

# THE MODEL PHYSICIAN-ASSISTED SUICIDE ACT AND THE JURISPRUDENCE OF DEATH

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Die, my dear Doctor?—That’s the last thing I shall do!  
—Lord Palmerston<sup>1</sup>

Your State has, let us suppose, a physician in one of its university-affiliated hospitals who is an admirer of Dr. Kevorkian, or a member of the Hemlock Society. The date is a year from now—December 1997. Your State has adopted the Model State Act to Authorize and Regulate Physician-Assisted

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1. Viscount Henry John Palmerston (1865), *quoted in* THE OXFORD BOOK OF DEATH 331 (D.J. Enright ed., 1983).

Suicide (the "Act").<sup>2</sup>

You now have an unexpected interest in the effects of the Act. A friend or a relative—your eighteen-year-old daughter or your nineteen-year-old younger brother or your fifty-five-year-old father—has approached a hospital seeking counseling and relief.<sup>3</sup> Concerned about the sort of advice your loved one may receive, and concerned even more deeply about what sort of procedures may be instituted, you pick up a copy of the Act.

On a casual perusal, you feel reassured: the Act seems to be addressed to patients in dire straits, and not to cases like that of your daughter, your brother, or your father. Perhaps you are right not to be concerned. But perhaps you are wrong.

This Article describes the Act and some of its background and effects in detail, showing that it goes further than at first appears, and comparing it in certain respects to the recently adopted Oregon statute on this subject<sup>4</sup> and to the rights held to be constitutionally protected in recent decisions by the United States Courts of Appeals for the Ninth<sup>5</sup> and Second<sup>6</sup> Circuits.

## I. THE BACKGROUND AND BASIC EFFECT OF THE ACT

The Act provides a general immunity from civil and criminal liability to someone who, acting according to procedures established in the Act, "provide[s] . . . medical means of

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2. See A MODEL STATUTE TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE (Charles H. Baron, Clyde Bergstresser, Dan W. Brock, Garrick F. Cole, Nancy S. Dorfman, Judith A. Johnson, Lowell E. Schnipper, James Vorenberg, & Sidney H. Wanzer, Proposed Draft 1996), reported in 33 HARV. J. ON LEGIS. 1, 25 (1996) [hereinafter "Act" or "Model Act."]. The material on pages 2-24, describing and defending the Act, is hereinafter referred to as the "Commentary."

3. Or perhaps your concern arises from the fact that you yourself are a health care worker or responsible for a health care facility. Section II B of this Article addresses the concerns of health care workers and management; Section V raises more general philosophic concerns about the Act.

4. See Oregon Death With Dignity Act, OR. REV. STAT. §§ 127.800-897 (1995). This statute was declared unconstitutional shortly after its enactment. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), criticized in *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995), reversed en banc, 79 F.3d 790, 838 (9th Cir. 1996), cert. granted sub nom. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

5. See *Compassion in Dying*, 79 F.3d 790. For criticism of this decision, see the opinions of Judges Kleinfeld and O'Scannlain, dissenting from the decision not to have the case reheard by the full Ninth Circuit. See *Compassion in Dying v. Washington*, 85 F.3d 1440 (9th Cir. 1996) (Kleinfeld and O'Scannlain, JJ., dissenting from the denial of rehearing). The Ninth Circuit permits panel judgments to be reviewed by fewer than all of the circuit's judges. Only eight judges, out of the twenty-three on the circuit, participated in the *Compassion in Dying* en banc decision.

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

suicide.”<sup>7</sup> Thus the effect of the Act is to afford an exception to the law of homicide, which would otherwise prohibit activities protected by the Act.<sup>8</sup> The Act also affords an immunity from liability for wrongful death and malpractice,<sup>9</sup> and for professional misconduct.<sup>10</sup>

What patients could be assisted to their death in reliance on these immunities? Much of the language in the Act relates to this issue, but, as described in detail in Section II of this Article, this language is far less limiting than it may at first appear. The Act comes close to the point of affording a right to death on request.

The Act is something of a think-tank project. The Commentary announces that the

authors now include three attorneys who represent patients, hospitals, and physicians; two law professors with interests in medical and constitutional law; a professor of philosophy who specializes in bioethics; a patient advocate and public policy economist; and two physicians with experience in academic medicine and community practice.<sup>11</sup>

An enormous footnote lists authors holding in the aggregate five law degrees, three Ph.D.s (two in philosophy and one in economics), two M.D.s, one master's degree, and six current university posts, including two at Harvard Law School: a former Dean and the Director of Health Services.

Absent, however, from this formidable catalogue is any trace of the parties most directly affected by the proposed legislation. There is, for example, no representative of hospital patients, or of the sick or elderly, or of the families of the sick or elderly.<sup>12</sup> No one is listed as having experience or credentials as a nurse or pharmacist. No one is listed as having experience or credentials specifically in the areas of hospice service, palliative care, death, dying, grief, or mourning. No one is listed as having

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7. Model Act § 3(a).

8. See, e.g., MODEL PENAL CODE § 2.10.5 (1980); WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., SUBSTANTIVE CRIMINAL LAW § 7.8 (1986).

9. See Model Act § 13(a).

10. See Model Act § 13(b).

11. Commentary, *supra* note 2, at 3.

12. The Commentary states that among the authors is “a patient advocate and public policy economist.” *Id.* This must refer to Nancy Dorfman, because she is the only author listed as holding a degree in economics. Nancy Dorfman is the Chairman of the Greater Boston Hemlock Society.

studied these areas from the point of view of psychology, sociology, or religion. None of them appears to be an expert on suicide.

## II. THE PRINCIPAL PROVISIONS OF THE ACT AND THEIR EFFECTS

The Act presents considerable grounds for concern both from the viewpoint of those who care about persons who might be assisted to commit suicide and from the viewpoint of those who care about physicians and other health care workers, hospitals, hospices, nursing homes, and insurers. This Section examines the Act from each of these points of view in turn.

### A. *Whose Suicide Can Be Assisted and How*

Among several legal reforms aimed at facilitating death that have been proposed in recent years, the Act is especially extreme in the following ways:

First, the Act is not aimed at simply letting people die. Rather, it is aimed at the termination of life through active intervention.

Second, the Act does not contain narrow limitations as to whose life can be terminated; it does not narrowly define the conditions from which patients must suffer before their lives can be terminated. Consider the language pertaining to the condition of the "patient." It stipulates that "the patient [must have] a terminal illness or an intractable and unbearable illness."<sup>13</sup> Examine the elements of this requirement:

"*Patient.*" Dispel the image of people flat on their backs in the hospital; no such condition is required. The term patient is not defined. Context elsewhere in the Act indicates that the term has little or no excluding effect. People living at home with their parents might qualify as patients.<sup>14</sup> (In this Article, we will accept the Act's abnormal usage and refer to its subjects as "patients.")

"*Terminal illness*" or "*intractable and unbearable illness.*" The key point here is that these terms operate in the disjunctive: one or the other need be shown, not both. In this respect the Act goes

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13. Model Act § 3(a)(2).

14. Model Act § 2(f) makes it clear that the Act can apply to someone "who is not in [a health care] facility." Nor, it appears, need the person whose death is to be assisted have been under the care of a physician prior to the commencement of steps under the Act. See language quoted in note 44, *infra*.

much further than the Oregon statute<sup>15</sup> and other acts proposed in recent years,<sup>16</sup> and goes beyond the rights recognized by the Ninth<sup>17</sup> and Second Circuits,<sup>18</sup> all of which require a terminal medical condition. People who are suffering from the requisite discomfort are eligible even though they have every prospect of living a long life; those who have only a short time to live are eligible even if they are perfectly comfortable. The great majority of patients who approach death's doorway with their pain well controlled by modern medicine would be eligible for assisted suicide under the Act.

