suicide and other forms of killing in America creates another danger not present in the Netherlands. Millions of Americans lack access to and trust in health care providers. Permitting assisted suicide would increase the vulnerability of all patients without sufficient funds to manage their own health care. Moreover, assisted suicide may prove too profitable to resist for American reimbursement systems, eager to discover alternatives to more expensive yet humane palliative care alternatives. Based on this analysis, we conclude that the recent decisions by the Ninth and Second Circuits are dangerous and undesirable, and we urge America not to embrace the future that follows from the law they create.

Before undertaking our analysis, we acknowledge that there are some patients who fit the image invoked by the Ninth and Second Circuit opinions to justify their position. There are, in extremely rare cases, terminally ill patients suffering unrelievable pain who competently and voluntarily seek a doctor's assistance in ending their lives. We must continue to treat these rare cases, however, as tragic, isolated occurrences. We must offer and make available all possible comfort and support. But we must not allow these heart-rending situations to open up the possibility of physician-assisted death as a quick, cost-effective way of ending serious and complex problems. Standing alone, these few cases cannot justify the line drawn by the recent judicial decisions. If we allow the Ninth and Second Circuits' approach to prevail, many thousands will die who are incompetent, do not voluntarily choose to die, are not terminally ill, and are not suffering pain which could not be relieved.

## I

## TWO CIRCUIT COURTS BREAK NEW GROUND

A. *The Ninth Circuit Majority Opinion*

Three terminally ill patients, five doctors, and an organization named Compassion in Dying brought suit in a federal district court in the State of Washington,<sup>9</sup> challenging the validity of a Washington statute<sup>10</sup> that made it a crime, with a substantial penalty of imprisonment, to aid a person in committing suicide. The district court ruled for the plaintiffs, holding that the Fourteenth Amendment Due Process Clause guarantees a competent, terminally ill, adult patient the right to physician assistance in committing suicide.<sup>11</sup> With one judge dissenting, a three-judge panel of the Ninth Circuit reversed the district court's holding, finding no liberty interest protected by the Due Process Clause which bars state criminalization of physician-assisted suicide.<sup>12</sup> Because of the exceptional importance of the issues involved, the Ninth Circuit agreed to rehear the case en banc.<sup>13</sup>

The Ninth Circuit en banc court weighed diverse interests to determine whether the Washington statute violated the Due Process Clause. The majority explained that due process analysis requires the court first to decide whether a cognizable liberty interest is implicated by a law and then "apply a balancing test under which we weigh the individual's liberty interests against the relevant state interests in order to determine whether the state's actions are constitutionally permissible."<sup>14</sup>

The Ninth Circuit discussed at length the patient's liberty interest, which it described as the right to determine "the time and manner of one's death,"<sup>15</sup> or the right to hasten one's death.<sup>16</sup> Although the court looked to several other Supreme Court cases in its search for some

9. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1456 (W.D. Wash. 1994) [hereinafter *Compassion in Dying*, District Court opinion], *aff'd en banc*, 79 F.3d 790 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

10. The relevant language of the Washington statute is: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." WASH. REV. CODE ANN. § 9A.36.060(1) (West 1988).

11. *Compassion in Dying*, District Court opinion, *supra* note 9, at 1467.

12. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

13. *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996). Pursuant to Pub. L. No. 95-486, §6, 92 Stat. 1633 (1978) (codified at 28 U.S.C. § 41 Editorial note (1994)), a circuit court of appeals that has more than 15 active judges may perform its duties as an en banc court according to rules adopted by that court of appeals. Under the Ninth Circuit's rules, an en banc court "shall consist of the Chief Judge of [the] circuit and 10 additional judges to be drawn by lot from the active judges of the Court." 9TH CIR. R. 35-3. Based on these rules, the case was heard by an eleven-member en banc court.

14. *Compassion in Dying*, en banc opinion, *supra* note 1, at 799.

15. *Id.* at 801.

16. *Id.* at 802.

precedent, it relied primarily on two recent High Court opinions: *Planned Parenthood v. Casey*,<sup>17</sup> the most recent qualified affirmation of a woman's right to have an abortion, and *Cruzan v. Director, Missouri Department of Health*,<sup>18</sup> which indirectly affirmed a competent patient's right to terminate life-saving medical treatment.

From *Casey*, the Ninth Circuit derived the principle that the right to die becomes stronger as the person's life approaches its end.<sup>19</sup> In *Casey*, the State's interest in restricting abortions was held to increase when fetal development progresses to viability.<sup>20</sup> By analogy, the Ninth Circuit reasoned that the State's interest in criminalizing the act of hastening one's death erodes as the person's medical condition deteriorates. Consequently, in the process of balancing the competing interests of the State in life and the individual in liberty, the Ninth Circuit concluded that the right to hasten one's death, like the right to choose to terminate a pregnancy, varies with changes in the physical or medical circumstances.<sup>21</sup> The Ninth Circuit also repeatedly cited language in *Casey* that affirmed a person's liberty interest in controlling those decisions that are most intimate and personal and that are central to the person's dignity and autonomy.<sup>22</sup> The Ninth Circuit concluded that when patients are in great pain and no longer able to enjoy life's pleasures, they similarly possess a vital liberty interest in hastening death rather than continuing to live in misery.<sup>23</sup>

In *Cruzan*, the Supreme Court had considered whether the Fourteenth Amendment protects a liberty interest of a competent patient to refuse or terminate medical treatment, even if it meant the patient would die.<sup>24</sup> The Court held that the State could impose a stringent evidentiary standard to prove that an incompetent patient, while competent, had expressed a desire to have life-saving medical treatment

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17. 505 U.S. 833 (1992).

18. 497 U.S. 261 (1990).

19. *Compassion in Dying*, en banc opinion, *supra* note 1, at 800.

20. 505 U.S. at 869-70 (opinion of O'Connor, Kennedy, and Souter, JJ.).

21. *Compassion in Dying*, en banc opinion, *supra* note 1, at 800. Judge Beezer's dissent raises more controversial and problematic issues. He recalls that a state's interest is stronger in protecting viable beings and that terminally ill persons seeking assisted suicide are viable. As a viable being, that person "consequently enjoys the full protection of the state's interest in preserving life." In contrast, "a person kept alive by life-sustaining treatment is essentially nonviable" and therefore presumably less entitled to the same state protection of life. *Id.* at 851 (Beezer, J., dissenting) [hereinafter *Compassion in Dying*, first dissent].

22. *Compassion in Dying*, en banc opinion, *supra* note 1, at 801, 813. We choose here to focus on end-of-life issues without relating them to the abortion debate. While we agree with the Supreme Court's decision in *Casey*, we do not think it offers support for the Ninth Circuit's majority opinion in *Compassion in Dying*.

23. *Id.* at 834. Justice O'Scannlain's dissent from the denial of rehearing characterizes this reasoning as "[e]ngaging in one of the most egregious judicial leaps." *Compassion in Dying*, second dissent, *supra* note 6, at 1444.

24. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

terminated.<sup>25</sup> In the Court's discussion of this evidentiary issue, however, a majority of the justices seemed to accept that a competent patient has a right to terminate medical treatment, even though it would clearly hasten death. From this decision, the Ninth Circuit derived its conviction that the Supreme Court had necessarily recognized a liberty interest of a person to hasten her own death.<sup>26</sup>

Interpreting these two Supreme Court decisions, the Ninth Circuit concluded that "*Casey* and *Cruzan* provide persuasive evidence that the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death—that there is, in short, a constitutionally recognized 'right to die.'"<sup>27</sup> The Ninth Circuit then proceeded to analyze the various State interests in prohibiting doctor assistance to help a person to die. The court insisted that, as long as the terminally ill patient's decision to hasten his death was voluntary, the State had no sufficient interest in prohibiting a doctor from assisting the death.<sup>28</sup> The court even suggested that it saw little difference whether lethal medication was administered by the patient (suicide) or by a doctor (euthanasia), provided that in each case the patient had voluntarily decided to hasten his death.<sup>29</sup>

The Ninth Circuit then concluded that the Constitution barred the State from prohibiting or criminalizing physician-assisted suicide.<sup>30</sup>

[N]o matter how much weight we could legitimately afford the state's interest in preventing suicide, that weight, when combined with the weight we give all the other state's interests, is insufficient to outweigh the terminally ill individual's interest in deciding whether to end his agony and suffering by hastening the time of his death with medication prescribed by his physician. The individual's interest in making that vital decision is compelling indeed, for no decision is more painful, delicate, personal, important, or final than the decision how and when one's life shall end.<sup>31</sup>

The court did insist, however, that the State can regulate the exercise of the right to physician-assisted suicide, in order to prevent "undue influence and other forms of abuse."<sup>32</sup> Thus, the Ninth Circuit held that the Washington statute making it a crime to aid suicide was

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25. *Id.* at 282-83.

26. *Compassion in Dying*, en banc opinion, *supra* note 1, at 816. Justice O'Scannlain's dissent from the denial of rehearing describes this conclusion as "dramatically expanding the narrow holding of *Cruzan*." *Compassion in Dying*, second dissent, *supra* note 6, at 1445.

27. *Compassion in Dying*, en banc opinion, *supra* note 1, at 816.

28. *Id.* at 821.

29. *Id.* at 831-32.

30. *Id.* at 837.

31. *Id.*

32. *Id.*



unconstitutional only "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians."<sup>33</sup>

### *B. The Second Circuit Majority Opinion*

Three terminally ill patients and three physicians brought suit in the United States District Court for the Southern District of New York to challenge the constitutionality of the New York Penal Law provisions that made it a crime to aid another person in committing, or attempting to commit, suicide.<sup>34</sup> The patients and doctors contended that the New York laws were invalid inasmuch as they prohibited doctors from helping competent, terminally ill, adult patients to hasten their deaths by prescribing lethal drugs to be self-administered by the patients.<sup>35</sup> The district court dismissed the complaint, rejecting both Fourteenth Amendment Due Process and Equal Protection Clause challenges, and granted summary judgment for the New York Attorney General, who defended the state laws.<sup>36</sup>

The Court of Appeals for the Second Circuit reviewed the district court's decision and reversed.<sup>37</sup> Disagreeing with the Ninth Circuit, the Court rejected the plaintiffs' contention that the State violated a liberty interest of terminally ill patients by making it a crime for doctors to assist them in hastening their death.<sup>38</sup> No right to assisted suicide, the court replied, had ever been recognized under state law, and no such right could be derived from the Fourteenth Amendment Due Process Clause.<sup>39</sup> The Second Circuit, however, agreed with the plaintiffs that the

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33. *Id.* Earlier in its opinion the court was less restrictive in its scope. In recognizing a constitutionally protected right to die, the majority added: "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness." *Id.* at 816.

34. *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996). The relevant provisions of the New York Penal Law provide: "A person is guilty of manslaughter in the second degree when: . . . [h]e intentionally . . . aids another person to commit suicide." N.Y. PENAL LAW §125.15 (McKinney 1987). "A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide." N.Y. PENAL LAW §120.30 (McKinney 1987).

35. *Quill*, 870 F. Supp. at 79-80.

36. *Id.* at 84-85.

37. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996). The separate, gentler concurring opinion by Judge Calabresi will not be analyzed. Judge Calabresi agreed with the majority of the Second Circuit that the New York law criminalizing doctor-assisted suicide was constitutionally suspect. But since he found the law was virtually unenforced, he preferred to remand the case to the legislature for a second, more current, look at the statute to determine whether the strength of the State's interests justified continuing the law in force. *Id.* at 732 (Calabresi, J., concurring).

38. *Id.* at 724.

39. *Id.* at 724-25.

New York prohibition against physician-assisted suicide violated the Equal Protection Clause.<sup>40</sup>

The Second Circuit restated the standard approach to equal protection analysis. States, when legislating or regulating, necessarily must have broad discretion to make some distinctions and define classifications. While classifications that affect some fundamental right or involve a suspect criterion receive the highest degree of judicial scrutiny, classifications in the area of social or economic regulation by the State warrant a much lesser degree of scrutiny. For such classifications, the court need only be convinced that the line the State has drawn "bears some fair relationship to a legitimate public purpose."<sup>41</sup>

The Second Circuit found that while the State of New York allowed competent, terminally ill, adult patients on life-support systems to direct medical personnel to withdraw life support and thereby hasten death,<sup>42</sup> under the challenged New York law, such patients who were not connected to life-support systems could not have a doctor hasten their death by providing lethal doses of an appropriate medication.<sup>43</sup> The distinction between these two classes of terminally ill patients, the court concluded, lacked any rational basis.<sup>44</sup> As the court explained:

[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. . . . And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," . . . when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."<sup>45</sup>

Based on this perceived lack of any rational basis for the legislation, the Second Circuit held the New York assisted suicide law unconstitutional, as a violation of the Equal Protection Clause.

Both the Ninth and Second Circuits, therefore, have held that a state law that criminalizes physician-assisted suicide is unconstitutional. At the same time, each has criticized the constitutional basis of the other's

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40. *Id.* at 727.

41. *Id.* at 725 (quoting *Plyler v. Doe*, 457 U.S. 202, 216 (1982)).

42. *Id.* at 727-28.

43. *Id.* at 729.

44. *Id.* at 727.

45. *Id.* at 729-30 (citing *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976), and quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).

decision. Both courts, however, would allow the states to provide some framework of regulations to protect the lives of vulnerable persons, such as requiring that more than one physician verify a patient is terminally ill, or requiring a psychological examination to rule out clinical depression.<sup>46</sup> The current line they have drawn, although not stated in these exact terms, makes the following elements crucial to a constitutionally protected exercise of the right to assisted suicide: a terminally ill patient,<sup>47</sup> who is competent,<sup>48</sup> suffering,<sup>49</sup> and voluntarily wants to hasten his death,<sup>50</sup> and a physician who prescribes or provides a lethal dose of medication for the patient himself to take.<sup>51</sup>

In effect, these recent decisions have done two things: they have declared that it is unconstitutional for a state to maintain a line prohibiting physician-assisted suicide in all cases, and they have drawn a new

46. *Id.* at 731; *Compassion in Dying*, en banc opinion, *supra* note 1, at 833.

47. *Quill*, 80 F.3d at 718 ("the final stages of terminal illness"); *id.* at 731 ("terminally-ill person in the final stages of his terminal illness"); *Compassion in Dying*, en banc opinion, *supra* note 1, at 798 ("terminally ill, competent adult patients who wish to hasten their deaths"); *id.* at 834 ("when a mentally competent adult is terminally ill"); *id.* at 837 ("terminally ill competent adults"); *cf. id.* at 816 ("Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness.").

48. *Quill*, 80 F.3d at 718 ("mentally competent patients"); *id.* at 731 ("mentally competent"); *Compassion in Dying*, en banc opinion, *supra* note 1, at 798 ("competent adult patients"); *id.* at 834 ("a mentally competent adult"); *id.* at 837 ("competent adults"); *cf. id.* at 816 ("Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness.").

49. *Quill*, 80 F.3d at 722 ("These patients, according to the physicians, . . . 'wish[ed] to avoid prolonged suffering . . .'"); *id.* at 730 ("And what business is it of the state to require the continuation of agony . . ."); *Compassion in Dying*, en banc opinion, *supra* note 1, at 821 ("life in the final stages of an incurable and painful degenerative disease [can involve] debilitating pain"); *id.* at 834 ("because his remaining days are an unmitigated torture"); *id.* at 837 ("whether to end his agony and suffering").

50. *Quill*, 80 F.3d at 719 ("The physician plaintiffs alleged that they encountered . . . 'patients who request assistance in the voluntary self-termination of life.'"); *Compassion in Dying*, en banc opinion, *supra* note 1, at 832 ("[W]e view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life."); *id.* at 834 ("when a mentally competent adult is terminally ill, and wishes, free of any coercion, to hasten his death").

51. *Quill*, 80 F.3d at 718 (holding that physicians "may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness."); *id.* at 731 (holding that statutes criminalizing assisted suicide violate the Equal Protection Clause when "they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness"); *Compassion in Dying*, en banc opinion, *supra* note 1, at 798 (holding the Washington statute, "as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment."); *id.* at 837 (holding that "the 'or aids' provision of [the] Washington statute . . . is unconstitutional as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians.") (citation omitted).

The Ninth Circuit suggested that it also would find that the doctor could, in some circumstances, administer the lethal dose herself. *See id.* at 831.

line, intended to allow physician-assisted suicide in some cases while protecting individuals from related harms, such as involuntary euthanasia. The question we must address is whether this alluring new line addresses all the relevant concerns implicated by personally chosen death and adequately protects the broader interests of society at large.

## II

### DRAWING THE LINE

Most lawmaking involves the drawing of lines.<sup>52</sup> Whether through legislation, administrative rules, or judicial decisions, lines, though often illusive or ill-defined, must be drawn. Since law strives to prevent serious harms, lawmakers must draw lines that protect individuals and society at large from anticipated injuries while at the same time safeguarding the liberty of the individual.

Of necessity, then, all participants in a discussion of the legal limits to hastening death must draw lines. An accurate current picture of dying in America must portray a broad spectrum of ways of ending life. This spectrum includes purely natural or accidental death, natural death hastened by refusal or withdrawal of medical treatment which might have extended the life (letting die), death by killing oneself (suicide), death by enlisting another person's assistance to commit suicide (assisted suicide), death by the direct intervention of another when voluntarily requested by the dying person (voluntary active euthanasia), and finally, death by the direct intervention of another where the person killed did not voluntarily select the intervention (involuntary active euthanasia, "mercy killing," or homicides).