Further, the term "intractable and unbearable illness" is defined as "a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death."<sup>19</sup> The most significant element here—the one that seems to impose an important restriction—is "severe suffering." This term is not defined.

Usually when the law accepts pain and suffering as an important element it imposes an objective test—requiring, for example, that a reasonable person under similar circumstances would experience the requisite degree of pain and suffering; sometimes physical injury is also required. No such requirements appear here. The Commentary makes it clear that the intention is quite to the contrary: "In the end, a bare majority of us agreed to allow anyone to be eligible whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death"<sup>20</sup> because "we realized that whether one's suffering is sufficiently unbearable to make death preferable to continued life is an inherently subjective determination on which people differ."<sup>21</sup>

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15. See OR. REV. STAT. § 127.805 (1995).

16. See *infra* note 162.

17. See *Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir.) ("We hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by *terminally ill*, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment.") (emphasis added), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

18. See *Quill v. Vacco*, 80 F.3d 716, 718 (2d Cir.) (holding "that physicians who are willing to do so 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*") (emphasis added), *cert. granted*, 117 S. Ct. 36 (1996).

19. Model Act § 2(d).

20. Commentary, *supra* note 2, at 11.

21. *Id.* Here the Commentary is somewhat misleading. Not only is the preference for death left to subjective judgment, so also is the degree of the suffering and indeed, it

Who would be ineligible for assisted suicide under the Act? Would your eighteen-year-old daughter be eligible, for example, if she, though not terminally ill, approached a physician and insisted that she was suffering badly and had made the "subjective determination" that she would prefer to die? Since Durkheim,<sup>22</sup> social factors have been recognized as playing an important part in suicides. People could readily use the Act to obtain death where their decision was based only in part on illness: people who were also motivated by unpopularity or unrequited love, for example, or unemployment,<sup>23</sup> divorce,<sup>24</sup> or a history of sexual abuse.<sup>25</sup> A recent article states:

Among the common social themes that arise in exploring patients' desires to hasten death are loss (or anticipated loss) of support from a spouse, distrust of family members' ability and willingness to provide care, anger related to perceived disappointments, and inability to relinquish the role of caretaker.<sup>26</sup>

People might seek suicide because of the effects of alcohol or drugs,<sup>27</sup> or because of nonphysical psychological distress such as depression,<sup>28</sup> low self-esteem,<sup>29</sup> despair, hopelessness, rage, or

seems, even the existence of the suffering.

22. EMILE DURKHEIM, *SUICIDE: A STUDY IN SOCIOLOGY* (John A. Spaulding & George Simpson trans., Free Press 1966) (1887).

23. Unemployment is positively correlated with suicide. See Robert L. Jin, Chandrakant P. Shah, & Tomislav J. Svoboda, *The Impact of Unemployment on Health: A Review of the Evidence*, 153 CAN. MED. ASS'N J. 529 (1995); David Lester, *Suicide in Quebec, 1951-86*, 76 PSYCHOL. REP. 122 (1995).

24. Divorce has been associated with a higher suicide rate. See Lester, *supra* note 23; Ingeborg Rossow, *Suicide, Alcohol, and Divorce; Aspects of Gender and Family Integration*, 88 ADDICTION 1659 (1993).

25. Sexual abuse has been associated with suicide attempts. See Michael Windle, Rebecca C. Windle, Douglas M. Scheidt, & Gregory B. Miller, *Physical and Sexual Abuse and Associated Mental Disorders Among Alcoholic Inpatients*, 152 AM. J. PSYCHIATRY 1322 (1995).

26. Susan D. Block & J. Andrew Billings, *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36 PSYCHOSOMATICS 445, 452 (1995).

27. Substance abuse was determined to be a predictor of suicide among a group of Danish patients with previous suicide attempts in Bent Nielsen, Palle Petersen, Per H. Rask, & Gertrud Krarup, *Selvmod og andre dødsårsager hos patienter indlagt efter selvmordsforsøg [Suicide and Other Causes of Death in Patients Admitted for Attempted Suicide]*, 157 UGESKR LAEGER 2149 (1995) and alcohol consumption was associated with suicide in Rossow, *supra* note 24.

28. See Alan Apter, Doron Gothelf, Israel Orbach, Ronit Weizman, Gidon Ratzoni, Dov Har-Even, & Sam Tyano, *Correlation of Suicidal and Violent Behavior in Different Diagnostic Categories in Hospitalized Adolescent Patients*, 34 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 912 (1995) (reporting correlations of impulse control deficiency and depression with suicide attempts); William Breitbart, Barry D. Rosenfeld,

guilt.<sup>30</sup> The Act would permit assisted suicide in such cases unless the patient's request was "the result of a distortion of the patient's judgment due to clinical depression or any other mental illness."<sup>31</sup> Indeed, the Act expressly indicates that social problems will be among a patient's motives, by providing in Section 4 that:

Before providing medical means of suicide, the responsible physician shall . . .

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services to determine whether services are available to the patient that could improve the patient's circumstances sufficiently to cause the patient to reconsider his or her request for medical means of suicide . . . .<sup>32</sup>

The Act does of course require that there be some physical

& Steven D. Passik, *Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238, 240 (1996) (reporting a significant correlation between depression and expression of interest in physician-assisted suicide, but no correlation with pain); Harvey Max Chochinov, Keith G. Wilson, Murray Enns, Neil Mowchun, Sheila Lander, Martin Levitt, & Jennifer C. Clinch, *Desire for Death in the Terminally Ill*, 152 AM. J. PSYCHIATRY 1185, 1185 (1995) ("The desire for death in terminally ill patients is closely associated with clinical depression—a potentially treatable condition . . ."); Paul J. van der Maas, Johannes J.M. van Delden, Loes Pijnenborg, & Caspar W.N. Looman, *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 672 (1991) (reporting that 23% of surveyed patients seeking death in the Netherlands did so because of "tiredness of life").

29. Low self-esteem is positively correlated with suicide. See James C. Overholser, Dalia M. Adams, Kim L. Lehnert, & David C. Brinkman, *Self-Esteem Deficits and Suicidal Tendencies Among Adolescents*, 34 J. AM. ACAD. CHILD ADOLESCENT PSYCHIATRY 919 (1995).

30. See Herbert Hendin, *Psychodynamics of Suicide, with Particular Reference to the Young*, 148 AM. J. PSYCHIATRY 1150, 1152 (1992) ("Rage, hopelessness, despair and guilt are important affective states in which young patients commit suicide.").

31. Model Act § 3(a)(3)(A). "Clinical depression" is not defined. This section seems to make even the clinically depressed eligible for assisted suicide when their judgment is not "distorted," a term also left undefined. See also § 3(b), which requires that the "actual use of such means" of assisted suicide be a "knowing, intentional, and voluntary physical act of the patient," and § 5(b), which requires an opinion that the patient's request is "not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, and is free of undue influence by any person." See generally Annette L. Beautrais, Peter R. Joyce, Roger T. Mulder, David M. Fergusson, Brian J. Deavoll, & Susan K. Nightingale, *Prevalence and Comorbidity of Mental Disorders in Persons Making Serious Suicide Attempts: A Case-Control Study*, 153 AM. J. PSYCHIATRY 1009, 1009 (1996) ("Individuals who made serious suicide attempts had high rates of mental disorders . . ."); David Orentlicher, *From the Office of the General Counsel: Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1845 (1989) ("For many patients, the progression of disease will result in the impairment of decision-making capacity, either from the effects of the disease itself or those of drug treatment. Consequently, it may be difficult to ensure that a competent decision is being made.").

32. Model Act § 4, §4(b).

problem, but it does not require that problem to be the patient's exclusive or even predominant motive. Someone might be eligible whose motive was in part to damage, through suicide, the well-being of family or associates.<sup>33</sup>

The terms "cannot be cured" and "successfully palliated" are not defined. They may not significantly limit the permissively subjective character of the Act. The physician can with today's medicines greatly palliate the painful effects of many severe illnesses, but so long as some residual effects remain, patients could, it seems, effectively characterize those effects to themselves as "severe suffering" and take full advantage of the services contemplated by the Act.

The Act does not contain adequate protections against the patient's being subjected to pressure. This is a severe defect, since some patients will be vulnerable owing to their fear and pain, their respect for and dependence on their health care providers, and their worries about becoming intolerable economic burdens on their families or on society.<sup>34</sup> Recently the House of Lords Select Committee on Medical Ethics, in determining to oppose the legalization of euthanasia, indicated its concern "that vulnerable people—the elderly, lonely, sick, or distressed—would feel pressure, whether real or imagined, to request early death."<sup>35</sup> A leading American Medical Association authority has noted the danger that "[p]atients who are enfeebled by disease and devoid of hope may choose assisted suicide not because they are really tired of life but because they

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33. Cf. Hendin, *supra* note 30, at 1150 (noting that among the "meanings" that may be assigned to death by suicidal patients are "death as retaliatory abandonment, [and] death as revenge"); note 117, *infra*, and accompanying text.

34. See Sidney Callahan, *A Feminist Case Against Self-Determined Dying in Assisted Suicide and Euthanasia*, 1 *STUD. IN PROLIFE FEMINISM* 303, 313-14 (1995) ("Subtle pressures can all too easily emerge to stop being a burden on others . . . . Women who have been socialized to be self-sacrificing may be the most vulnerable to such pressures."); Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 *NOTRE DAME L. REV.* 519, 539 (1995); Melinda A. Lee, Heidi D. Nelson, Virginia P. Tilden, Linda Ganzini, Terri A. Schmidt, & Susan W. Tolle, *Legalizing Assisted Suicide: Views of Physicians in Oregon*, 334 *NEW ENG. J. MED.* 310, 311 (1996) ("Most respondents thought that some patients might request physician-assisted suicide because of concern about being a burden to others (93 percent) or financial pressure (83 percent)."); see also Charles L. Sprung, Leonid A. Eidelman, & Reuven Pizov, *Changes in Forgoing Life-Sustaining Treatments in the United States: Concern for the Future*, 71 *MAYO CLINIC PROC.* 512, 513 (1996) (noting that physicians are no longer exclusively concerned about their patients' well-being but also are taking into account concerns about social costs).

35. H.L. Paper 21-1 para. 239 (1993-94), *reprinted in part in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 96, 103 (John Keown ed., 1995).

think others are tired of them.”<sup>36</sup> Similar concerns have been raised recently in a New York task force report<sup>37</sup> and a decision of the United States Court of Appeals for the Ninth Circuit.<sup>38</sup>

The Act does require that the patient’s decision be made “free of undue influence by any person.”<sup>39</sup> “Undue influence” is not a very precise term and is not defined. Physicians often exert a great deal of influence over their patients, especially in instances of serious illness. (How could it be otherwise, when physicians have the survival of the patient in their hands and control the system by which the patient’s pain is controlled?) How much influence is “due,” and what sorts of conduct are appropriate? In a thoughtful article about the Oregon statute, two physicians state:

The act does not forbid physicians from bringing up the issue of assisted suicide with terminally ill patients, rather than waiting for patients to broach the subject. . . . [P]atients with terminal illness may be particularly dependent on their physicians and may interpret the physician’s raising the topic as encouragement to commit suicide. Given the powerful psychology of the physician-patient relationship, we recommend that physicians generally should discuss their willingness to consider participating in assisted suicide only when patients raise the issue.<sup>40</sup>

Similarly, under the Act, it seems clear that physicians would be free to raise the possibility of assisted suicide with their patients.

Having raised the issue, physicians inevitably affect the decision by the way they present information. The Ethics and Health Policy Counsel of the American Medical Association reports:

Physician preferences may . . . become influential because the preferences of patients are shaped by their physicians’ values. Studies of decision making for health care problems,

36. Orentlicher, *supra* note 31, at 1845.

37. NEW YORK STATE TASK FORCE, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994).

38. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995), *rev’d en banc*, 79 F.3d 790, 837 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

39. Model Act § 3(a)(3)(C). However, no penalty is specifically provided. Further, no procedures are required for determining when such influence has been exercised. Physicians may be able to restrain themselves from exercising undue influence, but how can they determine whether patients have been unduly influenced by others?

40. Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 JAMA 483, 485 (1995) (references omitted).

as well as other kinds of problems, have consistently demonstrated that people's choices depend in part on the way that information is presented to them. When considering a surgical procedure, for example, patients are more likely to choose surgery when presented with the probability of surviving the procedure than with the probability of dying. Similarly, when patients are asked to make treatment choices for advance directives, they are more likely to choose treatment when the treatment is described in a positive way. . . . When physicians discuss end-of-life decisions with their patients, their own views about the desirability of treatment inevitably color their presentations to their patients.<sup>41</sup>

Having raised the issue and presented information to the patient, might the physician then go further and recommend that the patient avail himself of the procedures permitted by the Act? The Ethics and Health Policy Counsel has noted "the possibility that the hopelessly ill patient will not feel entirely free to resist a suggestion from the physician that suicide would be appropriate . . ." <sup>42</sup> The Counsel's overall conclusion is that "moves toward acceptance of assisted suicide or euthanasia should be tempered by the possibility that physician values may prevail in these decisions. One of the greatest concerns about permitting assisted suicide or euthanasia is that lives may be ended without the truly voluntary participation of patients."<sup>43</sup>

The Act seems to permit any physician licensed in the State to assist in a suicide, even if that physician has not been treating the illness.<sup>44</sup> In this respect the Act goes beyond what is recommended even by other proponents of physician-assisted suicide, who have recommended that such procedures "should be carried out only in the context of a meaningful doctor-

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41. David Orentlicher, *From the Office of the General Counsel: The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101, 2102 (1992) (noting that patients "who seem more intelligent and better educated receive more time and more explanations from their physicians"). See also Sprung, *supra* note 34, at 513 (noting that physicians "often present information based on their own views and preferences, which alters patient decisions").