Anyone who seriously discusses the moral or legal implications of these different ways of ending life must decide whether and where to draw a line on this spectrum.<sup>53</sup> Refusal to draw a line ultimately invites

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52. Scholars, discussing widely different areas of law, focus on the difficulty of drawing lines. See, e.g., Barbara Black, *Commentary: The Second Circuit's Approach to the 'in Connection with' Requirement of Rule 10b-5*, 53 BROOK. L. REV. 539, 545-46 (1987); Allen D. Boyer, *Federalism and Corporation Law: Drawing the Line in State Takeover Regulation*, 47 OHIO ST. L.J. 1037 (1986); Christopher A. Ford, *Administering Identity: The Determination of 'Race' in Race-Conscious Law*, 82 CALIF. L. REV. 1231, 1234, 1237 (1994); Bruce A. Green, *"Through a Glass, Darkly": How the Court Sees Motions to Disqualify Criminal Defense Lawyers*, 89 COLUM. L. REV. 1201, 1211 (1989); Christopher M. Mislaw, *Computer Microcode: Testing the Limits of Software Copyrightability*, 65 B.U. L. REV. 733, 799 (1985).

53. See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 237-41 (4th ed. 1994); EIKE-HENNER W. KLUGE, *THE ETHICS OF DELIBERATE DEATH* (1981); LAW REFORM COMM'N OF CANADA, *EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT* (Working Paper No. 28, 1982); NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* (1994) [hereinafter NEW YORK STATE TASK FORCE]; RICHARD A. POSNER, *AGING AND OLD AGE* 235-61 (1995); JAMES RACHELS, *THE END OF LIFE: EUTHANASIA AND MORALITY* (1986); Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L.

acceptance of the spectrum's endpoint: involuntary active euthanasia, with the ever-present danger of government sponsorship or mandate of the killing of those thought too worthless to continue living. Those who join in the debate surrounding assisted suicide are implicitly aware of—and often explicitly mention—the incredible and terrifying example of the mass involuntary killing by the Nazis of those whose lives were considered unworthy of life.<sup>54</sup> This example, from a modern, western, democratically selected government, makes involuntary killing of vulnerable persons more than just a distant nightmare among remote uncivilized people. Thus, made wiser by history, all participants in the present debate over physician-assisted suicide must address where the line should be drawn, not merely whether a line is necessary.

The Ninth and Second Circuit decisions attempted to draw a line by insisting, or at least implying, that physician-assisted suicide is constitutionally protected only if the patient is competent, suffering, terminally ill, and voluntarily decides to end her life. In contrast, the authors of this Essay insist that the line should be drawn elsewhere, between letting die and killing, a more traditional line which has echoes still audible through thousands of years of Judeo-Christian culture: "You shall not kill."<sup>55</sup> But all participants in the debate must agree that a line, as clear and definitive as possible, must be drawn.

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REV. 969 (1958); Leon R. Kass, *Is There a Right to Die?*, HASTINGS CENTER REP., Jan.-Feb. 1993, at 34; C. Everett Koop & Edward R. Grant, *The "Small Beginnings" of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing*, 2 NOTRE DAME J.L. ETHICS & PUB. POL'Y 585 (1986).

54. The full tragic story of the Nazi euthanasia project has been told elsewhere. See, e.g., ROBERT JAY LIFTON, *THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE*, 46-79 (1986); INGO MÜLLER, *HITLER'S JUSTICE: THE COURTS OF THE THIRD REICH*, 120-28 (1991). A few points, however, are worth recalling. Even before the Nazi Party had gained power in Germany, some respected scholars had argued for the direct medical killing of defective persons to protect the whole people, the *volk*, from harm. In 1920, a book, *The Permission to Destroy Life Unworthy of Life*, contended that killing the mentally ill, as well as feeble-minded and deformed children, would be justified as a healing process for the *volk*. See LIFTON, *supra*, at 46. Since these people were already dead, the authors argued, their killing was permissible because of the enormous economic burden they placed on society.

At first, the German government merely ordered sterilization of those who were considered defective: those with retardation, schizophrenia, manic depression, epilepsy, blindness, deafness, and severe physical deformities. See *id.* at 21-29. This eugenic program of sterilization laid the groundwork for the later program of euthanizing persons with physical or mental handicaps. By 1934, German hospitals were urged to neglect defective patients in order to develop an euthanasia mentality. Medical personnel received special training to develop the proper moral insensitivity so they would join in this euthanasia program. One film, *Existence without Life*, was shown to medical personnel who were expected to take part in the project. See *id.* at 76. By the end of the war, persons with mental retardation, mental illness, or other defects and, of course, the Jews, were killed by lethal injections, gas chambers, or starvation. Some 50,000 insane, retarded, or deformed persons were killed in gas chambers or by other means, along with some 4 to 6 million Jews. See MARK H. HALLER, *EUGENICS: HEREDITARIAN ATTITUDES IN AMERICAN THOUGHT* 180 (1984).

55. *Exodus* 20:13. (Revised Standard Version). More recent translations translate "kill" as "murder" to exclude defensive killings. *Exodus* 20:13 (New Revised Standard Version). See also

This insistence on the need to draw a line immediately revives the often-reviled slippery slope argument.<sup>56</sup> Yet all who take a position on physician-assisted suicide, whether they favor it or oppose it, employ a slippery slope argument. All are aware that further down the slope lies the human and societal tragedy of widespread, governmentally tolerated or sponsored involuntary euthanasia. Everyone who wants to discuss the question of physician-assisted suicide, therefore, must explain clearly how the line they would draw will constitute a firm toehold to prevent further descent down the slippery slope towards the greater danger of involuntary euthanasia. Our argument here is that the line between killing and letting die is a more secure toehold than any of its alternatives, including the line drawn by the recent circuit court decisions.

In order to make this argument, we must first accurately define the different methods of dying central to the debate over assisted suicide. Many discussions of a "right to die," especially in the popular media, have confused and blurred together three distinct formulations of such a right: (1) a right to refuse life-preserving medical treatment (sometimes called letting die or passive euthanasia), (2) a right to assisted suicide (self-killing with another's help), and (3) a right to another's direct intervention to end life (active voluntary euthanasia).

The first formulation, which we believe should constitute the extent of the "right to die," recognizes a full individual prerogative to let die, by refusing or terminating medical treatments, but no legal or constitutional right to either self-inflicted death with a doctor's assistance (physician-assisted suicide) or direct intervention by a third party (a doctor or someone else). The second usage of a "right to die" encompasses both letting die and assisted suicide but rejects active euthanasia. Proponents of this conception equate the right to refuse medical treatments with the right to obtain assistance in suicide on the grounds that both follow logically from individual patient autonomy or that distinctions between letting die and assisted suicide are arbitrary and irrational.<sup>57</sup> The Ninth and Second Circuits have explicitly adopted this position. Third, some advocates have argued that, in addition to the rights to let die and to assisted suicide, the "right to die" should include active voluntary euthanasia, in order to protect the underlying right to

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Allen Verhey, *Choosing Death: The Ethics of Assisted Suicide*, 113 CHRISTIAN CENTURY 716, 716-17 (1996) (discussing the traditional line's basis in Christian scriptural tradition).

56. The best discussion of this argument is by Frederick Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361 (1985). Schauer briefly describes the argument as follows: "A slippery slope argument claims that permitting the instant case—a case that it concedes to be facially innocuous and that it linguistically distinguishes from the danger case—will nevertheless lead to, or increase the likelihood of, the danger case." *Id.* at 369.

57. See, e.g., BEAUCHAMP & CHILDRESS, *supra* note 53, at 238-41.

have a physician end one's existence when life becomes unendurable. The Ninth Circuit appears inclined to accept this position.<sup>58</sup>

To document our reasons for favoring the traditional line between letting die and killing we show that this line, consistent with centuries of practice when most patients died at home, has been accepted after thoughtful public debate by the medical and legal consensus developed over the past twenty years. We then discuss the inadequacy of the line drawn by the Ninth and Second Circuits. Finally, we flesh out two relatively recent developments lightly dismissed by both courts: the experience over the past ten years in the Netherlands with legalized physician-assisted suicide, and the shift in America to managed care as a payment mechanism.

### A. *The Line Between Letting Die and Killing*

The line between letting die and killing was not drawn arbitrarily or unthinkingly. All human beings will ultimately die. "To be or not to be" has never been a matter of personal choice in the long run. Despite magnificent advances in medical science each person's life will someday end. Death is a part of nature. When death occurs because of the underlying pathology, nature takes its course. "There is and will always remain a fundamental difference between what nature does to us and what we do to one another"<sup>59</sup> or to ourselves.

The purpose of medicine is to heighten and support a person's natural response to disease or injury, not to inflict death. Therefore, when a patient refuses medical interventions, the patient is allowing the natural course of a disease, degeneration, or injury to bring about death sooner than it might occur with medical intervention. This implies a personal and socially reasonable judgment about the inherent limits of medical science, the futility of a particular medical intervention, and the ultimate inevitability of death.<sup>60</sup> Suicide, by contrast, requires a direct intervention in the natural course of an individual's life. The cause of death comes from outside of and beyond the person. It is no longer the body's own response to the pathological condition, but rather an intentional intervention by the patient or by an outside agent that causes death. This distinction, between death from within the person that is permitted to occur and death from outside the person that is made to occur, must be maintained, as it is the basis for the traditional legal distinction between letting die and killing.

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58. See *supra* notes 31& 51 and accompanying text.

59. DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY* 76 (1993). Callahan's thoughtful argument, *id.* at 76-82, obviously has influenced this entire discussion.

60. *Compassion in Dying*, second dissent, *supra* note 6, at 1444 n.12.

The moral and legal line between letting die and killing has been criticized as murky, arbitrary, and even untenable.<sup>61</sup> We acknowledge that the line is not perfectly straight or always clear. However, as we will explain at length below, the line between killing and letting die is vastly more tenable and legally enforceable than the alternative line required by those who would allow physician-assisted suicide. Termination of treatment, which thereby allows a patient to die, is vastly different from providing a lethal drug to enable a patient to kill himself. Termination of treatment, such as unplugging a respirator or removing a feeding tube, is not intended to cause, nor does it in fact cause, death. If a healthy person were attached to a respirator, its removal would not cause death. Refusal or removal of artificial medical technology, which has enabled a diseased body to continue to breathe or receive nutrition, merely places the body on its own and allows the natural forces of the weakened body to take their course, letting the person die.

Legal acceptance of the line between killing and letting die has not come easily. Twenty years ago, physicians and health care institutions commonly balked at withdrawing medical treatment, arguing that it might constitute homicide<sup>62</sup> or lead to malpractice liability.<sup>63</sup> This began to change with the decision of the New Jersey Supreme Court in the case of Karen Ann Quinlan.<sup>64</sup> There, members of the family of a comatose woman asked her health care provider to respect their best judgment about the patient's wishes, and accordingly to withdraw initially well-intended medical intervention. In response, the New Jersey Court rediscovered legal rights for patients to control and terminate bodily intervention.<sup>65</sup> In every court decision that followed, courts have ruled that withholding or withdrawing medical treatment with proper consent respects patients' rights and does not constitute homicide.<sup>66</sup> Courts also have assured health care providers that no civil liability could result from foregoing life support with appropriate patient or surrogate consent.<sup>67</sup> Both before and after the Supreme Court's decision in *Cruzan*, state-advanced directive statutes reiterated this immunity.<sup>68</sup>

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61. See, e.g., the critical comments of KLUGE, *supra* note 53, at 8-29; RACHELS, *supra* note 53, at 20-33, 40-45, 78-128.

62. Fears of criminal accountability stemmed from the fact that the patient's death occurred shortly after the withholding or withdrawal of life-sustaining treatment. Health-care providers worried that this might constitute the "killing of a human being," a phrase used in many homicide statutes. See, e.g., 2 ALAN MEISEL, *THE RIGHT TO DIE* 451 (2d ed. 1995) (quoting *In re Colyer*, 660 P.2d 738, 751 (Wash. 1983)); see generally *id.* at 450-521 (discussing criminal liability for assisted suicide and active euthanasia).

63. See *id.* at 350-445 (discussing potential liability for medical malpractice).

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

65. *Id.* at 664.

66. The decisive case was *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983).

67. Every state case bases the right to refuse life-sustaining medical treatment on the state court's prior recognition of the tort remedies of battery (the right to prevent unwanted bodily



Although individual rights to reject medical intervention have been uniformly recognized, state interests in preserving life and protecting vulnerable persons have justified some procedural limits on the right to refuse life-sustaining treatment identified in *Cruzan*. For example, it is not always medically certain that recovery is impossible or that a patient is experiencing pain. Similar gaps in information also may exist in the moral evidence concerning an individual patient's choice. In these situations, state rules seek to minimize error.<sup>69</sup> Competent persons have a right to refuse or terminate treatment even when such a decision means that death certainly will occur sooner. Incompetent persons also have a right to refuse or terminate treatment, but this right must be exercised by a surrogate. When evidentiary gaps exist and decisions must be made, most states defer to a caring interpreter, a person who can best represent the individual moral voice of the patient. But when a terminally ill person seeks a fatal dose of a drug to cause death, the state's right to protect that person from victimization becomes even stronger.<sup>70</sup>

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invasion) and informed consent (the right to knowledgeable control over body invasions). See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 271 (1990); *In re Lawrance*, 579 N.E.2d 32, 38-39 (Ind. 1991); *De Grella v. Elston*, 858 S.W.2d 698, 709 (Ky. 1993); *McKay v. Bergstedt*, 801 P.2d 617, 621 (Nev. 1990). See also *Rodriguez v. Pino*, 634 So. 2d 681, 685 (Fla. Dist. Ct. App. 1994) (reversing, as a matter of law, wrongful death verdict against physician where both deceased and her husband were competent and refused consent to the procedure the physician allegedly should have performed); *Anderson v. St. Francis-St. George Hosp.*, 671 N.E.2d 225, 229 (Ohio 1996) (finding that if a battery occurred, a patient who refused consent to treatment that was subsequently administered is entitled to compensation for injuries directly caused by the unwanted intervention).

68. Advanced directive legislation has now matured to the point of addressing the needs of both those who wish to draft such documents and those who do not. The Uniform Health-Care Decisions Act provides for a living will and durable power of attorney for those who wish to designate future choices regarding health care interventions or proxies. It also clarifies surrogate decision-making for those who do not execute an advanced directive by designating appropriate surrogates with power to decide. UNIF. HEALTH-CARE DECISIONS ACT §§ 2-5, 9 U.L.A. 224-37 (Supp. 1996).

Of course, occasional difficult cases continue to occur. Increasing numbers of these situations are resolved by institutional ethics committees, many of which have adopted mediation procedures as a means to assist decision makers. Some cases still are referred to state courts, but judges there show increased sophistication and comfort in this role. See COORDINATING COUNCIL ON LIFE-SUSTAINING MEDICAL TREATMENT DECISION MAKING BY THE COURTS, NATIONAL CENTER FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES (rev. 2d ed. 1993).

69. See, e.g., *In re Conroy*, 486 A.2d 1209, 1233 (N.J. 1985) (finding that unlimited power to make surrogate medical decisions "would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps").

70. The United States District Court for the District of Oregon recently followed a similar line of reasoning in overturning Measure 16, a ballot initiative that would have decriminalized assisted suicide for terminally ill persons. The act required that the attending and treating physicians inform a person requesting assisted suicide of comfort care options and determine whether the person suffers from impaired judgment and acts voluntarily. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995). Calling the law "a state-sanctioned option designed to hasten death," *id.* at 1431, the court found physician discretion alone insufficient to distinguish between the competent and incompetent person. *Id.* at 1434.

Though the law has recognized a right to refuse treatment, it has strongly rejected moving the line to tolerate active interventions to cause death. Courts have preserved the criminal and civil condemnation of assisted suicide as a means of buttressing state efforts to prevent self-destruction.<sup>71</sup> Some jurisdictions have prohibited assisted suicide by enacting specific statutes that make it a crime to assist or influence another to take his own life.<sup>72</sup>

Some states have not criminalized assisted suicide by enacting separate statutes. Instead, they address assisted suicide by relying on general homicide statutes that punish those who actively participate in the death of another.<sup>73</sup> A few of these jurisdictions allow a person to provide another with the means to commit suicide, but prohibit active participation in the actual suicide.<sup>74</sup> In all jurisdictions, active participation in causing the death of another, such as pulling a gun's trigger or pushing a sy-

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The district court pointed out that no other safeguards were mandated by the new law, even though they are commonly required in similar situations. For example, third parties, such as family members, routinely have been involved in providing substituted judgment on behalf of incompetent relatives. *Id.* Similarly, the court noted that civil commitment laws require a qualified, neutral health professional's opinion. Measure 16 required no such consultation with either family or professional colleagues. *Id.* at 1434-35. Instead, it immunized physicians from liability in assisting suicide if they acted in "good faith." *Id.* at 1436. This standard made it irrelevant whether the physician acted reasonably or negligently in determining competence, diagnosing terminal illness, or informing the patient of comfort care options. Without better safeguards, the court believed that vulnerable, seriously ill persons could be subject to potential abuse by others. *Id.* at 1437.

The Ninth Circuit has now explicitly rejected this analysis. With respect to disabled persons, the majority of the Ninth Circuit expressed its certainty that advocates of the disabled who had so zealously fought for their rights over the past three decades would continue to protect against abuses. With respect to the elderly, the court found that possible conflicts of interest of relatives are offset by the general humanity of physicians. *Compassion in Dying*, en banc opinion, *supra* note 1, at 825-27.

71. Historically, the American Colonies adopted the English common law rule that suicide, attempted suicide, and assisted suicide were crimes. At present, all jurisdictions have abolished criminal penalties for suicide or attempted suicide. See NEW YORK STATE TASK FORCE, *supra* note 53, at 55. States instead have opted for intervention and treatment programs to prevent others from encouraging self-death.

72. See, e.g., FLA. STAT. ch. 782.08 (1992); R.I. GEN. LAWS 11-60-1 to -5 (1996). In 1962, the American Law Institute promulgated its Model Penal Code. Section 210.5(2) makes aiding or soliciting suicide an independent offense: "[a] person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor." MODEL PENAL CODE § 210.5(2) (Official Draft 1980). The Comment to this section recognizes the ineffectiveness of criminal sanctions to deter suicide, but states that "this does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or influence another to take his own life." *Id.* cmts. 2, 5. Assisted suicide statutes have been used to obtain convictions against defendants who backed out of suicide pacts. See, e.g., *In re Joseph G.*, 667 P.2d 1176 (Cal. 1983); *State v. Bauer*, 471 N.W.2d 363 (Minn. Ct. App. 1991).

73. See, e.g., ARIZ. REV. STAT. § 13-1103(A)(3) (1996) (manslaughter).

74. See, e.g., *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied sub nom. Hobbins v. Kelley*, 115 S. Ct. 1795 (1995); *State v. Bouse*, 264 P.2d 800 (Or. 1953), *overruled on other grounds by State v. Fischer*, 376 P.2d 418 (1962), and *overruled on other grounds by State v. Brewton*, 395 P.2d 874 (1964).

ringe's plunger, constitutes a more serious crime, usually some form of intentional killing or homicide.<sup>75</sup>

Prior to the recent Ninth and Second Circuit decisions, four different courts, three at the federal level and one at the state level, upheld these statutes or rejected legislation that would have altered the traditional position.<sup>76</sup> All agreed that, while patient autonomy rights include the right to reject or halt medical interventions, they do not extend to a right to assistance in suicide. They pointed out that the *Cruzan* decision provided some basis for a constitutional right to die, but only in those situations where medical treatment is refused and death follows from underlying disease, injury, or disability.<sup>77</sup> These courts have found the distinction between refusing medical treatment and assisting a suicide reasonable and essential.<sup>78</sup>

The recent decisions by the Ninth and Second Circuits stand alone then, in finding a constitutional right to physician-assisted suicide. The generally clear distinction between letting die and killing has a solid foundation in the natural reality that all persons will die, as well as in the consequences which would follow if the state legalized the killing of patients. This line also has become explicitly accepted after at least twenty years of debate and discussion in the medical, ethical, and legal communities.<sup>79</sup> The result of this serious reconsideration of the dying process has been a near universal reaffirmation of the distinction between letting die and killing.

For some, this legal consensus emerges too weakly and too late. Although legal obstacles to patient autonomy have been dismantled, patients and families continue to confront powerful health care providers who are tempted by third party reimbursement to use or withhold available medical technology to prolong life. Some physicians continue

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75. See, e.g., *People v. Matlock*, 336 P.2d 505 (Cal. 1959); *People v. Cleaves*, 280 Cal. Rptr. 146 (Ct. App. 1991); *State v. Sexton*, 886 P.2d 811 (Kan. 1994); *State v. Cobb*, 625 P.2d 1133 (Kan. 1981); *State v. Bartz*, No. 95-2345-CR, 1996 WL 442200 (Wis. Ct. App. Aug. 7, 1996).

76. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996); *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995); *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996); *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994). A trial court later permanently enjoined Dr. Jack Kevorkian from participating in assisted suicides. *People v. Kevorkian*, 534 N.W.2d 172 (Mich. Ct. App. 1995), *appeal denied*, 549 N.W.2d 566 (Mich.), *cert. denied*, 117 S. Ct. 296 (1996).

77. See, e.g., *Compassion in Dying*, 49 F.3d at 591; *Quill*, 870 F. Supp. at 83.

78. The Canadian Supreme Court recently struggled with similar arguments. In a five to four decision, the court ruled that a terminally ill person had no right to physician-assisted suicide. Although a majority of judges found the patient's constitutional claims valid under the Canadian Charter of Rights, they also found that the criminal prohibition against aiding a suicide "protects all individuals against the control of others over their lives." Introducing any exception would "create an inequality" and weaken a barrier designed to protect all persons' lives, particularly those of vulnerable persons. *Rodriguez v. British Columbia*, [1993] 3 S.C.R. 519, 613.

79. See MEISEL, *supra* note 62, at 37-54; BEAUCHAMP & CHILDRESS, *supra* note 53, at 170-81.

to raise false hopes by inadequately disclosing the advantages and risks of possible treatments. Further, although financial incentives are changing from fee-for-service reimbursement to managed care plans, the cost of medical care near the end of life continues to rise.

We are convinced, however, that the line between letting die and killing should be upheld because it has not been drawn at random, nor adhered to unthinkingly. Though still imperfect, the current legal consensus provides a better response than its alternatives to the obstacles that continue to impair individualized medical decision-making near death. In particular, errors made due to gaps in information or ability return the person to his prior diseased or disabled state, but do not always eliminate the opportunity to reconsider a decision. The traditional line therefore most effectively protects the largest number of vulnerable people and best assures true autonomy for seriously ill patients. As we will show in the next Section, the traditional line between letting die and killing creates a better deterrent to prevent widespread abuse. The line which the Ninth and Second Circuits must fall back on is open to more far reaching abuse and is clearly unenforceable. It therefore invites new departures from the new ill-defined line, raising the risk of involuntary euthanasia.

### *B. The Perilous Line Between Physician-Assisted Suicide and Other Forms of Killing*

The Ninth and Second Circuits, as we have seen, must draw a line, but the line they have drawn is fragmented and inherently incoherent. These two court decisions state that they would recognize a constitutional right to physician-assisted suicide only for a competent patient who voluntarily seeks help in dying, is terminally ill, is suffering intolerable pain, and receives assistance from a physician in dying.<sup>80</sup> A careful analysis of each of these complex elements of the line demonstrates how untenable the positions of the Ninth and Second Circuits are. Their fragile and permeable line fails to prevent involuntary assisted suicide and euthanasia for a large number of vulnerable patients.

#### *1. Patient Competence*

Both the Ninth and Second Circuits extend the right of assisted suicide only to those patients who are "competent" to choose to die. It is often difficult, however, to determine whether a patient is truly competent to make this decision. The words of a seriously ill patient spoken to a family member or doctor—"Would you help me to end it all?"—

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80. See *supra* notes 47-51 and accompanying text.

carry no assurance that they accurately reflect the patient's authentic, autonomous self. No clear, simple litmus test exists to determine patient competence.<sup>81</sup> Indeed, quite to the contrary, several factors inherent in the typical assisted suicide case make it difficult to reliably evaluate the patient's competence. Patient competence, for example, exists all too often in the eyes of the beholder. Doctors, as well as family members, can be tempted to base their assessment of the patient's competence on whether the patient decides to accept the treatment the doctor or family member considers appropriate in the situation.<sup>82</sup> If doctors or family members, like the judges of the Ninth Circuit, are horrified at the sight of a patient reduced "to a childlike state of helplessness, diapered, sedated, [and] incontinent,"<sup>83</sup> they are likely to conclude that the patient is competent, at least in part because he has requested assistance in dying. The doctor's own fear of being in such a condition herself may color her view of what one might competently find to be an utterly intolerable existence.

The unique situation of a seriously ill patient presents other aspects that increase the difficulty of determining competence. For one, patients suffering from serious illness often require powerful medications. At the same time, the patient also can be suffering physical and mental anguish. Depression, as will be explained more fully in the discussion of voluntariness, can also impair decision-making capacity. Given these and other problems, it is difficult to imagine how a patient, weakened by illness, sedated by medication, frightened by an uncertain future, and dependent on health care providers and caregivers would be able to make a competent decision to kill himself.

In the face of such obstacles, courts often rely on clinical tests of competence. Medical authorities have applied a variety of approaches

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81. For an exploration of the complexity of legal tests for competence, see John Parry, *Incompetency, Guardianship, and Restoration*, in *THE MENTALLY DISABLED AND THE LAW* 369, 371-78 (Samuel Jan Brakel et al. eds., 3d ed. 1985); cf. John Parry, *A Unified Theory of Substitute Consent: Incompetent Patients' Right to Individualized Health Care Decision-making*, 11 *MENTAL & PHYSICAL DISABILITY L. REP.* 378, 379 (1987) ("[U]nfortunately, the definition of incompetency is of equal or greater complexity than substitute decision-making itself.").

82. See, e.g., R. Sean Morrison, et. al., *When Too Much is Too Little*, 335 *New. Eng. J. Med.* 1755, 1759-80. See D. Don Welch, *Walking in Their Shoes: Paying Respect to Incompetent Patients*, 42 *VAND. L. REV.* 1617, 1625-28 (1989). Cf. Wendy M. Margolis, Comment, *The Doctor Knows Best?: Patient Capacity for Health Care Decisionmaking*, 71 *OR. L. REV.* 909, 916-17 (1992) (explaining that frequently doctors believe they have obtained "informed consent" when they merely inform the patient of the procedure they will administer); S. Van McCrary & A. Terry Walman, *Procedural Paternalism in Competency Determination*, 18 *L., MED. & HEALTH CARE* 108, 112 (1990) (discussing the paternalistic presumption of incompetency for patients that refuse to consent to recommended treatment).

83. *Compassion in Dying*, en banc opinion, *supra* note 1, at 814. It should be noted that incontinence, sedation, and helplessness are not necessarily indications of terminal illness.

to determine whether a patient is competent.<sup>84</sup> The most appropriate test for competency dovetails with the law of informed consent by focusing on the patient's capacity to understand disclosure of relevant information and to communicate a personal choice.<sup>85</sup> It seeks to assure that the patient recognizes and grasps the risks and benefits of the medical procedures available, the prognosis, and the alternatives before being considered competent. This test requires that the patient be able to understand and identify the essential medical facts disclosed as a condition to being deemed competent to make a treatment decision. The weight the patient gives to each element is up to the patient, but she should at least grasp what those elements mean for her.<sup>86</sup>

Under such a test, the seriously ill patient will have to understand not only his own medical condition, but also the health care options available to treat it. These may include alternative, and perhaps better, treatments for physical and mental suffering, care in alternative facilities or at home, continued life in a debilitated state for a period of time, or death, caused either by his own hands or the direct intervention of another. Moreover, understanding alternatives to suicide also requires that the alternatives, such as improved pain management or hospice care, be made easily accessible for experiential trial by the person weighing a decision.<sup>87</sup>

Given the demands of this test and the unique setting of the terminally ill patient, it will not be easy or inexpensive to assure patient competence. If a State were serious about assuring competent decision-making by terminally ill patients requesting physician-assisted suicide, it would have to insist on competence determinations by specialists who are accustomed to interacting with seriously ill patients and who can remain emotionally detached from the decision. In such a highly charged atmosphere, determining whether the patient truly has grasped the options and competently made an authentic personal choice calls for seri-

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84. See Bernard Lo, *Assessing Decision-Making Capacity*, 18 L., MED. & HEALTH CARE 193, 195-99 (1990); Loren H. Roth et al., *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279, 280-83 (1977); Barbara Stanley et al., *The Functional Competency of Elderly at Risk*, 28 GERONTOLOGIST 53, 53-54 (Supp. 1988).

85. See UNIF. HEALTH-CARE DECISIONS ACT § 1(3), 9 U.L.A. 222 (Supp. 1996) ("'Capacity' means an individual's ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health-care decision."); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 45 (1983).

86. See ALLEN E. BUCHANAN & DAN W. BROCK, *DECIDING FOR OTHERS* 50 (1989); EDMUND D. PELLEGRINO & DAVID C. THOMASMA, *FOR THE PATIENT'S GOOD* 149 (1988).

87. The availability of a choice to receive life insurance benefits before death, often referred to as "living benefits," may enable patients to pay for such care. Federal law now requires life insurers to offer living benefits as an option for terminally ill policy holders. 5 U.S.C.A. § 8714d (1996). See generally Andrew L. Lee, Note, *Living Benefits: A Right of the Terminally Ill*, 2 B.U. PUB. INT. L.J. 55 (1992) (discussing features of living benefits).

ous and unbiased judgment. Such a safeguard, however, is not provided for in the recent circuit court decisions.

Despite the courts' reliance on patient competence as one factor in the line that demarcates constitutionally protected assisted suicide, competence simply does not assure sufficient protection from committing a fatal mistake for those who do not have the capacity to make this decision. The problems involved in evaluating competence undermine the possibility that it can be relied upon as an anchor for the line that prevents the euthanasia of any temporarily or permanently incompetent patients, especially persons with mental or emotional disabilities.

## 2. *Voluntary Decision*

If determining whether a request for physician-assisted suicide has been made by a competent patient will be complex and problematic, it will be even more difficult to assure that such a choice is voluntary. Competence and voluntariness often overlap. In practice, many of the factors used to assess whether a patient is competent also are central to determining whether a patient is making a voluntary decision.

The Ninth and Second Circuit opinions rely especially on the voluntariness of the request as a condition of constitutionally protected physician-assisted suicide. Both courts surely would blanch at the suggestion that they have endorsed involuntary euthanasia. A line defined in part by voluntariness, however, is elusive and treacherous at best. Many persons who request suicide are "beset with ambivalence, simply wish to reduce or interrupt anxiety, or are under the influence of drugs, alcohol, or intense pressure."<sup>88</sup> Further, such a person may entertain rescue fantasies. A "competent" request for suicide actually may convey a deep desire for relief from the distressing realities currently confronting the person.<sup>89</sup> When this occurs, granting assistance in suicide actually disregards the patient's true intent. These dynamics explain why some commentators familiar with suicide intervention believe that "suicide cannot really be 'chosen.'"<sup>90</sup> The compulsion of human self-preservation means that every person retains some "hope of being saved."<sup>91</sup>

If, despite this information, we assume, as the Ninth and Second Circuits did, that a patient's suicide request can be voluntary, then assessing the meaning of such a request often will be impossible without a

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88. Tom L. Beauchamp & James F. Childress, *Moral Problems of Suicide Intervention*, in *ETHICAL ISSUES IN DEATH AND DYING* 127, 128 (Tom L. Beauchamp & Robert M. Veatch eds., 2d ed. 1996).

89. *See id.* at 128-29.

90. ERWIN RINGEL, *Suicide Prevention and the Value of Human Life*, in BEAUCHAMP & VEATCH, *supra* note 88, at 144.

91. *Id.*

clinical evaluation. Depression, the major precursor of suicidal intent, often worms its way into serious illnesses and, especially among the elderly, can remain undiagnosed and untreated.<sup>92</sup> Besides depression, seriously ill patients can suffer organic mental dysfunction or the strong effects of medication, which may impair their judgment and make it impossible to remain unpressured while thoughtfully weighing the alternative choices.<sup>93</sup> A clinical evaluation is necessary to rule out the possibility that a suicide request results from one of these factors and is not a truly voluntary decision to die:

In many cases, a patient who requests euthanasia or assisted suicide may have undiagnosed major clinical depression or another psychiatric disorder that prevents him or her from formulating a rational, independent choice. Other patients may feel compelled to end their lives because they lack real alternatives due to inadequate medical treatment or personal support.<sup>94</sup>

Even if euthanasia can be limited, legally and practically, to competent persons with terminal illness, there remain good reasons to doubt the voluntariness of many if not most suicide wishes, absent a thorough psychiatric or clinical examination.<sup>95</sup> A psychiatrist who has studied suicidal patients for many years has written that "[t]he patient, who may have said she wants to die in the hope of receiving emotional reassurance that all around her want her to live, may find that . . . she has set in motion a process whose momentum she cannot control."<sup>96</sup> These factors become far more complex when the person experiencing depression comes from an ethnic or cultural tradition unfamiliar to his physician.<sup>97</sup>

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92. NEW YORK STATE TASK FORCE, *supra* note 53, at 32-33.

93. See Norman G. Levinsky, *The Purpose of Advance Medical Planning—Autonomy for Patients or Limitation of Care?*, 335 NEW ENG. J. MED. 741, 741 (1996).

94. NEW YORK STATE TASK FORCE, *supra* note 53, at 89. The Report, with great sensitivity, states later:

Care and support for terminally and chronically ill patients also impose serious burdens on family members and other caregivers. The burdens are both financial and emotional. Family members may be drained by these demands or may conclude, based on their own perspective, that the patient's life is no longer worth living. Out of this benevolence, or from sheer frustration or exhaustion, family members may suggest or encourage the patient to accept assisted suicide or euthanasia. Motivated by a sense of guilt or abandonment, many patients will feel that they have no choice once the option is presented. Indeed, if assisted suicide and euthanasia are widely available, patients may feel obligated to consider these options to alleviate the burden their illness and continued life imposes on those closest to them.