42. Orentlicher, *supra* note 31, at 1845.

43. Orentlicher, *supra* note 41, at 2104.

44. The Model Act provides that the "responsible physician" may assist, and defines that term as follows: "The physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill, and (2) takes responsibility for providing medical means of suicide to the patient." Model Act § 2(h). This leaves open the possibility that the "partial responsibility" may have been minimal, perhaps not even related to the illness at issue. Perhaps a physician could qualify merely by catering to the request for suicide.

patient relationship. . . . Rather than create a new subspecialty focused on death, assistance in suicide should be given by the same physician who has been struggling with the patient to provide comfort care . . . .”<sup>45</sup>

The Act does not require that the “responsible physician” be disinterested. A physician could therefore assist in the suicide of someone on whom that physician had previously performed surgery with unsatisfactory results.<sup>46</sup>

Another questionable feature of the Act is its failure to provide for advance judicial approval. Legal challenges after the fact are of course possible, but health care workers who bend the rules will be protected if they establish “an honest belief that the requirements of this Act have been . . . met.”<sup>47</sup> (The Commentary underlines the “lack of any requirement of reasonableness.”)<sup>48</sup> The importance of this brief phrase in sheltering noncompliant health care workers can hardly be exaggerated. Disputes about their conduct will turn not on whether they complied with the Act but on whether their noncompliance was “honest.” (The relevant information will be recorded in documents prepared by the defendants and kept in the custody of the health care facility. The patient will not be around to tell a different story.)<sup>49</sup>

Furthermore, the Act is extremely permissive in its individualism—that is, in not requiring consent by or even consultation with the family of the patient,<sup>50</sup> or any other person

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45. Timothy E. Quill, Christine K. Cassel, & Diane E. Meier, *Sounding Board: Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1382 (1992).

46. Some authorities have expressed concerns about the effects of physicians' and health care institutions' economic interests. See *infra* notes 153-54 and accompanying text.

47. Model Act §§ 7(a), (c). An “honest belief” defense is afforded the responsible physician by Model Act § 3(a).

48. Commentary, *supra* note 2, at 19-20.

49. Model Act § 6 requires a report to the Commissioner of the Department of Public Health. The Act does not directly address the question of whether a plaintiff's attorney would be able to obtain a copy of this report, but does suggest that the report would be very difficult to obtain. Model Act § 10(a) provides that “[t]he information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf.” Model Act § 10(a). Model Act § 8(b) prohibits the inclusion of the patient's name (requiring instead an anonymous coding system), and § 10(b) provides that the report “is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].” Model Act § 10(b).

50. See also *Compassion in Dying v. Washington*, 79 F.3d 790, 827 n.100 (9th Cir.)

closely involved with the patient's life: for example, co-workers, teachers, or school principals.<sup>51</sup> The Act requires various items of information to be furnished to the patient, but these items include only "medical information," not information as to the effects on survivors.<sup>52</sup> There is no provision requiring notice to next of kin—before, during, or after.<sup>53</sup>

So, let us return to the case of your eighteen-year-old daughter or your nineteen-year-old brother, posited in the first few paragraphs of this Article. Neither has a terminal illness, but each does have an illness, and each, in the tumult of adolescence, deems it "unbearable." Or, in the case of your fifty-five-year-old father, he may be reasonably comfortable but is likely to pass away during the coming few months. Your daughter or brother or father approaches a well-publicized medical ideologue. *Each one is fully eligible for the treatment.* No stay in a hospital is required. No one need say anything to you.<sup>54</sup>

(stating, in dictum, that a statutory requirement of family approval "would raise constitutional concerns"), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

51. The Act requires the physician to "counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest." Model Act § 4(c). This provision indicates that the family may be "inform[ed]" rather than "consulted," thereby making a place for the patient's interest but not the family's. See Ezekiel J. Emanuel & Elisabeth Daniels, *Oregon's Physician-Assisted Suicide Law: Provisions and Problems*, 156 ARCHIVES INTERNAL MED. 825, 827 (1996) (advocating a requirement that family be consulted because "patients may desire assisted suicide for fear of being a financial and emotional burden on their family or because they feel socially isolated. Families may best be able to address these concerns, whether real or imagined, and thus provide another safeguard against inappropriate use of assisted suicide"). *But cf.* Model Act § 4(b), which relates to consultation with a social worker, and which does not contain a "best interest" limitation.

52. See Model Act § 4(d). For a discussion of the adverse effects on children and other survivors, see *infra* text accompanying notes 132-36.

53. One of the drafters seems to embrace a minimalist view of family rights and interests in other areas as well:

When we go to the family for a decision . . . it sets a dangerous precedent . . . [W]e may be suggesting that family members have more life and death decision-making power than we really want to ascribe to them. And this could come back to haunt us in other areas. . . . In other situations . . . we are not so ready even to pretend that families make decisions. The *Twitchell* case . . . a 1990 Massachusetts homicide conviction of Christian Science parents who allowed their child to die of a bowel obstruction because they opposed medical intervention on religious grounds . . . is only a very recent reminder that our legal and medical establishments do not accept even parents' medical decisions when there is much at stake and the decision is believed to be clearly erroneous.

Charles H. Baron, *Why Withdrawal of Life-Support for PVS Patients is Not a Family Decision*, 19 LAW, MED., & HEALTH CARE 73, 74 (1991).

54. And if you do find out what is going on and rush off to try to dissuade Dr. Death,

You may never get the full story.<sup>55</sup>

Members of the social science professions may be involved, however. And they can certainly make a profit from it: the Act has provisions that help ensure insurance coverage.<sup>56</sup>

*B. How Physicians, Health Care Workers, Hospitals, and Other Entities  
May Be Legally Required or Otherwise Obligated to Cooperate with  
Assisted Suicide*

Imagine that you are a doctor or nurse or administrator at a hospital or at a clinic located in a high school or junior college. You have no desire to see yourself or your institution become involved in assisted suicides (and especially not in cases like those of the teenagers mentioned above). But you are concerned because you and your institution sometimes receive requests for assisted suicide<sup>57</sup> and your State has adopted the Act. Concerned about what the Act might say, you pick it up and read it. On first perusal you feel reassured. It is written with the intention of permitting assisted suicides, it seems, not requiring them. And besides, it has a freedom-of-conscience provision. You feel reassured, but should you be?

The Act actually requires individuals and institutions to assist in suicide under some circumstances. This is the effect of Section 12(a), which provides:

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the Act will not only permit but probably require the doctor to ignore your wishes. See Section II.B of this Article.

55. Another concern relates to the possibility that people may express a desire for assisted suicide who in fact do not have a settled desire for death. Some people may be trying to send a call for help. See Block & Billings, *supra* note 26, at 448 (reporting that "the patient's request for hastened death may be a cry for help in feeling valued, a plea for someone to share in the grief"). Some people have only a transient desire for death and would choose to live if they were given more time and the chance to think it over (and discuss it with their families). See Chochinov, *supra* note 28, at 1185 (finding that terminally ill patients surveyed, 44.5% expressed an occasional wish for death but only 8.5% of these expressed a "serious and pervasive" desire to die, and concluding that "[i]nformed debate about euthanasia should recognize the importance of... the inherent transience of many patients' expressed desire to die."). The Act makes some allowance for such concerns by requiring two patient requests at least fourteen days apart. See Model Act § 3(a)(3)(D).

56. The Act provides that "[n]o... health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan... may refuse to provide medical... benefits to an individual because such individual has requested medical means of suicide." Model Act § 12(a).

57. For statistics as to how frequently physicians and critical care nurses receive such requests and from whom, see note 145, *infra*. See also note 184, *infra* (reporting the percentage of deceased patients who would have preferred euthanasia or assisted suicide).

No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan . . . may refuse to provide medical services and medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.<sup>58</sup>

The terms “medical services” and “medical benefits” are not defined, but could reasonably be construed to include not only collateral assistance but the actual “benefit” of assisted suicide itself (“medical means of suicide,” as the Act calls it). This appears to be the intention of the drafters, since they state in the Commentary: “Unless physicians, institutions, and insurers opt out for reasons of conscience under section 11, they must honor patients’ choices to seek or avoid assistance in suicide.”<sup>59</sup> In this the drafters are consistent with the stated purposes of the Act, which are not merely to allow the practice of assisted suicide but also to enhance its availability.<sup>60</sup>

Besides direct legal requirements, there lurks the possibility of other pressures, as described below.