*Id.* at 124.

95. See Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 NEW ENG. J. MED. 1100, 1101-02 (1991).

96. Herbert Hendin, *Selling Death and Dignity*, HASTINGS CENTER REP., May-June 1995, at 19, 23.

97. See, e.g., Byron J. Good et al., *The Interpretation of Iranian Depressive Illness and Dysphoric Affect*, in CULTURE AND DEPRESSION 369 (Arthur Kleinman and Byron J. Good eds.,



The rate of depression among terminally ill patients appears to be "much higher than would be expected in the general population."<sup>98</sup> Depression tends to accompany the transient stress or mental crisis generated by the shock, disbelief, anger, or perceived helplessness that accompanies the stark reality of serious illness.<sup>99</sup> Typically, these transient stress reactions do not result in sustained desires for suicide;<sup>100</sup> ordinarily, depressed terminally ill patients respond to personal intervention or clinical treatment.<sup>101</sup> This may partially explain why suicide rarely occurs among such persons.<sup>102</sup>

Simply offering suicide may make all the difference. The mere mention of suicide as a legally sanctioned clinical option by a trusted doctor could overwhelm the spirit of the already-dejected patient. At the very least, it will redefine the boundaries of acceptable behavior. Seriously ill persons become vulnerable as they become dependent on health care providers. The right to die could well be perceived by such a person as a duty to die, an obligation to relieve the stress of relatives and friends or alleviate the burdens of medical costs.<sup>103</sup> True personal autonomy could be lost if the patient, increasingly dependent on caregivers, in pain, exhausted from illness, or worried about the lingering suffering of family members or burdensome costs of continued health care, is offered a quick way out by his doctor or family. Furthermore,

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1985); ARTHUR KLEINMAN, *SOCIAL ORIGINS OF DISTRESS AND DISEASE: DEPRESSION, NEURASTHENIA, AND PAIN IN MODERN CHINA* (1986); Edward L. Schieffelin, *The Cultural Analysis of Depressive Affect: An Example from New Guinea*, in *CULTURE AND DEPRESSION*, *supra*, at 101.

98. James Henderson Brown et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 *AM. J. PSYCHIATRY* 208, 210 (1986).

99. See generally NANCY J. OSGOOD ET AL., *SUICIDE AMONG THE ELDERLY IN LONG-TERM CARE FACILITIES* (1991) (discussing, as a factor contributing to depression, the "loss" attending illness and declining health); Leslie Hartley Gise et al., *Medical Psychiatric Rounds on a Gynecologic Oncology Service: End-Stage Cervical Carcinoma in a Jehovah's Witness Refusing Treatment*, 11 *GEN. HOSP. PSYCHIATRY* 372 (1989) (interview with end-stage cancer patient demonstrating her feelings of depression, anger, and anxiety generated by her deteriorating condition).

100. See, e.g., John R. Peteet, *Depression in Cancer Patients: An Approach to Differential Diagnosis and Treatment*, 241 *JAMA* 1487, 1487 (1979) (describing symptoms of depression seen in cancer patients and noting that diagnosis is not typically accompanied by "persisting . . . suicidal ideation.").

101. Leonard R. Derogatis et al., *The Prevalence of Psychiatric Disorders Among Cancer Patients*, 249 *JAMA* 751, 757 (1983).

102. See Michael Bond, *Psychological Aspects of the Treatment of Cancer Pain*, in *PALLIATIVE CARE* 242, 249 (Derek Doyle ed., 1984); Peter M. Levine et al., *Mental Disorders in Cancer Patients: A Study of 100 Psychiatric Referrals*, 42 *CANCER* 1385, 1387 (1978) (explaining that suicide is "uncommon among patients with cancer").

103. A recent survey of Oregon physicians found that 93% thought patients might request assisted suicide because of a concern they will be a burden on others. Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *N. ENG. J. MED.* 310, 312 (1996). Interestingly, a poll indicates that oncologists, cancer patients, and the general public believe that assisted suicide is least justifiable in situations where patients feel their existence burdens others. Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public*, 347 *LANCET* 1805, 1809 (1996).

communication by even the most well-intentioned physician can be skewed where religious or cultural differences in expression cloud or change meaning.<sup>104</sup> The suicide option created by the Ninth and Second Circuits risks changing the social perception of legitimate behavior. The plaintiffs in those cases, fighting for the right to kill themselves, might be followed by patients who, once offered the option of suicide, must fight to justify their continued existence.

Courts should have learned by now that they lack any mystical vision to determine if an action or decision is voluntary. They can only look to various external, objective criteria to arrive at a hunch that, for instance, a criminal defendant's confession was voluntary,<sup>105</sup> or that a testator's will was executed voluntarily, that is, without undue influence.<sup>106</sup> If a doctor says that a seriously ill patient voluntarily sought assisted suicide, on what basis could a court challenge the statement? Will it require disclosure of alternatives to suicide? A psychiatric or clinical consultation to determine whether the dying person has been overtly or subtly coerced? How will a court prevent subtle coercion from the physician or family? How will it understand differences in cultural expression? Will courts be forced to construct a battery of questions, in the tradition of *Miranda*<sup>107</sup> warnings, to assure the consent is voluntary? Ultimately, the line the Ninth and Second Circuits attempt to draw at voluntary requests is no firm line at all.

### 3. Terminally Ill

Obviously, the Ninth and Second Circuits do not suggest that physician-assisted suicide should be available for every healthy young person confronted with failure, medical disability, clinical depression, or personal loss. In order to avoid this, both courts have reserved physician-assisted suicide for terminally ill patients.<sup>108</sup> Yet, once again, this factor contributes to an inherently ill-defined line. Many will recall that,

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104. See generally ETHNIC VARIATIONS IN DYING, DEATH AND GRIEF: DIVERSITY IN UNIVERSALITY (Donald P. Irish et al. eds., 1993) (discussing variations in experience, expression, and understanding by African-Americans, Mexican-Americans, Hmong, and Native Americans, as well as principles and orientations of Jewish, Buddhist, Islamic, Quaker, and Unitarian beliefs).

105. See JOSEPH D. GRANO, CONFESSIONS, TRUTH, AND THE LAW 59-83 (1993); Laurence A. Benner, *Requiem for Miranda: The Rehnquist Court's Voluntariness Doctrine in Historical Perspective*, 67 WASH. U. L.Q. 59, 92-119 (1988); Yale Kamisar, *What is an 'Involuntary' Confession? Some Comments on Inbau and Reid's Criminal Interrogation and Confessions*, 17 RUTGERS L. REV. 728 (1963); Stephen J. Schulhofer, *Reconsidering Miranda*, 54 U. CHI. L. REV. 435, 436-53 (1987).

106. See Mary Louise Fellows, *In Search of Donative Intent*, 73 IOWA L. REV. 611, 621-22 (1988); Milton D. Green, *Fraud, Undue Influence and Mental Incompetency*, 43 COLUM. L. REV. 176, 179-80 (1943); Alexander M. Meiklejohn, *Contractual and Donative Capacity*, 39 CASE W. RES. L. REV. 307, 367-72 (1989).

107. *Miranda v. Arizona*, 384 U.S. 436 (1966).

108. See *supra* note 47 and accompanying text.

after the long ethical and legal debate about removing Karen Quinlan from a respirator, which all observers expected would surely lead to her death in a short time, she lived for another nine years without the respirator.<sup>109</sup> The timing of death, with its silent footsteps, often lies beyond the prognosticating power of modern medical science.

Neither of the recent circuit court opinions attempts to define "terminal illness." The expression itself could mean that the patient's death is imminent, only hours or days away, or it could mean that the patient will die in a relatively short time, say six months, which is the cut-off for hospice care under Medicare guidelines.<sup>110</sup> Regardless of where we draw the line, estimates of how soon a patient will die are difficult to make. As Joanne Lynn points out, the majority of Americans do not die from cancer (whose patients make up 80% of those who use hospice) but from organ system failure, such as heart or lung disease.<sup>111</sup> "The timing of death from these diseases is much less predictable than it is for the usual hospice population."<sup>112</sup> In fact, the number of patients deemed terminally ill from a physician's point of view will depend not only on time, but also on statistical probability. "For every patient who would be [deemed terminally ill] if the criterion were a probability of less than 10 percent of living for an additional six months, thousands [more] would be eligible if the threshold probability were 50 percent."<sup>113</sup>

Doctors usually can recognize the signs that a patient is near death, in the sense that death from natural causes will occur within a few hours.<sup>114</sup> But beyond this, it is often extremely difficult for doctors to identify any meaningful definition of terminal illness.<sup>115</sup> In particular,

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109. See Hannah C. Kinney et al., *Neuropathological Findings in the Brain of Karen Ann Quinlan*, 330 NEW ENG. J. MED. 1469 (1994).

110. See Joanne Lynn, *Caring at the End of Our Lives*, 335 NEW ENG. J. MED. 201, 201 (1996). Hospice care emphasizes interdisciplinary therapeutic services designed to comfort persons with terminal illness. Hospice emphasizes pain control and other palliative support rather than services designed to cure disease or disability.

111. *Id.*

112. *Id.*

113. *Id.* at 201-02. "Predicting that a condition is 'terminal' within any specific time period or opining on the 'imminence' of death has been very difficult for the medical profession. . . . Distinguishing between serious illnesses, life-threatening conditions, and terminal illnesses is frequently difficult for physicians and nearly impossible for the legal community." *In re Guardianship of Browning*, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989).

114. See Jonathan Gavrin & C. Richard Chapman, *Clinical Management of Dying Patients*, 163 W.J. MED. 268, 268 (1995).

115. A recent study of Oregon physicians' views on assisted suicide found that 50% "were not confident that they could predict that a patient had less than six months to live." Lee et al., *supra* note 103, at 312. This may explain a finding by a similar survey of Michigan physicians that doctors with "the least contact with terminally ill patients were the most likely to support the legislation of assisted suicide." Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward*

when a person first learns of the diagnosis of an eventually terminal illness, can the initial suffering caused by this knowledge be relieved by assisted suicide? Do the Ninth and Second Circuits mean to suggest that a person recently diagnosed with the early stages of Alzheimer's disease, for example, which ultimately will be terminal, can be assisted with suicide as she struggles to absorb the first shattering diagnosis?<sup>116</sup> As Doctor Lynn reminds us, if we define "terminally ill" to include everyone with less than a fifty percent chance of living six months, "most of the frail elderly in nursing homes" would be considered terminally ill.<sup>117</sup> Given the many different interpretations to which the characteristic is subject, "terminally ill" does little to secure the line drawn by the Ninth and Second Circuits.

#### 4. *Suffering*

The often unspoken premise of many proponents of physician-assisted suicide is that it is needed to avoid intolerable suffering.<sup>118</sup> To many, the more traditional line between letting die and killing has seemed inhumane and difficult to maintain in the face of long-lasting, unbearable pain. Indeed, the presence of suffering is one of the criteria relied upon by the Ninth and Second Circuits to define the line that they have drawn. Yet, law and medical ethics have long distinguished between treating pain and killing. Relying on suffering as a factor in the line that distinguishes acceptable assisted suicide from other forms of killing will serve only to blur this distinction.

In acute care situations, patients often are asked to endure suffering or even risk death in order to press for a cure to a potentially fatal disorder. Towards the end of life, the opposite occurs. Patient and clinical

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*Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 308 (1996).

116. When Janet Adkins was helped by Dr. Kevorkian to commit suicide, she had been diagnosed with Alzheimer's disease and feared for her future. But when she received doctor assistance for her suicide, she was 54 years old, not in imminent danger of death, and not suffering pain. She had played tennis just a few days before her death. See *People v. Kevorkian*, 534 N.W.2d 172, 173-74 (Mich. Ct. App. 1995), *appeal denied*, 549 N.W.2d 566 (Mich.), *cert. denied*, 117 S. Ct. 296 (1996). Of course, Kevorkian, a pathologist, was probably not competent to independently confirm her diagnosis or to discover whether she was depressed. At any rate, his limited contact with her did not allow time for him to undertake such examination. See *id.*; BEAUCHAMP & CHILDRESS, *supra* note 53, at 237-38. Some suggest that medical advocates for assisted death, like Dr. Kevorkian, will be most often successful with vulnerable women. Stephanie Gutmann, *Death and the Maiden: Dr. Kevorkian's Woman Problem*, NEW REPUBLIC, June 24, 1996, at 20. Others point out that Kevorkian's primary goal has always been the use of tissue from newly dead bodies for medical experimentation. Robert A. Burt, *Choosing Death: For Oneself / For Others*, in PATIENT'S RIGHTS 63, 80-82 (Lotta Westerhäll and Charles Phillips eds., 1994). At any rate, the trial court injunction permanently barring Kevorkian from participating in assisted suicide can now be enforced. See *Kevorkian*, 534 N.W.2d at 175.

117. Lynn, *supra* note 110, at 202.

118. See *supra* note 49.

focus can shift to achieving comfort, when patients value relief from suffering over a cure. In some situations, aggressive pain management risks physical side effects, such as depressed respiration. Where the patient and doctor seek relief from suffering in a manner that risks an earlier death, law and medicine have invoked the doctrine of double effect.<sup>119</sup> Under the doctrine of double effect, a morally correct action (relief of suffering) is justifiable in spite of a bad consequence or harm (hastened death) so long as the harm is not intended, and the act is not intrinsically wrong.<sup>120</sup> Intentionally ending life by using a lethal overdose differs. Here, the intention is to cause death.<sup>121</sup>

The doctrine of double effect holds that a vast moral gulf separates the doctor who, on the one hand, strives to support the patient's life, but realizes that the treatment or medication necessary to relieve suffering risks hastening the death of the patient, from the doctor, on the other hand, who intends to relieve suffering by ending the patient's life. Unfortunately, in real life, clinical intentions can be impetuous, blurred, confused, and multidimensional, reflecting the complexity of human life.<sup>122</sup> However, the doctrine of double effect reminds the physician, or any moral actor, to reflect in advance in order to focus as clearly as possible on his real intentions. The physician who honestly and reasonably seeks to support a person's quality of life during the final stages need not fear criminal prosecution, even if the pain medication shortens that

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119. *Compassion in Dying*, en banc opinion, *supra* note 1, at 822-29. The principle gets its name from Catholic moral teachings beginning four decades ago. In 1951, Pope Pius XII spoke about a situation where "the saving of the life of the future mother . . . should urgently require a surgical act or other therapeutic treatment which would have an accessory consequence, in no way desired nor intended, but inevitable, the death of the fetus . . . Under these conditions the operation can be lawful, like other similar medical interventions—granted always that a good of high worth is concerned, such as life, and that it is not possible to postpone the operation . . . nor to have recourse to other efficacious remedies. . . ." KEVIN D. O'ROURKE & PHILLIP BOYLE, *MEDICAL ETHICS: SOURCES OF CATHOLIC TEACHINGS* 104 (2d ed. 1993).

120. Thus, for a physician who gave a patient a lethal dose of chemotherapy or pain killer to be criminally liable under the Model Penal Code's prohibition on assisted suicide, the physician must have acted with the purpose (or "conscious object") to cause the patient's death. MODEL PENAL CODE §§ 2.02(b)(2), 210.5(2) (Official Draft 1985). If so, the act cannot be justified by appeal to another goal, such as curing cancer or ending pain. If, on the other hand, the act merely risked the harm, but the patient consented to it in order to achieve a different goal, then the act would not be criminal. See *Compassion in Dying*, en banc opinion, *supra* note 1, at 858 (Kleinfeld, J., dissenting).

121. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN OTHERS MUST CHOOSE* 208-11 (1992). When physicians were surveyed about their beliefs regarding particular end-of-life decisions, almost all approved of administering pain medication that is intended to relieve pain but has a known side effect of shortening life. Frederick Y. Huang & Linda L. Emanuel, *Physician Aid in Dying and the Relief of Patients' Suffering: Physicians' Attitudes Regarding Patients' Suffering and End-of-Life Decisions*, 6 J. CLINICAL ETHICS 62, 64-65 (1995). Yet, among the same group of physicians, the vast majority opposed assisted suicide (between 68% and 91%) and direct euthanasia (between 84% and 94%). *Id.* at 65.

122. See Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 NEW ENG. J. MED. 1039 (1993).

person's life. On the other hand, the doctor who administers chemicals which can only cause death, intending only to relieve pain by ending life, invites prosecution.<sup>123</sup>

Far too often, doctors have been remiss in failing to provide adequate palliative care. Yet, legally and medically, pain and suffering can and should be relieved in the overwhelming majority of cases.<sup>124</sup> Frequently, it is not the pain itself, but pain joined with depression or the patient's sense that she has lost control, which instills a desire in the patient to end her life.<sup>125</sup> Anxiety may be generated by the fear that pain will not be adequately controlled. Physicians who treat patients with severe pain routinely report that many have previously requested assisted suicide. One recent survey of physicians in the state of Washington found that a great number of patients who ask their physicians to help them die fear losing control or burdening others.<sup>126</sup> These requests commonly "dissolve with adequate control of pain and other symptoms."<sup>127</sup> "Taken together, modern pain relief techniques can alleviate pain in all but extremely rare cases. Effective techniques have been developed to treat pain for patients in diverse conditions."<sup>128</sup>

Embracing legalized assisted suicide will pose new challenges to the continuing advancement of palliative care. Death, through physician-assisted suicide or physician-administered euthanasia, will surely end pain. Unfortunately, it also could end interest and research in palliative care. To "palliate" means to "ease[e] without curing."<sup>129</sup> Palliative care, which is also often referred to as comfort care, is intended to relieve the symptoms of a disorder and improve a patient's quality of

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123. See Norman L. Cantor & George C. Thomas III, *Pain Relief, Acceleration of Death, and Criminal Law*, 6 KENNEDY INST. OF ETHICS J. 107, 114-23 (1996).