Many will object to assisting in suicides—probably more than half of physicians, for example.<sup>61</sup> How well are they protected by the freedom-of-conscience provision? Consider several categories:

1. *Conscientiously Objecting Individuals.* These are the people with the least to worry about. The freedom-of-conscience provision speaks directly to their concerns. It provides: “No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.”<sup>62</sup>

58. Model Act § 12(a). Owing to what appears to be a drafting error, this section is not limited to instances in which the patient’s request meets the conditions of Model Act § 3 (which requires, for example, that patients be eighteen years of age or older and that they have terminal or unbearable illness).

59. Commentary, *supra* note 2, at 23.

60. *See id.* at 8-9.

61. *See* Jerald G. Bachman, Kirsten H. Alcsér, David J. Doukas, Richard L. Lichtenstein, Amy D. Corning, & Howard Brody, *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 306 (1996) (finding that 52% of Michigan physicians surveyed would not participate in physician-assisted suicide even if the practice were legal); Lee, *supra* note 34, at 312 (reporting that in Oregon, 52% of doctors surveyed would object to assisting in suicides).

62. Model Act § 11(a). Better drafting would have omitted the phrase “a responsible physician.” A conscientious objector should not be required to assist *anyone* in providing

But how well are objectors really protected? The Act's intention must be to forbid hospitals and similar employers from requiring objectors to assist suicides. However, because this provision uses the passive voice and does not even mention employers, it loses much of its bite. No penalty is established for failure to respect the wishes of those who do not want to assist suicides.

Conscientiously objecting individuals must continue to worry about suasions short of "requirements." "Loss of privileges," for example, is ruled out in the section of the Act that aims to protect those who *do* assist in suicides;<sup>63</sup> but here, in the section aimed at protecting those who *do not* assist in suicides, loss of privileges is not mentioned.

The suicide of a patient may be economically beneficial. Insurers and HMOs often seek to lower their costs by screening out from their approved lists physicians and facilities with poor economic track records. This suggests that physicians who refrain from assisting in suicide (and indeed physicians who are slow to recommend it) may be damaged economically, and eliminated from major payment systems.<sup>64</sup> Another possibility is that of pressure from colleagues.<sup>65</sup>

Conscientiously objecting individuals must also worry about attempts to require them to perform acts that further suicide but that fall short of "providing a patient with medical means of

means of suicide, least of all those who are not themselves permitted to provide it because they are not "responsible physicians."

63. Model Act § 13(b).

64. Cf. Alpers & Lo, *supra* note 40, at 484 (warning that "it may serve the interests of a physician or a managed care plan to provide a quick and inexpensive lethal prescription rather than palliative care, which can be emotionally difficult, time consuming, and expensive").

65. See Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, September 11, 1995, at A3 ("A number of doctors [in the Netherlands] have said they feel too much pressure from patients and sometimes from colleagues to engage in euthanasia when they personally oppose it or when they are not sure the circumstances are appropriate."); see also Elizabeth J. Latimer & James McGregor, *Euthanasia, Physician-Assisted Suicide and the Ethical Care of Dying Patients*, 151 CANADIAN MED. ASSOC. J. 1133, 1134-35 (1994); cf. Courtney S. Campbell, Jan Hare, & Pam Matthews, *Conflicts of Conscience: Hospice and Assisted Suicide*, HASTINGS CTR. REP., May-June 1995, at 36.

[The Oregon Death with Dignity Act] permits providers and institutions to opt out of participation in the law. Yet to many hospice caregivers this provision for dissent and conscientious objection appears to permit abandonment of a patient. Thus, an important policy and practical question for the hospice community . . . concerns whether fidelity and nonabandonment of the hospice patient *requires* some level of participation by the hospice.

*Id.* at 40.

suicide . . . or . . . assist[ing] a responsible physician in doing so."<sup>66</sup> Objectors may be pressured, for example, to inform patients about assisted suicide. Such pressure may be based on the argument that both informed consent doctrines<sup>67</sup> and the federal Patient Self-Determination Act<sup>68</sup> require the provision of this information. Objectors might further be pressured to refer patients to assisted-suicide programs (even though many doctors would object to making such referrals).<sup>69</sup> They might be required to train interns and residents in the procedure. Pharmacists might be required to supply the drugs.<sup>70</sup>

2. *Individuals Who Are Not "Conscientiously Opposed" Within the Meaning of the Act.* The freedom-of-conscience provision applies only to those who are "conscientiously opposed." This term is not defined. Might courts craft a definition like that employed in connection with conscientious objection to military service, under which only "generic" or across-the-board objection would count? Such a definition might deny the protection of Section 11 to physicians and other health care workers who were conscientiously opposed only in a particular case or a limited category of cases. For example, physicians who were willing to assist with the suicides of patients who were about to die might be required to assist in the suicides of patients who were not terminally ill, and physicians who were willing to assist with the suicides of patients whose families consented might be required to assist in the suicides of patients whose families objected.

The freedom-of-conscience provision does not protect the physician or other health care worker who merely has qualms or doubts; who wishes to refrain out of respect for tradition, public opinion, the opinions of other patients,<sup>71</sup> the opinions of

66. Model Act § 11(a).

67. See PAUL S. APPELBAUM, CHARLES W. LIDZ, & ALAN MEISEL, INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 54-55, 165 (1987).

68. 42 U.S.C. § 1595cc (Supp. 1994) (requiring disclosure of patients' state-law rights).

69. See Bachman, *supra* note 61, at 307 (reporting that of physicians surveyed who would refuse to participate in assisted suicide or voluntary euthanasia, 38% would also refuse to refer patients for those purposes).

70. Another concern relates to individuals who are conscientiously obliged to resuscitate patients who have attempted to commit suicide. Might the hospital forbid such conduct, authorizing "do not resuscitate" orders for suicidal patients? Might it discipline objectors for disobeying such an order? Might courts recognize a remedy on behalf of a resuscitated patient who has been deprived of the "benefit" conferred by the Act?

71. See Ezekiel Emanuel, Diane L. Fairclough, Elisabeth R. Daniels, & Brian R.

colleagues, or the strictures of the Hippocratic Oath<sup>72</sup> and other provisions of medical<sup>73</sup> and nursing ethics;<sup>74</sup> or who has concerns about exposure to legal liabilities. According to an Oregon survey, twenty-one percent of physicians may fall into these categories.<sup>75</sup> Many physicians

were concerned that the patient's family might sue, . . . were concerned about the possible harm if an attempt failed[,] . . . that someone other than the patient might use the prescription[,] . . . or that writing it might violate federal laws governing the prescription of drugs . . . , jeopardize their license to practice in another state . . . , or lead to sanctions by hospitals . . . or ostracism by colleagues.<sup>76</sup>

3. "*Health Care Facilities*" That Object. The freedom-of-conscience language takes special heed of this area of concern, providing:

A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.<sup>77</sup>

Concerns remain despite this provision.

First, the health care facility must of course adopt such a policy. Many small and sleepy institutions not actively represented by attorneys may find themselves required to honor requests for suicide until they wake up and adopt one.<sup>78</sup>

Second, the immunity afforded by this section only permits an

Clarridge, *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public*, 347 LANCET 1805, 1808 (1996) (finding that "19.0% of patients and 26.5% of the general public thought they would change physicians if their physician told them he or she 'had provided euthanasia or assisted suicide' for other patients").