124. See Robert G. Twycross, *Where There is Hope, There is Life: A View from the Hospice*, in EUTHANASIA EXAMINED 141, 141 (John Keown ed., 1995) (asserting that sufficient pain relief is almost always possible in patients with incurable cancer); Ada Jacox et al., *New Clinical-Practice Guidelines for the Management of Pain in Patients with Cancer*, 330 NEW ENG. J. MED. 651, 651 (1994) (stating that in 90% of cancer patients experiencing pain, the pain can be controlled by "relatively simple means."); Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678, 1679-81 (1992) (presenting certain circumstances in which the use of barbiturates by a physician intending to relieve pain, rather than to kill, is justified).

125. See NEW YORK STATE TASK FORCE, *supra* note 53, at 25. In one recent survey of American cancer patients, patients who were actually experiencing pain were more likely to find euthanasia or physician-assisted suicide unacceptable than those who were not currently in pain. Emanuel et al., *supra* note 103, at 1805.

126. Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 921-22 (1996) (reporting that 77% of the terminally ill patients surveyed were concerned about future loss of control and 75% of them were concerned about being a burden).

127. Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. PAIN & SYMPTOM MGMT. 289, 290 (1991).

128. NEW YORK STATE TASK FORCE, *supra* note 53, at 40.

129. Derek Doyle, *Palliative Symptom Control*, in PALLIATIVE CARE, *supra* note 102, at 297.

life.<sup>130</sup> It is not restricted to controlling physiological pain alone but also includes the amelioration of all the subjective symptoms of suffering, whether physical,<sup>131</sup> psychological,<sup>132</sup> situational,<sup>133</sup> or spiritual.<sup>134</sup>

Until about a decade ago, little systematic study had been done of dying patients or their need for palliative care.<sup>135</sup> This began to change in the early 1970's with the publication of the work of psychiatrists, such as Elisabeth Kubler-Ross,<sup>136</sup> who studied and classified the mental states of dying patients. Other studies chronicled the circumstances of death in modern industrialized countries, finding them less family-centered, more institutionalized, and more medically controlled than ever before.<sup>137</sup> In these studies, physicians familiar with pain control for dying patients documented that poor pain assessment, fear of addiction, fear of possible legal complications, and fear of death itself often prevented doctors from providing adequate palliative care.<sup>138</sup> Doctors who contend that patients suffering severe pain should be allowed help in killing themselves might all too often be trying to protect themselves

130. See Cornelius J. van der Poel, *Ethical Aspects in Palliative Care*, AM. J. HOSPICE & PALLIATIVE CARE, May/June 1996, at 49; see also Laura S. Hitchcock et al., *The Experience of Chronic Nonmalignant Pain*, 9 J. PAIN & SYMPTOM MGMT. 312, 314-18 (1994).

131. See, e.g., Derek Doyle, *supra* note 129, at 265; Neil L. Schechter, *The Management of Pain Associated with Diagnostic Procedures in Children with Cancer*, in CURRENT & EMERGING ISSUES CANCER PAIN 371, 376-78 (C. Richard Chapman and Kathleen M. Foley eds., 1993); Gavrin & Chapman, *supra* note 114, at 269-70; Hitchcock et al., *supra* note 130, at 312-14; van der Poel, *supra* note 130, at 50.

132. See Robert A. Pearlman et al., *Insights Pertaining to Patient Assessments of States Worse than Death*, 4 J. CLINICAL ETHICS 33, 39-40 (1993); James S. Reitman, *The Debate on Assisted Suicide—Redefining Morally Appropriate Care for People with Intractable Suffering*, 11 ISSUES L. & MED. 299, 302-04 (1995) (discussing the need to recognize and alleviate despair while treating terminally ill patients); Mark D. Sullivan & Stuart J. Youngner, *Depression, Competence, and the Right to Refuse Lifesaving Medical Treatment*, 151 AM. J. PSYCHIATRY 971, 971 (1994) (suggesting the need to diagnose and treat depression in patients with serious medical illnesses before honoring a patient's request to die).

133. See Ivan Lichter, *Communication*, in PALLIATIVE CARE, *supra* note 102, at 444, 450; Ian Thompson, *Ethical Issues in Palliative Care*, in PALLIATIVE CARE, *supra* note 102, at 461, 463.

134. See Peter W. Speck, *Spiritual Issues in Palliative Care*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 515 (Derek Doyle et al. eds., 1993); van der Poel, *supra* note 130, at 53; see also Alan C. Mermann, *Spiritual Aspects of Death and Dying*, 65 YALE J. BIOLOGY & MED. 137, 137-39 (1992) (discussing spiritual aspects of death which may confront the terminally ill).

135. See Council on Scientific Affairs, American Med. Ass'n, *Good Care of the Dying Patient*, 275 JAMA 474, 474 (1996).

136. ELISABETH KÜBLER-ROSS, ON DEATH AND DYING (1969).

137. See, e.g., PHILIPPE ARIÈS, WESTERN ATTITUDES TOWARD DEATH: FROM THE MIDDLE AGES TO THE PRESENT 87-92 (1974); IVAN ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH 141-50 (1975).

138. Ronald H. Blum et al., *Factors Limiting the Use of Indicated Opioid Analgesics for Cancer Pain*, 7 AM. J. HOSPICE & PALLIATIVE CARE 31, 31-32 (1990); Eduardo Bruera et al., *Changing Pattern in the Treatment of Pain and Other Symptoms in Advanced Cancer Patients*, 2 J. PAIN & SYMPTOM MGMT. 139, 139 (1987); Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592 (1994); Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 NEW ENG. J. MED. 844, 846-47 (1989).

from further exposure to the patient's suffering and gradual decline. A dying patient provides a mirror into which few are eager to stare.

Over the past fifteen years, these practices have changed.<sup>139</sup> In the last decade in particular, dramatic advances in knowledge about palliative care has occurred in at least two categories. First, huge medical and technical gains have taken place that now enable health care providers to supply a wide range of pain symptom management.<sup>140</sup> Second, gains have been realized in understanding and responding to the human suffering of dying patients beyond physical pain. There is now "a small but growing number of trained clinicians who have addressed the special needs of this population and have developed guidelines for the evaluation and treatment of pain, other symptoms, and psychological distress."<sup>141</sup>

Medical gains became clear with the publication of pain guidelines for physicians by the World Health Organization in 1986.<sup>142</sup> These guidelines taught clinicians to classify different types of pain<sup>143</sup> and to identify the relationship between psychological anxiety and physical symptoms.<sup>144</sup> Methodologies also were suggested to assess pain and to improve communication between patients and health care providers. Today, in settings where staff is adequately trained, it is now routine to control pain fairly easily in 98% of all patients.<sup>145</sup> Even in rare cases where pain control is more difficult, it can be managed.<sup>146</sup>

These developments have sparked other initiatives. New curricular guidelines for physicians' and nurses' training have been devised.<sup>147</sup> New national and international organizations, such as the American Pain

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139. See Foley, *supra* note 127, at 289.

140. See Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 NEW ENG. J. MED. 1124, 1124 (1996).

141. Foley, *supra* note 127, at 290.

142. WORLD HEALTH ORG., CANCER PAIN RELIEF (1986); see also EXPERT COMM. ON CANCER PAIN RELIEF AND ACTIVE SUPPORTIVE CARE, WORLD HEALTH ORG., CANCER PAIN RELIEF AND PALLIATIVE CARE (1990).

143. See, e.g., Kathleen M. Foley, *Pain Assessment and Cancer Pain Syndromes*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE, *supra* note 134, at 148, 149-51 (discussing various classifications of pain).

144. See, e.g., Hitchcock et al., *supra* note 130, at 313 (discussing effect of pain on psychological well-being).

145. Council on Scientific Affairs, *supra* note 135, at 475.

146. *Id.* ("Certainly, no one need be in serious pain, since physicians could always relieve pain with anesthesia or profound sedation. For some, this is an unacceptable trade-off, but it is always available.") (citations omitted); Levy, *supra* note 140, at 1124.

147. See, e.g., TASK FORCE ON PROF'L EDUC., INT'L ASS'N FOR THE STUDY OF PAIN, CORE CURRICULUM FOR PROFESSIONAL EDUCATION IN PAIN (1991); Ad Hoc Comm. on Cancer Pain, American Soc'y of Clinical Oncology, *Cancer Pain Assessment and Treatment Curriculum Guidelines*, 10 J. CLINICAL ONCOLOGY 1976 (1992); see also Betty R. Ferrell et al., *Pain and Addiction: An Urgent Need for Change in Nursing Education*, 7 J. PAIN & SYMPTOM MGMT. 117, 122-23 (1992).



Society, the American Society of Hospice Physicians, the International Association for the Study of Pain, and the International Psycho-Oncology Society have been created.<sup>148</sup> These and other groups have developed clinical practice guidelines intended to educate health care providers.<sup>149</sup> Gradually, information about pain management has become available to physicians in all specialties.<sup>150</sup> Physicians have learned, for example, that patients dealing with chronic pain often report it less graphically than those experiencing acute episodes.<sup>151</sup> Dying patients also under-report pain<sup>152</sup> because they misunderstand its significance or fear the consequences of further bothering the physician. Failure to explain the basis for the distress, however, may only increase anxiety, which in turn increases pain.<sup>153</sup>

Similar strides have been made in understanding the causes and amelioration of suffering distinct from physical pain. As Eric Cassell put it:

Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. It follows, then, that although it often occurs in the presence of acute pain, shortness of breath or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of person.<sup>154</sup>

For example, the treatment of depression and its relationship to medical decisions concerning the dying process have been documented.<sup>155</sup> Common fears of dying persons such as abandonment, loss of family relationships, or dying alone can be quieted.<sup>156</sup> Other studies have examined the psychological challenges faced by those caring for dying patients. Significantly, psychiatrists note that physicians can over-identify with a patient's psychological distress without recognizing

148. See Foley, *supra* note 127, at 290.

149. See AMERICAN PAIN SOC'Y, *PRINCIPLES OF ANALGESIC USE IN THE TREATMENT OF ACUTE PAIN AND CANCER PAIN* (3d ed. 1992); JUDITH H. WATT-WATSON & MARILEE IVERS DONOVAN, *PAIN MANAGEMENT: NURSING PERSPECTIVE* (1992); Health & Pub. Policy Comm., American College of Physicians, *Drug Therapy for Severe, Chronic Pain in Terminal Illness*, 99 ANNALS OF INTERNAL MED. 870 (1983).

150. See, e.g., Gavrin & Chapman, *supra* note 114, at 268; Jacox et al., *supra* note 124, at 651.

151. See Doyle, *supra* note 129, at 298.

152. See Foley, *supra* note 143, at 148.

153. See Bond, *supra* note 102, at 249; Doyle, *supra* note 129, at 302-03.

154. ERIC J. CASSELL, *THE NATURE OF SUFFERING* 33 (1991).

155. See Bond, *supra* note 102, at 246-49; William Breitbart & Steven D. Passik, *Psychiatric Aspects of Palliative Care*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE, *supra* note 134, at 6090; Doyle, *supra* note 129, at 306-07; Sullivan & Youngner, *supra* note 132, at 975-76.

156. See Nathan I. Cherny et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. PALLIATIVE CARE 71, 73-76 (1994).

the "risk of colluding with the patient's feelings of hopelessness and helplessness."<sup>157</sup>

While these advances represent a revolution in palliative care,<sup>158</sup> they are not yet available to all dying patients. Some receive less than adequate comfort care measures because they lack access to health care resources.<sup>159</sup> Others have insurance, but coverage may be lacking for needed interventions.<sup>160</sup> Too many suffer because their primary care physician chooses to remain uninformed about palliative care options.<sup>161</sup> Organizational change is necessary. For example, hospice care, though expanding rapidly, still does not reach all the patients who could benefit from it.<sup>162</sup> Similarly, managed care incentives may be needed to induce physicians to treat less attractive or less profitable groups of patients.<sup>163</sup> Third party payers may need to be encouraged by legal regulation to cover home care and hospice alternatives.

If assisted suicide becomes a legally available choice for dying patients, these palliative care advances will both affect and be affected by its implementation. First, because many patients recant a suicide wish when adequately treated for pain and suffering, no decision to elect suicide should be viewed as truly voluntary unless viable palliative care alternatives have been attempted. Second, current costs of palliative care span a wide spectrum.<sup>164</sup> Nevertheless, none can approach the lure of cheaper cost promised by assisted suicide. In an increasingly cost-conscious health care system, physician-assisted death could become one of the only covered options. Third, physicians may fail to recognize that demands from patients for suicide often represent pleas for better care or reassurance that they will not be abandoned. The emergency room visit for pain control by those without primary health care

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157. Susan D. Block & J. Andrew Billings, *Patient Requests to Hasten Death*, 154 ARCHIVES OF INTERNAL MED. 2039, 2044 (1994).

158. See J. Cambier, *A Modern View: Pain Today, Epilogue* to ROSELYNE REY, *THE HISTORY OF PAIN* 331 (1995) ("[T]he past thirty years have modified our relationship to pain more than all the previous centuries combined.").

159. See Betty R. Ferrell & Hurdis Griffith, *Cost Issues Related to Pain Management: Report from the Cancer Pain Panel of the Agency for Health Care Policy and Research*, 9 J. PAIN & SYMPTOM MGMT. 221, 232-33 (1994); Foley, *supra* note 127, at 292.

160. See Ferrell & Griffith, *supra* note 159, at 232.

161. Doctors generally lack knowledge of effective pain management techniques and fear addiction in patients. They also worry that pain control might be viewed as euthanasia. See Charles S. Cleeland, *Documenting Barriers to Cancer Pain Management*, in *CURRENT & EMERGING ISSUES CANCER PAIN* 321, 322-24 (C. Richard Chapman and Kathleen M. Foley eds., 1993); Foley, *supra* note 127, at 291-92.

162. See Lynn, *supra* note 110, at 201.

163. See Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 217-19 (1995).

164. See Ferrell & Griffith, *supra* note 159, at 223-33.

providers could, if the nation follows the Ninth and Second Circuits, result in advocacy for permanent relief, through assisted death.<sup>165</sup>

Patients continue to suffer needlessly. Physicians and other health care providers must accelerate the implementation of palliative care options.<sup>166</sup> Over the past twenty years, the consistent thrust of legal developments regarding the right to forego life-sustaining medical treatment has been to enlarge the scope of individual patient control and choice. Palliative care options have been developed, implemented, and multiplied as a result. Legal approval of assisted suicide as a patient right, however, risks reducing real choice and control by slowing this progress or replacing it altogether.

The proponents of physician-assisted suicide assert that patients who suffer intolerably are the most obvious candidates to be considered for this option of a quick death. Yet the alternative of truly adequate palliative care including options to forego life-sustaining treatment, which would benefit far more patients, will remain concealed from doctors and patients alike as a life-reinforcing option whenever assisted suicide appears easier or less expensive. By relying on the criteria of suffering as a means of drawing the line that allows physician-assisted suicide, the Ninth and Second Circuits have ignored recent advances in palliative care for all patients and instead have created legal incentives that will subtly or overtly encourage seriously ill patients to end pain by terminating life.

##### 5. *Physician Assistance*

The Ninth and Second Circuits take it for granted that assisted suicide will involve physicians. The doctor, not a family member, pharmacist, nurse, or friend, is to provide a lethal dose for the patient to use. The Ninth Circuit further hints that if the patient is unable to take the dose on his own, then the physician could perform the lethal act herself.<sup>167</sup> Once again, by presuming that doctor participation will provide

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165. One recent study documents that 42% of outpatients with pain were not given adequate pain treatment. "Patients seen at centers that treated predominantly minorities were three times more likely than those treated elsewhere to have inadequate pain management." Cleeland et al., *supra* note 138 (quoting abstract).

166. The Health Care Financing Administration's recent approval of a diagnosis code for palliative care should facilitate such efforts. See Christine K. Cassel & Bruce C. Vladeck, *ICD-9 Code for Palliative or Terminal Care*, 335 NEW ENG. J. MED. 1232, 1232 (1996). Hendin suggests establishing a national commission "to explore and develop a consensus on the care and treatment of the seriously or terminally ill—a scientific commission similar to the President's Commission that in 1983 gave us guidelines about foregoing life-sustaining treatment with dying patients." Hendin, *supra* note 96, at 23.

167. *Compassion in Dying*, en banc opinion, *supra* note 1, at 831 ("We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician . . . may be the only way the patient may be able to receive them. The question whether

a protective line, these courts in fact demonstrate the inadequacy of the line.

Three possible rationales exist for relying on physicians rather than others to perform the task. First, physicians may be preferred because they generally have the most clinical expertise. Doctors are the parties least likely to err in assessing clinical facts, such as patient competence or voluntariness or whether the patient is terminally ill. Further, their clinical expertise enables them to assist death in the most humane manner possible. They also have the legal power to prescribe an appropriate drug. Second, physicians may be preferred because they are perceived to be relatively immune to conflicts of interest in assessing clinical facts. Third, the moral role of physicians and the nature of their relationship with patients, it is hoped, will provide a built-in protection against abuse, particularly for seriously ill and vulnerable persons.

Careful scrutiny reveals that none of these rationales can carry its intended weight. Further, legalizing physician-assisted suicide probably will compromise the trust patients currently have in doctors by changing both the self-image and the role of physicians. We believe it is utterly naive for the Ninth and Second Circuits to rely on any perceived moral characteristics of the profession as a whole to protect vulnerable, sedated, depressed, lonely, and frightened patients from abuse. Granting clinical acceptability to the act of killing actually is a means of obscuring the reality that other alternatives may be more expensive, difficult, or time-consuming to provide. Further, the person to whom the "service" is provided does not remain alive to question the decision.

As to the first rationale for reliance on physicians, clinical expertise has its own limits. Doctors, like everyone else, make mistakes. These mistakes may be errors in clinical diagnosis, prognosis, or treatment, or they may involve inadvertent or intentional manipulation of patient choice.<sup>168</sup> Errors can be compounded when a physician acts outside her particular specialty. Suicide assisted by a dermatologist, radiologist, pathologist, or ophthalmologist certainly will have resulted from a far different clinical assessment than a suicide assisted by a family physician or oncologist. Yet all are presumed qualified by the Ninth and Second Circuits to assess diagnosis and prognosis (terminal illness), competence, and the voluntariness of a patient's request.

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that type of physician conduct may be constitutionally prohibited must be answered directly in future cases, and not in this one.") (footnote omitted).

168. A recent study of the actions of internal medicine residents found that 29% admitted intentionally manipulating a patient to accept or reject a test or procedure, and 18% said they had discontinued life-sustaining interventions without permission from a patient or proxy. Michael J. Green et al., *Do Actions Reported by Physicians in Training Conflict with Consensus Guidelines on Ethics?*, 156 ARCHIVES INTERNAL MED. 298, 300-01 (1996).

Further, even if suicide assistance is restricted to the physician with a primary care relationship with a patient, studies show that most doctors from this group are unfamiliar with the signs of clinical depression.<sup>169</sup> A physician who misses such a diagnosis can make assisted suicide available without eliminating a major cause of lack of patient competence or voluntariness. Fatal mistakes will be made that cannot be repaired. Not surprisingly, a recent poll shows that physicians with the most experience in interacting with dying patients favor legalizing assisted suicide the least.<sup>170</sup> The perverse implication is that those doctors without clinical expertise may well perform the bulk of assisted suicides.

Ultimately, even if it were possible to identify a group of physicians capable of assessing all of the clinical factors that the Ninth and Second Circuits have made prerequisites to assisted suicide, their expertise will usually perceive and analyze only the physical dimension of the patient. Most physicians have no particular expertise in grasping or assessing a patient's deeper thoughts, beliefs, values, and motivations, all of which are central to understanding her true wishes.<sup>171</sup> Certain groups of patients, such as those with disabilities, whether physical, mental, or age-related, would be particularly vulnerable to error in this regard. Cultural and language differences between provider and patient further aggravate this problem. Those without any choice of a physician or health care provider will be unable to select a person whom they trust to evaluate these factors.

With respect to the second rationale for physician assistance—freedom from conflicts of interest—it is clear that physicians have their own needs and agendas, such as personal time, professional advancement, research projects, or financial rewards.<sup>172</sup> They often have little time to discover or wisdom to understand the patient's best interests. Most physicians today do not have the type of close relationship with their patients that would enable them to distinguish the patient's request for suicide from a cry for some other kind of help.

Further, power inequalities inherent in the doctor-patient relationship create additional conflicts. Patients and physicians are not equals. The doctor acts as an authority figure whose greater knowledge and experience allows her to prescribe the professionally conceived best course of action for the patient.<sup>173</sup> As physicians come to see assisted suicide as an alternative to other forms of medical care, there exists a risk that assisted suicide will become treatment that a doctor prescribes to a patient

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169. Gavrin & Chapman, *supra* note 114, at 270-71.

170. Bachman et. al., *supra* note 115, at 308.

171. See generally WILLIAM F. MAY, *THE PATIENT'S ORDEAL* (1991) (exploring the issues of medical ethics from patients' perspectives to provide insight for practitioners).

172. See SHERWIN B. NULAND, *HOW WE DIE* 249-54 (1994).

173. See RUTH MACKLIN, *ENEMIES OF PATIENTS* 24 (1993).

rather than something that is granted by the doctor after a patient requests it. This dynamic will result in a shift of focus from the patient to the physician. Assisted suicide will no longer be a question of patient choice, but one of the doctor's assessment of the patient's situation. Patients, who lack the information that their physicians possess, will be inclined to accept a prescription of death as the best alternative available, even though this is not a decision they would have made without the guidance of a physician. This grim reality will be documented in the next Part on the experience in the Netherlands.

As to the third rationale for reliance on physicians, we can expect that physician-assisted suicide will drastically alter the traditional role of the physician, preventing it from constituting a real protection against abuses. Erasing legal barriers to killing patients will change the doctor-patient relationship.<sup>174</sup> If doctors assume the role of actively intervening to assist suicide or to cause death, their preexisting moral position, relied on by patients and courts alike, will be altered. With the spread of physician-assisted suicide, the medical relationship of trust between doctor and patient may take on a new and sinister dimension. Some doctors will gain notoriety as ministers of death, rather than exclusively as professionals dedicated to delivering, restoring, saving, and comforting life. Patients may not have the same trust and confidence in the advice they offer. Most troubling, even a doctor's mention to a seriously ill, dependent, and suffering patient of the option that death might be hastened, will force the patient to justify her remaining existence.

Breakthroughs in medical ethics, which have emphasized patient definitions of beneficence, also will be altered. Doctors will be encouraged to add assistance in death to their list of "beneficent" acts. "Doing no harm," as required by the medical oath,<sup>175</sup> will no longer always involve refusing to kill. How will this change physicians' incentives to seek patient involvement early and continually throughout an illness? The laudable goal of involving patients in decision-making can easily vanish once a quick, final solution appears on the legal horizon. Ironically, the Ninth and Second Circuits' decisions to rely upon physician control when delineating acceptable cases of assisted suicide could eventually lead to a situation in which patient autonomy and control will yield further to medical control over death and its discussion.

The real reasons for preferring physicians over others may boil down to their ability to carry out the lethal act. Physicians usually are available during a terminal illness, and they are legally and clinically

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174. See *id.* at 204-06.

175. This maxim of medical ethics—"at least, do no harm"—has been attributed to Hippocrates. BEACHAMP & CHILDRESS, *supra* note 53, at 189. Yet, "it is not found in the Hippocratic corpus," except by a "strained translation." *Id.*

able to administer the fatal drug. They also form a group of persons cloaked with moral trust by a society that depends on them for much of its health needs. But these realities also offer a tempting diversion from the power that they hide. First, allowing physicians to kill sanitizes the act itself. The cloak of legality encourages both physicians and patients to view killing as merciful and included in the category of "medically indicated" treatments. Second, burdening doctors with this responsibility diverts moral accountability for the act of killing away from others.

Once "medicalized" killing is labeled merciful, it also will become difficult to argue that those initially not included within the law's scope should remain ineligible for its benefits. Those who are incompetent or lack voluntary choice because of poverty or choice of the wrong physician certainly can suffer at least as much as the truly competent, voluntary, consenting patient who is terminally ill. If killing is lawful, merciful and available from physicians, there seems little reason to deny it to those in such circumstances.

Human beings certainly suffer a great deal in life, often long before they develop a fatal illness. Some of this suffering results in symptoms for which a physician's care and treatment are sought. Arguing that physicians could offer death as a way out of suffering in these circumstances seems absurd. We expect them to comfort, ameliorate, cure, and care. Since the dawn of time, human beings also have suffered near the end of their lives. This suffering often has been attended to by physicians as well. Yet, at least since the Hippocratic Oath, physicians have refused to offer death as a way out of suffering. Patients and family members call on physicians to ease pain but not to be the agent of death. Once we ordain physicians as the latter, we change their role, inviting both the profession and the public to rely on their judgment about when suffering is acute enough to warrant death.

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The Ninth and Second Circuits' supposed protections against abuse from physician-assisted suicide, therefore, turn out to provide a line as insecure, elusive, and deceptive as the will-o'-the-wisp. Asserting that only competent, terminally ill patients who voluntarily choose to end their lives because of intolerable pain will be granted the assistance of a doctor in ending their lives is a claim that no legal system can guarantee, a line no court can enforce. Once physician-assisted suicide becomes legally recognized, even if the patient who is helped to die was not competent to make the decision, or even if the patient's decision was not fully voluntary, or even if the patient was not terminally ill, or even if the patient did not suffer from intolerable and unrelievable pain, or perhaps even if the aid in dying was not given by a physician—there will

seldom, if ever, be a successful prosecution. Many will die; few seriously ill persons will be protected.

The Ninth and Second Circuits' new line allowing physician-assisted suicide but attempting to protect a state's citizens from involuntary euthanasia, and even from state-encouraged involuntary euthanasia, simply can not hold. Because the Ninth and Second Circuits' decisions open the door to viewing death as merciful, they take us further down the slippery slope. These decisions invite practices that further threaten their new line and continue to move it closer to involuntary euthanasia or killing the incompetent. The line that we insist should be maintained, between letting die and killing, might not always be a perfectly clear line, but it has been vastly more effective at preventing abuse, over a long period of time, than its alternatives can ever be. Indeed, as the next Part demonstrates, recent developments in the Netherlands clearly document the inadequacy of the perilous line in which the Ninth and Second Circuits have placed their faith.

### III

#### THE EXPERIENCE IN THE NETHERLANDS

Before leaping to acceptance of the new medical, legal, and moral world offered by the Ninth and Second Circuit decisions, we should pause long enough to examine the experience of a country that has recently tried just such a solution to pain and serious illness. A close look at the experience of the Netherlands exposes the naiveté of our circuit courts' trust in the states' ability to prevent abuse and avoid undue influence once physician-assisted suicide becomes legally recognized.

Just a dozen years ago the Netherlands, like most western countries, upheld the line between letting die and killing. But then a legal decision similar to that of the Ninth and Second Circuits was handed down and the entire medical, moral, and legal landscape was changed. In 1984, the highest court in the Netherlands reversed the criminal conviction of Doctor Alkmaar, a Dutch physician who assisted a patient suicide.<sup>176</sup> The Dutch court explained that the physician had confronted a *force majeure*, or conflict between two evils. On the one hand, assisting the patient in suicide meant killing a human being. On the other, ignoring the patient's request to die meant refusing to relieve her suffering. Choosing to end the suffering by killing, the court concluded, excused the physician from criminal accountability because he chose between

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176. See Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical and Empiric Perspectives*, 154 ARCHIVES INTERNAL MED. 1890, 1896 (1994). The Alkmaar case followed over a decade of debate sparked by the Postma case in 1971, where a physician intentionally administered a lethal dose of morphine to her mother, who had asked repeatedly to die. Dr. Postma was convicted of murder but given a suspended sentence. See *id.*



two equally conflicting obligations: one toward the law and another toward the patient.<sup>177</sup>

Following this decision, strict legal guidelines were negotiated between the chief criminal prosecutor and the Royal Dutch Medical Society. Although euthanasia remained a crime,<sup>178</sup> it would not be prosecuted as long as three conditions were satisfied. First, suicide could be assisted only after repeated voluntary and competent requests from a patient. Second, the patient must be experiencing suffering that could only be relieved through death. Third, an independent consulting physician had to assess the patient's condition and voluntary request and concur that euthanasia was appropriate.<sup>179</sup> In 1990 the same group added a requirement that each assisted death be reported to authorities, who would have discretion to investigate the surrounding circumstances and prosecute if all the legal prerequisites were not met.<sup>180</sup> In 1993, the Dutch Parliament approved these guidelines, formally guaranteeing physicians immunity from criminal prosecution for assisting a patient suicide. We immediately recognize the Dutch attempt to draw essentially the same line the Ninth and Second Circuits have drawn: competent, voluntary, terminally ill, and intolerably suffering patients can be assisted by a physician in suicide.

In 1991, several years after the adoption of the prosecution guidelines, the Dutch government set up the Remmelink Committee to ascertain the actual number of euthanasia deaths and to determine whether the guidelines should be enacted into positive law.<sup>181</sup> The committee, named after its chair, the attorney general of the Dutch Supreme Court, documented that at least 2,700 cases of assisted suicide or euthanasia were occurring yearly, accounting for just over two percent of all deaths

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177. See *id.* at 1897. American criminal law would not allow such a choice-of-evils justification unless one conflicting obligation outweighed the other. Thus, the physician would have to prove that the continuing obligation to care for the suffering patient was a greater harm or evil than causing the patient's death. See MODEL PENAL CODE §3.02(1)(a) (1962).

178. Dutch Penal Code Article 293 prohibits the taking of "another person's life even at his explicit and serious request." Penalties include up to 12 years imprisonment and a fine of \$60,000. See Emanuel, *supra* note 176, at 1897.

179. See *id.* at 1896-97.

180. See Gerrit van der Wal et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED 1706 (1996).

181. As used in the report, "assisted suicide" means the provision of lethal drugs to the patient who uses them to take his or her own life. "Euthanasia" means intentionally taking the life of a person at his or her explicit request. The Committee completed both a retrospective study of all recent deaths and a prospective study of a stratified random sample of physicians. They guaranteed confidentiality to the first group and legal immunity to the second to encourage response. As a result, they received detailed responses from 75 to 80 percent of physicians surveyed. Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 670-72 (1991); see also Gerrit van der Wal & Robert J.M. Dillman, *Euthanasia in the Netherlands*, 308 BRIT. MED. J. 1346, 1346-47 (1994) (discussing results of van der Maas study).

in the Netherlands.<sup>182</sup> The Rummelink Report also concluded that none of the initial lines drawn by Dutch law had held.<sup>183</sup>

First, over one-half of all physician-assisted suicides and euthanasias remained unreported.<sup>184</sup> Second, many physicians failed to consult colleagues for independent verification of the patient's condition and the voluntariness of the request.<sup>185</sup> Most alarming, Dutch physicians admitted that in some 1,000 additional cases they had intentionally taken the patient's life involuntarily, without an explicit request from either patient or family.<sup>186</sup> The Rummelink Committee labeled these deaths "life-terminating acts without the explicit request of the patient."<sup>187</sup> In the short span of a decade, involuntary euthanasia had become a significant reality.

Follow-up studies indicate why Dutch physicians stepped over the lines established by law. Some physicians deem the lines too cumbersome or too invasive of the privacy of patient or physician. Both reasons have been articulated to justify failure to report assisted suicides to authorities.<sup>188</sup> Legal investigation may involve questioning both physician and family members. These interviews take time and may create the impression that the guidelines have been transgressed.<sup>189</sup> In situations where the guidelines have been violated, physicians do not wish to subject their conduct to legal scrutiny, obviously fearing criminal sanctions. For example, where assisted death occurred involuntarily, physicians initially argued that, because the guidelines did not apply, they had no responsibility to report their own crime.<sup>190</sup> Since the Rummelink Committee Report in 1991, the government and the medical society have made explicit the requirement that all assisted deaths, whether requested or not, be reported.<sup>191</sup> Nevertheless, follow-up studies continue to document large numbers of unreported cases.<sup>192</sup>

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182. Based on figures indicating that 2,175,613 United States residents died in 1992, two percent of deaths would amount to more than 43,500 cases of assisted suicide in the United States each year. See BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 94 (1995).

183. See Emanuel, *supra* note 176, at 1898.

184. See van der Wal, *supra* note 180, at 1707.

185. See John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, in EUTHANASIA EXAMINED, *supra* note 124, at 261, 281.

186. See John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 L.Q. REV. 51, 66-67 (1992); Johannes J.M. van Delden et al., *The Rummelink Study Two Years Later*, HASTINGS CENTER REP., Nov.-Dec. 1993, at 24, 24.

187. Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1196 (1993).