72. See *infra* note 147 and accompanying text.

73. See *infra* notes 148-50 and accompanying text.

74. See *infra* note 151 and accompanying text.

75. See Lee, *supra* note 34, at 312.

76. Lee, *supra* note 34, at 312 (reporting that 53% of physician respondents were concerned about suits, 51% about possible harm if the attempt failed, 33% about the possibility that someone other than the patient might use the prescription, 25% that they might violate federal drug prescription laws, 23% that their license to practice might be jeopardized, 24% that hospitals might sanction them, and 25% that colleagues might ostracize them).

77. Model Act § 11(b).

78. Even after a policy was adopted, requests might need to be honored for some time thereafter, if the notice requirement referred to in the Act implies a waiting period.

institution to refuse to provide *means* of suicide. No immunity is afforded from the legal requirement that patients be informed of the option of suicide<sup>79</sup> nor from attempts by accrediting agencies to require conscientiously objecting teaching hospitals to provide instruction in suicide assistance.

Third, the immunity applies only to an institution assisting in the suicide of a "patient who is within its facilities or under its care." These terms are not defined. Uncertainty remains as to whether the immunity would permit an institution to refuse to allow staff members to assist in suicides of walk-in patients.<sup>80</sup>

4. *Objecting Entities That Are Not "Health Care Facilities"* (For Example, Some Universities, Employers, and Schools). The Act's freedom-of-conscience provision applies only to individuals and "health care facilities," a term that does not cover nonmedical facilities and is doubtful in its application to institutions that are not primarily medical in nature but do offer some limited on-site or off-site medical services.<sup>81</sup> Special concerns thus arise about certain universities, business employers, and schools with health care clinics. (Although Dr. Wanzer, one of the drafters, is the Director of Harvard Law School Health Services, the drafters do not seem to have taken account of the special problems the Act might pose for such entities).

If it fell outside the freedom-of-conscience provision, an institution would not enjoy the privilege to "adopt a policy opposed to providing patients with medical means of suicide" and the consequent privilege to "prohibit . . . staff members from providing such means to a patient who is within its facilities or under its care." Harvard, for example, might not be within its rights to restrain an associate of Dr. Wanzer's from assisting in the suicides of Harvard Law School students.<sup>82</sup>

5. *Insurers*. Insurers are required by the Act to cover assistance in suicide, and are not covered by the freedom-of-conscience

79. See *supra* notes 67-68 and accompanying text.

80. Another question concerns whether the policy, to be effective, must be facility-wide. Could a chief of medicine adopt such a policy for a single department or does the use of the term "facility" indicate that the entity as a whole must adopt it? And must it be a consistent policy for the entire "facility"?

81. The term "health-care facility" is defined as "a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States." Model Act § 2(c).

82. Owing to the confidentiality provisions in the Act, Harvard might never find out about instances in which this was done.

provision.<sup>83</sup> There is no protection for religiously-affiliated benefit plans, for example.

6. *Entities That Do Not in General Object to Assisted Suicide but Aim to Control It.* Entities falling into this category are impeded from regulating assistance in suicide by Section 13(b), which provides:

No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject therefor to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility that complies with Section 11(b) of this Act.<sup>84</sup>

This wording raises doubts about such an entity's right to enforce provisions governing the time, place, and methodology of assisted suicide.<sup>85</sup>

Thus Section 13(b) puts hospitals in an impossible position from the point of view of self-governance and raises doubts about the rules and standards hospitals must apply in order to receive accreditation, obey controlled-substances laws, and avoid liabilities in tort. Even record-keeping would be impeded, because of the confidentiality provisions contained in Section 10 of the Act. As the preceding discussion indicates, similar problems would be created for certain universities, business employers, and schools.

*Conclusion.* So, revert to the supposition that you are a physician or an administrator in an institution which is approached by someone who seeks assistance in suicide:

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83. The Commentary states that insurers are protected by the freedom-of-conscience provision: "Unless physicians, institutions *and insurers* opt out for reasons of conscience under section 11, they must honor patients' choices to seek or avoid assistance in suicide." Commentary, *supra* note 2, at 23 (emphasis added). But this is not consistent with the language of § 11, which applies only to "individual[s]" and "health care facilit[ies]"; it is unlikely that an insurer is a "health care facility" as defined in § 2, and in any event the privilege afforded a health care facility by § 11 is only that of "prohibit[ing] staff members from providing" medical means of suicide; and nothing is said about a privilege not to extend insurance coverage. Model Act § 11.

84. Model Act § 13(b).

85. This section would raise concerns even in the limited instance in which an institution went no further than imposing safeguards to ensure that the Act's own standards of patient eligibility were complied with: for example, by requiring a potential suicide to show a driver's license as proof of age. A physician who ignored this proof requirement might still be acting within the Act and so be protected from discipline. Even if the physician turned out to have goofed and assisted in the suicide of a sixteen-year-old, the physician might be protected if the physician acted "on the basis of an honest belief." Model Act § 3(a).

perhaps the suffering eighteen-year-old mentioned earlier in this Article or the terminally ill but comfortable fifty-five-year-old. You, your Board of Trustees, and your community strongly oppose such a step, and so do the patient's relatives if they happen to hear about it. But the Act has become the law and on your staff is Dr. Hemlock, a supporter of Dr. Kevorkian. Examining the Act with greater care, you may, depending on facts that need not be improbable ones, be driven to the following conclusions:

—You cannot order Dr. Hemlock to keep off this case by threatening dismissal or “professional sanction.”

—You cannot even enforce by threat of professional discipline a rule that would merely require Dr. Hemlock to act in conjunction with other staff, consult the patient's family or school, verify the severity of pain, or take other preliminary actions.

—Finally, if it happens that the case is such a distasteful one for suicide that even Dr. Hemlock wishes to abstain, the law may nevertheless require the doctor to go through with it and require your facility to cooperate.

### III. THE MORALITY AND JURISPRUDENCE OF THE ACT

One of the stated purposes of the Act is “promoting patients' well-being.”<sup>86</sup> Causing the deaths of some people—or, as the Commentary calls it, “hastening” their deaths—“promote[s] [their] . . . well-being.”<sup>87</sup> The drafters of the Act believe that people are better off dead when their deaths will “provide relief from suffering.”<sup>88</sup>

Accept these views, and many things will change, not only matters concerning the ill and the elderly. Encourage the growth of views such as these as a part of the morality by which the United States government operates, or its military, or its domestic security forces, or as a matter of our people's social morality, and many consequences not discussed by the drafters are sure to follow. Encourage the medical profession to adopt and implement this philosophy and its nature and purpose as a

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86. Commentary, *supra* note 2, at 5.

87. *Id.*

88. *Id.* at 4.

healing profession will be fundamentally redirected.<sup>89</sup>

Would such changes be a good thing? Surely the burden of proof rests on those promoting such a fundamental set of alterations. The Commentary offers little towards carrying this burden. It presents no sustained moral or philosophical argument, and does not even cite much of the relevant literature. Its failure to present even a *prima facie* case for assisted suicide is sufficient reason for rejecting the Act.

But we are confronted by an international movement that is sure to press the point, both as regards assisted suicide and as regards other circumstances of death.<sup>90</sup> Let us try, therefore, to uncover and criticize its underlying philosophy.