188. See CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 124-25, 130 (1991).

189. See *id.* at 117-18.

190. See *id.* at 43.

191. See van Delden et al., *supra* note 186, at 25.

192. See van der Wal, *supra* note 180, at 1710-1711.

Some Dutch physicians perceive inherent contradictions in the legal lines drawn by Dutch law. Conditions such as the requirement that the patient voluntarily request death seem too restrictive to some physicians because they permit some suffering to persist.<sup>193</sup> This may in part be attributed to the fact that the Dutch health care system lacks many modern palliative care alternatives, such as hospice care and medical training in aggressive pain therapy.<sup>194</sup> Without a perceived alternative, many doctors have opted for euthanasia as a means of controlling suffering. A recent survey of physician practice over time indicates that Dutch physicians who have become more restrictive in their practice of euthanasia cite recent advances in better palliative medical care as their reason for this change.<sup>195</sup>

Examples abound of how assisted death has extended beyond the line originally drawn by the Dutch prosecutor and Parliament. In 1993, a special commission of the Royal Dutch Medical Association (which represents about 60% of the nation's physicians<sup>196</sup>) recommended that assisted suicide should be extended to make mercy killing available to psychiatric patients considered legally and medically incompetent. The panel said that this service should be available to those in "unrelievable mental or physical pain who repeatedly request death in a lucid frame of mind."<sup>197</sup> Less than a year later, the country's highest court refused to punish a physician who provided a toxic drug combination to a depressed, but otherwise healthy, fifty-year-old woman. The physician's lawyer summarized the court's ruling as recognizing "the right of patients experiencing severe psychic pain to choose to die with dignity," despite the fact the physician failed to have another colleague examine the patient.<sup>198</sup> Another physician was convicted, but given a three-month suspended sentence, for ordering narcotics to end the life of a 63-year-old patient in a coma. The patient's children had asked the doctor to administer a lethal dose, but the patient's wife objected.<sup>199</sup> Dutch courts have likewise held that the mercy killing of a newborn baby handi-

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193. See Pijnenborg et al., *supra* note 187, at 1199.

194. See Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 ISSUES L. & MED. 123, 166-67 (1994).

195. Paul J. van der Maas et al., *Changes in Dutch Opinions on Active Euthanasia, 1966 Through 1991*, 273 JAMA 1411, 1412 (1995).

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

197. *Dutch Doctors Want Easier Suicide Rules for Mental Patients*, PRESS ASS'N NEWSFILE, November 26, 1993.

198. Randall E. Otto, *Bottom of the Slope: Euthanasia in the Netherlands*, COMMONWEAL, May 19, 1995, at 5. For a complete discussion of this case by an American psychiatrist who interviewed the defendant and other participants, see Hendin, *supra* note 194.

199. See *Doctor Given Suspended Sentence for Ending Life of Coma Patient*, STICHTING ALGEMEEN NEDERLANDS PERSBUREAU, Oct. 26, 1995.

capped with spina bifida was justified.<sup>200</sup> Hospitals with neonatal units now enact policies regarding the involuntary euthanasia of defective newborns.<sup>201</sup>

Three factors, each of which has a parallel in American medicine, explain these results. First, physicians involved in involuntary mercy killings have claimed that the patient's condition was so clinically compromised that they acted humanely by ending that person's misery.<sup>202</sup> Second, while physicians and courts initially recognized only physical pain as a justification for assisted suicide, they soon extended the same idea to those with psychic pain as well.<sup>203</sup> This removed pressure for a precise interpretation of one of the limiting conditions: terminal illness.<sup>204</sup> Finally, Dutch physicians began to argue that not euthanizing incompetent, suffering patients discriminated against incompetents by denying them a medical intervention that would be available if they were competent.<sup>205</sup>

Apparently, Dutch physicians initially listened compassionately to an individual's wish to end his life.<sup>206</sup> They then tested the voluntariness and competence of that request by observing and documenting the extent of that person's disease or disability. The more degenerative and disabling the patient's medical condition, the greater the likelihood that such a suicide wish was deemed rational by the physician.<sup>207</sup> Competence, as we have already noted, often exists in the eyes of the be-

200. The court said that it was permissible for the physician to end the life of a newborn as long as the infant was in unbearable and unrelievable pain and the parents explicitly and repeatedly requested the killing. See *Court Says Doctor Made Right Decision in Ending Baby's Life*, STICHTING ALGEMEEN NEDERLANDS PERSBUREAU, Nov. 9, 1995; *Doctor Freed in 'Justified' Mercy Killing*, CHICAGO TRIB., Apr. 27, 1995, at 21.

201. *Health Quarterly: Choosing Death - Act III - The Slippery Slope*, (WGBH Educational Foundation television broadcast, Mar. 23, 1993) (transcript on file with author) (indicating that three of eight neonatal units in Holland have policies of active euthanasia).

202. See, e.g., Pijnenborg et al., *supra* note 187, at 1198 (discussing Dutch cases in which "the hopelessness of the situation, the unbearable suffering, and the futility of further medical treatment" or the "very poor quality of life with no chance of improvement, further treatment being futile" were cited as main arguments for mercy killings.)

203. See, e.g., Keown, *supra* note 185, at 261, 265 (describing an interview with a Dutch euthanasia practitioner who would not rule out euthanasia if the patient's reasons for seeking to die were that he felt he was a nuisance to his relatives and that they wanted him dead so that they could enjoy his estate).

204. Cf. NEW YORK STATE TASK FORCE, *supra* note 53, at 132 (noting that most legalized suicide proposals eliminate a terminal illness requirement, out of a desire to make suicide available to relieve all comparable pain and suffering).

205. See, e.g., Pijnenborg et al., *supra* note 187, at 1198 (explaining life-terminating acts without the patient's explicit request as "a response to the injustice that a patient unable to make an explicit request has to suffer to the end even when his or her doctor . . . and perhaps the relatives also feel confident that the patient's wishes would have been for life to be ended.").

206. See Maurice A.M. de Wachter, *Euthanasia in the Netherlands; Dying Well? A Colloquy on Euthanasia and Assisted Suicide*, HASTINGS CENTER REP., Mar. 1992, at 23, 24.

207. See van Delden et al., *supra* note 186, at 26.

holder.<sup>208</sup> Once physicians accepted the notion that there are some who, because of disease or disability, understandably prefer to accelerate their own death, it became easier to presume an unspoken request from the next patient with a similar medical condition.<sup>209</sup>

The experiences reported from the Netherlands clearly demonstrate that assisted dying has already become a medical decision made by doctors, rather than the autonomous, voluntary choice of competent, terminally ill patients. A follow-up study to the Remmelink Committee Report further documents that Dutch physicians focus on a patient's condition and extent of suffering as a measure of that person's right to assisted suicide, rather than whether the request is competent and voluntary. In describing some of the details of "life-terminating act[s] without the explicit request of the patient," the same authors relate cases where the patient has "made only vague remarks but not an explicit request," as well as those where "the patient is no longer able to make such a request."<sup>210</sup> In both situations, "very poor quality of life," "the hopelessness of the [patient's] situation, the unbearable suffering, and the futility of further medical treatment" were cited by physicians as the most important factors justifying involuntary euthanasia.<sup>211</sup>

This reasoning obviously has shifted both individual and societal attention away from the autonomy, competence, and voluntariness of a patient's request for assisted suicide to the medical condition that precipitated it.<sup>212</sup> Physicians accustomed to classifying patients by diagnosis, prognosis, degree of impairment, or degree of suffering apparently found it confusing to, on one day, grant a suicide wish to one patient, while having to withhold it the next day from another patient in a similar medical situation simply because the second patient was incompetent. This subtle shift in emphasis undercuts the major rationale for assisted suicide—autonomous choice. It replaces a voluntary, autonomous request with a physician-controlled judgment about a patient's

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208. See *supra* notes 81-87 and accompanying text.

209. See GOMEZ, *supra* note 188, at 137.

210. Pijnenborg et al., *supra* note 187, at 1197.

211. *Id.* at 1198.

212. See H. Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. MED. ETHICS 212, 212-13 (1994) (concluding that a patient's request for euthanasia "is not in practice the basis on which physicians decide to perform euthanasia, but rather they base such decisions on the condition of the patient."). Adding assisted suicide to the list of legal rights likewise appears to open a new psychological door to discussing death. For example, a recent study of AIDS deaths in the Netherlands suggests that physician willingness to consider assisted suicide was a support to many patients. At the same time, however, presenting the option of assisted suicide early can cause the doctor-patient conversation to skip past other alternatives which may require additional cost and effort. In the Dutch study, the average frequency of assisted suicide and euthanasia in the AIDS patient group was almost 12 times higher than the frequency for all other deaths. Patrick J.E. Bindels et al., *Euthanasia and Physician-Assisted Suicide in Homosexual Men with AIDS*, 347 LANCET 499, 503 (1996).

quality of life.<sup>213</sup> This change in physician focus risks a similar change in social perception, especially when considering persons with disabilities. Since the vast majority of us are disabled when nearing death, the risk that social and physician perceptions will change in this manner should alarm all of us.<sup>214</sup>

On a societal level, this shift in attention to objective appraisal of the patient's medical condition and perceived degree of suffering has translated into praise for those who request to die. In the Netherlands, opting for assisted death is characterized as a brave, wise, or progressive choice. This characterization, in turn, subtly applies pressure on other similarly situated patients. For example, Dutch television recently aired a documentary entitled *Death on Request*, detailing a typical case of euthanasia.<sup>215</sup> The program showed a doctor preparing and administering a lethal injection to end the life of 63-year-old Cees van Wendel, who was dying at home of a motor neuron disease. The hour-long program was intended to praise Mr. van Wendel's decision. Yet, throughout the documentary, his physician failed to speak to him alone, communicating with his wife instead. The doctor also refrained from touching his patient and, at his wife's request, left Mr. van Wendel alone to cry. A consultant called in for a second opinion similarly "ma[de] no attempt to communicate with Cees alone, and he too permit[ted] the wife to answer all the questions."<sup>216</sup> Herbert Hendin, an American psychiatrist, concludes: "From the beginning, the loneliness and isolation of the husband haunts the film. Only because he is treated from the start as an object does his death seem inevitable."<sup>217</sup>

This example, intended to portray Dutch practice in the best possible light, also casts doubt upon the existence of true "voluntary choice" for a disabled, elderly, or seriously ill person. Once that person becomes a burden to others, the obligation to discuss euthanasia or to request it may become inescapable.<sup>218</sup> Once a particular stage in a specific disorder is reached, a voluntary option of physician-assisted suicide shades into an involuntary determination. A Dutch disability rights group worries enough about this danger that it makes available to members anti-euthanasia wallet cards which request that "no treatment be administered with the intention to terminate life."<sup>219</sup>

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213. See GOMEZ, *supra* note 188, at 133-39.

214. See NEW YORK STATE TASK FORCE, *supra* note 53, at 131-34; LAW REFORM COMM'N OF CANADA, *supra* note 53, at 46-47.

215. At least 13 million people have watched the program in the Netherlands and abroad. See Jon Henley, *MPs Accuse Dutch of Euthanasia Abuse*, THE GUARDIAN (London), Mar. 15, 1995, at 8.

216. Hendin, *supra* note 96, at 20.

217. *Id.*

218. See Margaret A. Somerville, *The Song of Death: The Lyrics of Euthanasia*, 9 J. CONTEMP. HEALTH L. & POL. 1, 47 (1993).

219. Wesley J. Smith, *Going Dutch?*, NAT'L REV., Oct. 10, 1994, at 60, 64.

In late 1995, the Royal Dutch Medical Association issued a 39-page policy document concerning euthanasia intended to bind its 24,000 members.<sup>220</sup> Much of the statement reiterates prior policy, such as the duty to report all assisted deaths to public authorities. The guidelines also require that a medical consultant see and examine the patient instead of consulting by telephone alone. A striking shift in policy can be seen in one provision, however. The document mandates that doctors should have patients take the lethal drug themselves. This change would ease the moral pressure on the physician by making the patient accountable for the final, lethal act. Requiring the patient to act also would serve as one last signal of the patient's voluntary acceptance of death.<sup>221</sup> Such a change evidences a desire to ensure the voluntariness of assisted suicides. However, the impact of this otherwise laudable effort is undermined by the caveat that exceptions are to be made "when a very sick person is not able to swallow."<sup>222</sup>

The creep towards involuntary euthanasia and mercy killing in the Netherlands has gone unchecked, despite legal conditions designed to guarantee voluntariness. All of this has occurred in a country that guarantees access to health care, including primary care physicians whom patients know and trust. Over ninety-nine percent of all patients in the Netherlands have health care insurance, including coverage for the cost of a protracted illness. Sixty-three hundred general practitioners serve 15 million Dutch residents. Forty percent of patients die at home. No explicit financial incentives encourage family or health care providers to limit patient care.<sup>223</sup> Despite these guarantees, the recognition of an individual's right to physician-assisted suicide indisputably has led to involuntary killing. Moreover, the majority of cases in the Netherlands where doctors intentionally shorten life "remain unnotified, unchecked and invisible to justice."<sup>224</sup> Indeed, some Dutch physicians themselves have recently expressed concern about the pressure they feel from colleagues and patients to provide euthanasia.<sup>225</sup>

The Ninth and Second Circuits both proffer legal safeguards similar to those initially imposed in the Netherlands. These protections have been widely ignored in the Netherlands, and for similar reasons they are at least as likely to be bypassed in America. Some physicians will probably see them as too cumbersome. For example, an anonymous doctor in this country recently confessed in print to giving an involun-

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220. See Simons, *supra* note 196.

221. See *id.*

222. *Id.* (quoting Dr. Robert Dillmann, member of the Royal Dutch Medical Association ethics commission).

223. See van der Wal & Dillman, *supra* note 181.

224. Jochemsen, *supra* note 212, at 215; van der Wal, *supra* note 180, at 1707.

225. See Simons, *supra* note 196.

tary lethal injection to Debbie, a patient dying of cancer. He was exhausted from overwork and did not know Debbie, who needed pain control. His own overburdened frame of mind prevented him from considering whether to consult with colleagues regarding palliative care that could have eased her suffering or with relatives of the patient who knew her wishes.<sup>226</sup> Instead, he ended her pain by killing her.

Others in this country, like doctors in the Netherlands, may find the new legal safeguards too invasive of patient privacy. Doctor Timothy Quill's story of Diane, a patient whom he assisted in a suicide, illustrates this concern.<sup>227</sup> Quill had known Diane and been her primary care physician for some time. He valued her spirit and lamented with her about her diagnosis of leukemia. When Diane expressed an interest in suicide, Quill worried that it was a manifestation of the depression she had struggled with most of her adult life. However, eventually he alone decided that her request made sense. Unaware that he may have lacked objectivity, he protected Diane's privacy by neither recommending nor consulting with a specialist in psychology or any other physician. Understandably, Diane trusted her primary care physician to respect her rights and her privacy. Respecting her desire, however, also may have prevented a caring physician from offering a full range of alternatives.<sup>228</sup>

The experience in the Netherlands demonstrates the tragic consequences of not preserving the traditional legal and moral distinction between letting die and killing. The Dutch Supreme Court relied on *force majeure*, a concept intended to excuse crimes committed in defense of life, to justify the taking of life through medicalized assisted suicide and euthanasia. Once the line between killing and letting die was shifted to encompass assisted suicide, despite both strict legal guidelines and social conditions that virtually guarantee access to abundant health care, the line has not held. Respect for individual autonomy has been replaced by physician perceptions of suffering as the major justification for voluntary and involuntary euthanasia. Individualized decision-making near the end of life has become subjugated to physician control. As the Netherlands experience demonstrates, well-meaning physicians, working in a society that values and trusts them, can, "in the name of humanitarian goals inappropriately end other people's lives."<sup>229</sup> A western democratic society, through its courts, has tolerated

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226. Anonymous, *It's Over, Debbie*, 259 JAMA 272 (1988).

227. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision-Making*, 324 NEW ENG. J. MED. 691 (1991).

228. One commentator argues that Dr. Quill was not a neutral party, but rather a powerful actor, in Diane's story, since he interjected "his own values into the clinical situation" by referring Diane to the Hemlock Society. Patricia Wesley, *Dying Safely*, 8 ISSUES L. & MED. 467, 484 (1993).

229. Hendin, *supra* note 194, at 167.



a perversion of the traditional role of physicians as healers. Once the Netherlands established formal legal guidelines, Dutch doctors became accustomed to ending life, helping thousands of persons die, some of whom were not competent, had not voluntarily chosen to die, and were not terminally ill nor in intolerable, unrelievable pain. This recent experience must be seen as strong support for our position that physician-assisted suicide relies on an untenable and unenforceable line.<sup>230</sup>

#### IV

#### THE COSTS OF LIFE AND DEATH

One more reason exists to be skeptical about how secure the line established by the recent circuit court decisions really is: the current structure of the American market for health care includes many financial incentives that will encourage uses of assisted suicide inconsistent with the justifications identified in the Ninth and Second Circuit opinions. If physician-assisted suicide is ever considered legally and morally acceptable in the United States, it will be controlled, at least in part, by the power of third party reimbursement. The Ninth and Second Circuits' faith in the ability of the states to prevent undue influence and abuse ignores the powerful voice of money inherent in this or any other reimbursement scheme.

If physician-assisted suicide should become established, insurance companies and managed health care providers probably would stampede to pay for this new medical service. One might even imagine third-party payers rewarding doctors who meet their quota of assisted deaths with a year-end bonus. If this sounds unduly harsh, it is well to recall that the medical system is already rife with crime and fraud. Abuse and fraud cost the health care system about \$80-90 billion each year.<sup>231</sup> Profit, rather than humane concern for autonomous human beings, has become the driving force behind many decisions made by health care providers.<sup>232</sup> In the United States, the slide down the slippery

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230. In commenting on the Dutch experience, Margaret Somerville concludes, "It is proposed that euthanasia is not acceptable at the societal level, even if one has no personal moral inhibitions against it at the individual level and that its unacceptability at the societal level outweighs the acceptability of the best case argument for it at the individual level." Somerville, *supra* note 218, at 27.