The Commentary states that the Act is guided by “[t]he most basic values that support and guide all health care decision making,” namely “promoting patients’ well-being and respecting their self-determination or autonomy.”<sup>91</sup> Thus, the Act has two ideological foundations. One is libertarian: it is aimed at promoting autonomy by extending the sphere of self-determination. The other is utilitarian: it seeks to diminish pain (“well-being” in context means only that).<sup>92</sup> No other sources of philosophical support are mentioned.<sup>93</sup>

The next two sections of this Article examine the libertarian (autonomy-based) and utilitarian cases for the Act.

#### IV. THE ARGUMENT FROM AUTONOMY

As mentioned, the Commentary supports the Act on grounds of “self-determination and autonomy”<sup>94</sup> (without defining or expounding upon those terms). In this the Commentary is badly

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89. *See infra* Sections V.5 and V.6 of this Article.

90. *See infra* notes 161-81.

91. Commentary, *supra* note 2, at 4-5.

92. *See* notes 105-06, *infra*, and accompanying text.

93. The hint of another criterion appears in the Commentary’s reference to the allegedly “meaningless” lives of certain patients. *See* Commentary, *supra* note 2, at 5; *cf.* Baron, *supra* note 53, at 74. The author of the latter piece, one of the Model Act’s drafters, refers to the possibility that people in persistent vegetative states may experience “years of pointless existence at great expense to society.” *See id.* Other criteria that have been mentioned include dignity and “critical interests.” *See* RONALD M. DWORKIN, *LIFE’S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* (1993). For criticisms of similar criteria, see John Finnis, *The Value of Human Life’ and the ‘Right to Death’: Some Reflections on Cruzan and Ronald Dworkin*, 17 S. ILL. U. L.J. 559 (1993).

94. Commentary, *supra* note 2, at 5.

mistaken. Whatever else might be said in favor of suicide, it cannot well be defended as a means of affording the victim self-determination or autonomy.

The major reason why this is so is obvious: suicide puts an end forever to all choices. Any reasonable theory of freedom and related goods<sup>95</sup> must take into account the whole life; any reasonable argument that to act in a certain way promotes freedom or autonomy must take into account consequences beyond the immediate. Assisting people to become slaves would not promote their freedom but would deprive them of it.<sup>96</sup> To determine whether we have promoted people's autonomy or self-determination, we must consider their futures as a whole. Assisting people in dying would effect an even more severe deprivation of self-determination and autonomy than would enslaving them.<sup>97</sup>

A second reason why suicide does not promote autonomy looks not forward in time but backwards. Any reasonable theory of freedom and related goods must consider not only the immediate choice but also choices that the subject may have made previously. This is why enforcing contracts promotes freedom rather than restricts it—"freedom of contract" helps people to determine their own (joint) futures. When people are required to honor contracts, they are held to courses of action they chose for themselves. The same can be said for other voluntary concordances: for example, relationships of trust, of guardianship, of marriage, of parenting, and of friendship.<sup>98</sup> The implications for suicide are obvious: in those many instances in which the subjects are married to people who rely

95. See generally STANLEY I. BENN, *A THEORY OF FREEDOM* (1988); Isaiah Berlin, *Two Concepts of Liberty*, in ISIAH BERLIN, *FOUR ESSAYS ON LIBERTY* 188 (1969); GERALD DWORKIN, *THEORY AND PRACTICE OF AUTONOMY* (1988); THOMAS E. HILL, *AUTONOMY AND SELF RESPECT* (1991); RICHARD LINDLEY, *AUTONOMY* (1986); Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CTR. REP., Mar.-Apr. 1992, at 52; Amartya K. Sen, *Freedom of Choice: Concept and Content*, 32 EUROPEAN EC. REV. 269 (1988) (and other works by Professor Sen cited therein); works cited in other notes to this Section IV.

96. See generally Joel Feinberg, *Voluntary Euthanasia and the Inalienable Right to Life*, 7 PHIL. & PUB. AFFAIRS 93, 116 (1978) (discussing the slavery contract). Feinberg also examines the proposition that individuals cannot alienate certain rights. See *id.* *passim*.

97. Leaving aside of course the life to come. As to that, see DANTE ALLIGHIERI, *Canto XIII, INFERNO* 118 (John Ciardi trans., Rutgers University Press 1954) (1321).

98. Cf. Feinberg, *supra* note 96, at 119 (noting that while voluntary euthanasia may be defensible, "[m]ost people in normal circumstances do have a duty not to kill themselves that is derived from the rights of other people who rely or depend on them").

and depend upon them, or have children, or have obligations to fellow workers or employees, suicide effects a departure from the course they chose for themselves, and assisting the suicide constricts self-determination and autonomy rather than enhancing them.<sup>99</sup>

A third reason looks neither to the past nor the future, but to the moment of choice, and notes that acceding to a choice does not enhance the chooser's autonomy unless the chooser has chosen under satisfactory conditions.<sup>100</sup> But people who may seek assistance in suicide are necessarily ignorant of many of the consequences of their choices and may be influenced by fear or other distorting influences. Section V of this Article describes such circumstances in greater detail.

A fourth line of argument raises the most basic issues: those concerning the fundamental nature and value of autonomy. One view on this subject considers autonomy and autonomous action to be goods *independent of the ends pursued*. Thus David Richards states in *Sex, Drugs, Death, and the Law*:

[T]he idea of "human rights" respects [the] capacity of persons for rational autonomy—their capacity to be, in Kant's memorable phrase, free and rational sovereigns in the kingdom of ends. . . . [T]he concern embodied in the idea of human rights is not with maximizing the agent's pursuit of any particular lower-order ends, but rather with respecting the higher-order capacity of the agent to exercise rational autonomy in choosing and revising his ends, *whatever they are*.<sup>101</sup>

This may be the mainstream understanding of autonomy among those groups that sponsor legislation like the Act.

The alternative view—and the correct view, in the opinion of the authors of this Article—asserts that autonomy can be

99. *But cf.* John A. Powell & Adam S. Cohen, *The Right to Die*, 10 *ISSUES IN L. & MED.* 169, 177 (1994) (advocating a right to suicide even for parents of small children on the grounds that "[t]he general rule in American law is that people do not have a duty to care for others if they do not wish to do so").

100. This point appears often in writings on autonomy. *See, e.g.*, JOHN RAWLS, *A THEORY OF JUSTICE* 515 (1971) (arguing that acting autonomously is acting "from principles that [the actors] would acknowledge under conditions that best express their nature as free and equal rational beings"); JOSEPH RAZ, *THE MORALITY OF FREEDOM* 371 (1988) ("The autonomous person . . . must be capable of understanding how various choices will have considerable and lasting impact on his life.").

101. DAVID A.J. RICHARDS, *SEX, DRUGS, DEATH, AND THE LAW* 9 (1982) (emphasis added). A helpful criticism of Richards' theory is presented in ROBERT P. GEORGE, *MAKING MEN MORAL: CIVIL LIBERTIES AND PUBLIC MORALITY* 129-160 (1993).

understood as a good only in the context of the ends autonomously pursued.<sup>102</sup> Kant, for example, who never wrote the “memorable phrase” attributed to him by Richards,<sup>103</sup> instead adhered to the view that autonomy involves acting consistently with objective moral norms.<sup>104</sup> (Kant also believed that these standards would be contravened by suicide). Other philosophers, guided by Aristotle and emphasizing virtues and virtuous actions rather than Kantian rules and principles, understand autonomy as a good only when it is instantiated as a component of virtuous action.