231. Pamela H. Bucy, *Crimes by Health Care Providers*, 1996 U. ILL. L. REV. 589, 590. The author quotes from the United States General Accounting Office: "Instances of fraud and abuse can be found involving all segments of the health care industry in every geographical area of the country. . . . Health care fraud has expanded beyond single health care provider frauds to organized activity affecting health care programs in both the government and private insurance sectors." *Id.* (alteration in original) (quoting U.S. GEN. ACCOUNTING OFFICE, HEALTH INSURANCE: VULNERABLE PAYERS LOSE BILLIONS TO FRAUD AND ABUSE 2 (1992)).

232. See BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS xi (1991).

slope leads more directly to involuntary euthanasia made profitable by third party payers than it does to government-sponsored involuntary euthanasia. One need only consider the vantage point of a health insurance company or managed care provider for a moment to appreciate the different consequences for the "bottom line" between a quick, physician-assisted death and a long, lingering medical condition requiring hospital, nursing home, or hospice care or other compassionate alternatives.

Adding assisted suicide to the mix of medical treatments for the seriously ill will reduce, rather than further, the incentives to provide appropriate palliative care. The quick fix of a lethal dose will tempt us to offer a unitary solution to problems of great human dimension, such as care of the mentally or physically handicapped, the aged, and the seriously ill. This temptation will be accelerated by our knowledge that some alternatives that may save a little expense, such as hospice,<sup>233</sup> can be replaced by others, such as assisted suicide, that will save much more. Incentives to develop palliative and caring alternatives that comfort persons near death will be ignored or outweighed by other concerns.<sup>234</sup> Those alternatives already in place, such as hospice, may be diverted from their central mission by the internal strife generated by this new option.<sup>235</sup>

Adding to these problems is the fact that 37 million Americans, including many from low income families, are uninsured for some part of each year, which significantly restricts their ability to obtain quality health care.<sup>236</sup> Those without medical insurance must rely on the goodwill of relatives or government for care near the end of life. Half of all Medicare expenditures for patients in the last year of life occur in the final two months, and dying patients account for more than a quarter of

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233. See Ezekiel J. Emanuel & Linda L. Emanuel, *The Economics of Dying: The Illusion of Cost Savings at the End of Life*, 330 NEW ENG. J. MED. 540, 541 (1994) (discussing the conflicting evidence over whether hospice care saves medical care costs).

234. See Hendin, *supra* note 194, at 167; cf. Richard Fenigsen, *Physician-Assisted Death in the Netherlands: Impact on Long-Term Care*, 11 ISSUES L. & MED. 283, 294-95 (1995) (initial warnings that euthanasia in Holland would mean that physicians would abandon other treatment options have now become reality).

235. See generally Courtney S. Campbell et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, HASTINGS CENTER REP., May-June 1995, at 36 (discussing the role of Oregon hospice programs in the wake of the Oregon referendum legalizing assisted suicide).

236. Regarding the number of uninsured, see Katherine Swartz, *Dynamics of People Without Health Insurance: Don't Let the Numbers Fool You*, 271 JAMA 64, 64-66 (1994). For discussion of the impact of being uninsured on health care quality and results, see Helen R. Burstin et al., *Socioeconomic Status and Risk for Substandard Medical Care*, 268 JAMA 2383, 2387 (1992), and Peter Franks et al., *Health Insurance and Mortality*, 270 JAMA 737, 740 (1993). With respect to the correlation between low income and being uninsured, see Katherine Swartz et al., *Personal Characteristics and Spells Without Health Insurance*, 30 INQUIRY 65, 69 (1993).

each year's budget.<sup>237</sup> In today's political environment, where programs that benefit the few are cut to placate the many, physician-assisted suicide would present a quick and effective way to reduce some of these costs. This possibility is even more pernicious in light of the fact that barriers to health care access disproportionately burden racial and ethnic minorities.<sup>238</sup> The racially discriminatory rationing that already infects our health care system<sup>239</sup> will not be improved by adding another medical option likely to tempt further discriminatory judgments.

Even for those with private medical coverage, the cost of care near the end of life continues to rise. Such patients are increasingly at the mercy of giant corporate health care providers. Ethics committees staffed by hospital employees can favor institutional over individual patient concerns. Legal and moral rights of seriously ill patients often are overlooked in the daily press of professional practice. Interventions designed to counter these tendencies have proven expensive and less than totally effective.<sup>240</sup>

Although the cost of health care may have played a role in health care decisions for institutions, physicians, and individuals,<sup>241</sup> this influence has seldom been identified in bedside discussions.<sup>242</sup> The published judicial opinions that have framed the legal consensus concerning termination of treatment reflect this trend. Cost rarely is mentioned by any of these courts. Those that do mention it ignore its significance.<sup>243</sup> However, none of these court decisions were made in cases involving limited payment for health care. Without the availability of payment for

237. See Anne A. Scitovsky, "The High Cost of Dying" Revisited, 72 MILBANK Q. 561, 563 (1994).

238. See, e.g., John Z. Ayanian et al., *Racial Differences in the Use of Revascularization Procedures After Coronary Angiography*, 269 JAMA 2642, 2644-46 (1993); Cleeland et al., *supra* note 138, at 595; H. Jack Geiger, *Race and Health Care—An American Dilemma?*, 335 NEW ENG. J. MED. 815, 815 (1996); Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791, 797-98 (1996).

239. H. Jack Geiger, *Race and Health Care—An American Dilemma?*, 335 NEW ENG. J. MED. 815 (1996).

240. See *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591, 1591 (1995).

241. See COORDINATING COUNCIL ON LIFE-SUSTAINING MEDICAL TREATMENT DECISION MAKING BY THE COURTS, *supra* note 68, at 96-97. The use of life insurance as a living benefit could ameliorate some of this trend. See *supra* note 87. However, in a recent survey, 83% of Oregon physicians stated their belief that financial pressure would be a reason patients might request assisted suicide. Lee et al., *supra* note 103, at 311.

242. See NANCY NEVELOFF DUBLER & LEONARD J. MARCUS, *MEDIATING BIOETHICAL DISPUTES* 38 (1994).

243. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 266 (1990) (observing, without attaching any significance to, the fact that "[t]he State of Missouri is bearing the cost of [the patient's] care.").

aggressive medical treatment, most, if not all, of these cases might never have occurred because the patient likely would have died first.

The rule of money in health care decision-making currently is being compounded by the relatively new role of physicians as gatekeepers in managed care health systems. If physician-assisted suicide becomes legal, health care providers' control over medical decision-making, already quite apparent, will be enhanced by the new power to limit life as well as access to treatment.<sup>244</sup> Managed care initially may appear to wed itself to the American penchant for managed death.<sup>245</sup> In the long run, however, it may provide cost control incentives that act to ration care at the end of life. Plainly, both the Ninth and Second Circuit opinions overlooked the power dynamics of medical institutions, the medical profession, and money.

A more detailed look at the economic incentives in the present world of health care reveals exactly how powerful health care payers can effect the use of physician-assisted death. Already, those who do not have health care insurance receive less health care. New economic incentives increasingly create pressure on health care providers to avoid medical expense. These economic and social realities, combined with the intense pressure of medical practice, can lead doctors to grudgingly accept killing as the most efficient and economical way to care for each patient. Adding assisted suicide to the physician's pharmacopoeia may reverse traditional medical priorities by letting the cost of care or presumed misery trump the personal value of life.

The economic incentives of yesterday, which made it profitable for doctors to provide extensive and intensive care for each patient, are in the process of rapid and dramatic transformation. Although fee-for-service medicine still holds some sway in the health care reimbursement system, today many fees are subject to review by insurers or colleagues.<sup>246</sup> Physicians and patients increasingly are told by third party payers that certain kinds of care are not covered or must be provided in a less expensive manner.<sup>247</sup> Doctors who once raised costs and practiced

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244. See Hendin, *supra* note 96, at 19 (discussing case descriptions in which "people who are helpless or seriously ill are vulnerable to influence or coercion by physicians").

245. See generally Daniel Callahan, *Frustrated Mastery: The Cultural Context of Death in America*, 163 W.J. MED. 226 (1995) (discussing Americans' unique "passion to conquer death") (quoting abstract).

246. See, e.g., Health Care Study Group, *Report: Understanding the Choices in Health Care Reform*, 19 J. HEALTH POL., POL'Y & L., 499, 512 (1994) (discussing forms of fee review associated with different types of health care services); Robert M. Veatch, *DRGs and the Ethical Allocation of Resources*, HASTINGS CENTER REP., June 1986, at 32, 32-33 (discussing DRG (Diagnosis Related Group) system of payment controls for Medicare system).

247. See, e.g., Donald W. Light, *Life, Death, and the Insurance Companies*, 330 NEW ENG. J. MED. 498, 498-99 (1994) (discussing articles examining coverage determinations); William P. Peters & Mark C. Rogers, *Variation in Approval by Insurance Companies of Coverage for Autologous Bone Marrow Transplantation for Breast Cancer*, 330 NEW ENG. J. MED. 473 (1994) (concluding

defensive medicine now sign contracts with third party payers to act as gatekeepers.<sup>248</sup>

Managed care plans soon may dominate third party payment of health care. Managed care companies package health care services by contracting with physicians or groups of physicians.<sup>249</sup> Health maintenance organizations (HMOs) provide physician and institutional care for groups of patients, sometimes in conjunction with a preferred provider organization (PPO) such as a hospital that agrees to discount rates. Managed care plans typically depend on primary care physicians, many of whom are paid a yearly capitation fee for each patient covered by the plan.<sup>250</sup> A portion of the capitation rate may be set aside to cover higher than anticipated costs. Some plans agree to pay primary care physicians part of this reserve as a yearly bonus if they keep within targeted cost budgets.<sup>251</sup> Others assess monetary penalties for subpar patient volume or expenditures that are higher than allowed.<sup>252</sup>

These arrangements bring with them changed incentives for health care expenditure.<sup>253</sup> Referrals to specialists may decline. Pharmacy benefits could encourage the substitution of medication for surgery or curtail the availability of certain drugs. Physicians accustomed to relative freedom in setting fees and interactions with patients now may be instructed to limit use of expensive medications or shorten time spent with each patient in order to maximize efficient operation of the managed care plan. Further, when managed care becomes the rule in a community, physicians may be forced to join or lose their practices. Managed care organizations also define contractual obligations to patients.<sup>254</sup> In the context of managed care, who will pay for psychiatric referrals to determine competency and to assess whether a request for suicide is voluntary?

Empirical studies justify these concerns. Though managed care controls save cost, they often do so at the expense of physician accessi-

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"predetermination" (advance approval) requirement of insurers for clinical trial treatments has constituted a barrier to treatment).

248. See MACKLIN, *supra* note 173, at 158-60.

249. See David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 158-59 (1996).

250. See Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 NEW ENG. J. MED. 1678, 1680 (1995).

251. See Orentlicher, *supra* note 249, at 160.

252. See GRAY, *supra* note 232, at 228-29; MARC A. RODWIN, *MEDICINE, MONEY, AND MORALS* 232-33 (1993).

253. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J. L. & MED. 241, 242 (1995); Susan M. Wolf, *Health Care Reform and the Future of Physician Ethics*, HASTINGS CENTER REP., Mar.-Apr. 1994, at 28, 33.

254. See Jerome P. Kassirer, *Managed Care and the Morality of the Marketplace*, 333 NEW ENG. J. MED. 50, 50-51 (1995).

bility and patient satisfaction.<sup>255</sup> Patient dissatisfaction and lack of access to physicians only become problematic, however, if they lead to lower quality health care. To date, several studies have documented substantial reductions in hospital use by managed care groups, which may indicate overuse in the past, or underuse in the present.<sup>256</sup> There is some recent evidence, however, that differences in technical quality of care (as measured by clinical health outcome) exist between fee-for-service and HMO samples.<sup>257</sup> Studies have also observed substantially reduced patient satisfaction with care (measured by waiting time and access to, continuity of, and communication with physicians) in HMOs as compared to fee-for-service programs.<sup>258</sup>

These results do not bode well for the future of health care decision-making. They suggest a future dominated by larger health care bureaucracies with built-in incentives to reduce costs at the expense of patient care. Several pieces of empirical data suggest that this corner already may have been turned. Studies of Medicare expenditures indicate that doctors are less prone to authorize aggressive treatment for older and frailer patients.<sup>259</sup> American doctors, like their Dutch counterparts, seem to be influenced by both the functional status and the age of a patient in recommending medical interventions near the end of life.<sup>260</sup> Physician-assisted suicide will be all too tempting in this cost-conscious model of health care.

Several other studies compare patients' medical choices with those of their designated surrogates and physicians. These studies show that, as a group, physicians would treat patients less aggressively than the patients themselves would elect.<sup>261</sup> When asked to explain their reasoning,

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255. See, e.g., Donald A. Barr, *The Effects of Organizational Structure on Primary Care Outcomes Under Managed Care*, 122 ANNALS OF INTERNAL MED. 353, 357 (1995) (concluding that larger managed care organizations are generally more impersonal and have lower patient satisfaction).

256. See, e.g., Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, 310 NEW ENG. J. MED. 1505, 1509 (1984).

257. See *id.* at 1509-10; Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1516 (1994); John E. Ware, Jr. et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-For-Service Systems*, 276 JAMA 1039, 1046 (1996).

258. Allyson Ross Davies et al., *Consumer Acceptance of Prepaid and Fee-for-Service Medical Care: Results from a Randomized Controlled Trial*, 21 HEALTH SERVICES RES. 429, 443-47 (1986); Miller & Luft, *supra* note 257, at 1516.

259. See, e.g., Scitovsky, *supra* note 237, at 579-80.

260. See *id.*

261. Joseph G. Ouslander et al., *Health Care Decisions Among Elderly Long-Term Care Residents and Their Potential Proxies*, 149 ARCHIVES INTERNAL MED. 1367, 1369, 1371 (1989); Allison B. Seckler et al., *Substituted Judgment: How Accurate are Proxy Predictions?*, 115 ANNALS INTERNAL MED. 92, 94 (1991); Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY 115, 117 (1988); Nancy R. Zweibel

physicians apparently rely on age<sup>262</sup> and quality of life<sup>263</sup> as factors. Thus, physicians appear to have increased awareness of the problems created by overly aggressive treatment at the end of life.<sup>264</sup> At the same time, financial and structural incentives pressure them to consider medical resource expenditures, including time spent with patients, more than ever before.

If managed care means less time for physician-patient communication, then physician-assisted suicide rests on an increasingly slender reed. If managed care means less choice of providers or medical treatments, then physician-assisted suicide becomes even more troubling. The Ninth and Second Circuits rely on the autonomous choice of a patient as the moral underpinning for the recognition of a constitutional right to assistance in killing oneself. Yet American physicians increasingly have less time to truly understand what those choices mean. Further, like their Dutch counterparts, American doctors increasingly rely on their clinical perceptions of a patient's quality of life in deciding when to forego treatment. Their subjective perceptions will therefore control whether a request for suicide is deemed voluntary, competent, and rational. These two courts, thereby have handed American physicians a new "therapeutic" alternative at the very time health care cost pressures threaten their ability to use it responsibly. These cost controls provide one more reason to be skeptical of arguments supporting a move away from the line between killing and letting die. The real cost of physician-assisted suicide will be loss of the moral value of autonomy that tempted courts to justify its legal recognition in the first place.

## V

### THE CHOICE OF A FUTURE

The Ninth and Second Circuits have opened our eyes to a new and alarming future. They have confronted the legal system with a crucial moment of choice. In this Essay, we have tried to contribute to the debate at this important juncture by raising some serious problems posed by the new perilous line drawn by the two circuit court decisions.

We have argued that support for life, a precious value in our society, will be trivialized if we reject the traditional legal and moral distinction between letting die and killing. It is one thing to accept that someone is ready to die from the natural consequences of disease, dis-

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& Christine K. Cassel, *Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies*, 29 GERONTOLOGIST 615, 620 (1989).

262. See Ouslander et al., *supra* note 261, at 1371.

263. See Seckler et al., *supra* note 261, at 95; Zweibel & Cassel, *supra* note 261, at 620; Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 19 (1993).

264. See Solomon, *supra* note 263, at 19.

ability, or injury, but quite another to end life before it unravels on its own. With physician-assisted death as a legal and moral option, courts and legislatures, like those in the Netherlands, undoubtedly would struggle mightily to maintain a new protective line against abuse. But close examination of the new line reveals that it will inevitably prove untenable and unenforceable. Physician-assisted suicide, once made legally and morally acceptable, opens the door to involuntary euthanasia. With the enormous financial pressure of increasing health care costs, the quick and cheap solution of physician-assisted death will offer a seductive option that many, in an inequitable society, will find hard to resist.

In the end, the Ninth and Second Circuits may have done us all a service by compelling American society to approach the unpleasant topic of death and the need to reassert a full individual right to choose to forego life-sustaining medical interventions. But, in fact, their attempts to extend individual rights beyond this point threaten the very autonomy they desire to extend. We all will need the courage and freedom to tell our own story as the end approaches.<sup>265</sup> Our stories should not be muted by court decisions that cut short the final chapter.

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265. Cf. ARTHUR W. FRANK, *THE WOUNDED STORYTELLER: BODY, ILLNESS, AND ETHICS* (1995) (portraying ill people in the ancient tradition of those whose infirmity has transformed them into insightful storytellers).