Autonomy enhances the merits of meritorious conduct. An act of courage—for example, standing up in war against the attack of a Nazi tank unit—is the more praiseworthy the more it is taken unconstrainedly: more praiseworthy when it is the result of calm deliberation rather than a rush of rage; more praiseworthy when it is undertaken by a volunteer than by a conscript under the baton of a sergeant. An act taken autonomously is more thoroughly one’s own act, and usually reflects a settled intention to pursue the good. The picture is very different, however, when the action is not a meritorious one. Then the wider the actor’s autonomy, the greater the actor’s culpability. Running away from a situation where duty requires courage is worse, not better, when deliberate and uncommanded. Attacking an innocent person is worse when the attacker acts free of compulsion, in full knowledge of the meaning of the act.

To establish, then, that an action instantiates the good of the actor’s autonomy, more must be shown than that the actor chose to act. A successful argument from autonomy must be based on a thorough understanding of the future toward which the action tends, of the web of commitments that the actor has in the past developed, and of the larger moral questions surrounding the act. In the area of medical care, it will often be

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102. Something like the argument here advanced is set forth, with reference to euthanasia, in SUBMISSION TO THE SELECT COMMITTEE OF THE HOUSE OF LORDS ON MEDICAL ETHICS BY THE LINACRE CENTRE FOR HEALTH CARE ETHICS § 1.3 (1993), reprinted in EUTHANASIA, CLINICAL PRACTICE, AND THE LAW 111, 129-33 (Luke Gormally ed., 1994).

103. See John Finnis, *Legal Enforcement of Duties to Oneself: Kant v. Neo-Kantians*, 87 COLUM. L. REV. 433, 440 (1987).

104. See IMMANUEL KANT, GROUNDWORK OF THE METAPHYSIC OF MORALS 93-102 (H.J. Paton trans., 1948) (1785).

easy to conclude that the good of patients' autonomy is served by assisting their pursuit of health. The good of autonomy is not served when caretakers accede to patients' determinations to pursue death.

#### V. THE ARGUMENT FROM UTILITY

The drafters of the Act appear to rest their case on the classic, pleasures-and-pains act utilitarianism of Bentham and Mill.<sup>105</sup> In this form, utilitarianism is

[t]he creed which accepts as the foundation of morals "utility" or the "greatest happiness principle" [It] holds that actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure.<sup>106</sup>

A cognate conclusion would be that the value of a human life rests on the person's capacity for enjoyment and for conferring pleasure.

Are the drafters of the Act right on utilitarian grounds? Let us ask them eight hard questions.

1. *Would Patients Attempt to Perform the Utilitarian Calculus?* The utilitarian argument must rest on the view that suicides under the Act would improve utility. This conclusion must rest on the prediction that patients will perform the utilitarian calculus, accurately weighing the consequences and seeking suicide only when the pains of continuing to live would exceed the pleasures.

Would they do that? The familiar assumption, by writers in the utilitarian tradition, that human beings are "economic" persons who aim (skillfully) to maximize their utility<sup>107</sup> is

105. This is indicated by their frequent references to "suffering." (By suffering the drafters do not seem to mean something to be distinguished carefully from pain. The importance of the distinction is suggested in ERIC J. CASSELL, *THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE* (1991)). It appears the drafters are not arguing from the type of "preference-based" utilitarianism defended in John C. Harsanyi, *Rule Utilitarianism and Decision Theory*, 11 *ERKENNTIS* 25, 27-28 (1977) and BARUCH A. BRODY, *LIFE AND DEATH DECISION MAKING* 19-21 (1988).

106. JOHN STUART MILL, *UTILITARIANISM* 18 (Samuel Gorovitz ed., Bobbs-Merrill Co., Inc. 1971) (1863).

107. See AMARTYA K. SEN, *ON ETHICS AND ECONOMICS* 80 (1987) ("In the usual economic literature a person is seen as maximizing his utility function, which determines all his choices."); George J. Stigler, *Economics or Ethics?* in 2 TANNER *LECTURES ON HUMAN VALUES* 143, 190 (Sterling M. McMurrin ed., 1981) ("[W]e live in a world of reasonably well-informed people acting intelligently in pursuit of their self-

indefensible in general,<sup>108</sup> and especially hard to support in the instance of people contemplating suicide. The medical literature establishes what common sense would in any event suggest: many people contemplating self-destruction are in no way thinking like Enlightenment *philosophes*.

Pain would not determine their decisions. A recent major study concludes that "having pain does not predispose a person to desire or take actions to end his or her life."<sup>109</sup> This study reports that "[p]atients experiencing pain were not inclined to euthanasia or physician-assisted suicide."<sup>110</sup>

Instead, important causes of suicidal acts and desires include depression,<sup>111</sup> "anxiety . . . impulsivity . . . subtle cognitive impairments"<sup>112</sup> aggressive tendencies, "a wish not to be here for a time (impulse control),"<sup>113</sup> and "preexisting substance abuse disorders."<sup>114</sup> Another factor is a self-destructive state of mind:

Self-destructive patients with borderline personality disorder may also seek physician-assisted death. Self-destructive patients may be unconsciously seeking a physician

interests."). For a general discussion of these issues, see Charlie D. Broad, *Egoism as a Theory of Human Motives*, in PROBLEMS OF MORAL PHILOSOPHY 111-18 (Paul W. Taylor ed., 1978).

108. The assumption is not supported by conclusive empirical evidence. See SEN, *supra* note 107, at 18 (1987). It is rejected by prominent economists. See, e.g., DEREK PARFIT, REASONS AND PERSONS (1984); Amartya K. Sen, *The Formulation of Rational Choice*, 84 AM. EC. REV. 385, 386 (1994) ("A divergence between choice and well-being can easily arise when behavior is influenced by some motivation other than the pursuit of one's own interest or welfare. . .").

109. Emanuel, *supra* note 71, at 1809. This study also reports that "[t]his finding is consistent with data from the Netherlands demonstrating that pain was the only reason for euthanasia in just 10% of cases and a contributing factor in fewer than 50% of cases. It is also consistent with data from American physicians who had carried out euthanasia." *Id.* (references omitted). Further, "[p]atients in pain were significantly more likely to find euthanasia and physician-assisted suicide unacceptable," *id.* at 1807, and that "those who had pain . . . were not more likely to have discussed euthanasia or physician-assisted suicide or to have read *Final Exit*," *id.* at 1808.

110. *Id.* at 1809.

111. See *supra* note 28.

112. Block & Billings, *supra* note 26, at 449 (noting that [n]onpsychiatrist physicians frequently fail to recognize, diagnose, and appropriately treat these disorders"). The authors also state that

[i]n a more extreme form, self-reliance, perfectionism, self-control, rigidity, and the tendency to be judgmental may be conceptualized as part of a narcissistic or obsessive-compulsive personality disorder. In our experience, these are the most common personality configurations seen in patients . . . who persistently seek hastened death.

*Id.* at 450.

113. Apter, *supra* note 28, at 912.

114. Block & Billings, *supra* note 26, at 459.

to hurt or abuse them to confirm their views of themselves as damaged and unworthy. These patients often have significant associated depression and impaired decision-making capacity.<sup>115</sup>

Young people especially are likely to seek suicide when in the grip of states of mind that can impair rational decisionmaking. For example, “[r]age, hopelessness, despair, and guilt are important affective states in which young patients commit suicide.”<sup>116</sup> Young people may assign unusual “conscious (cognitive) and unconscious meanings . . . to death . . . [for example,] death as reunion, death as rebirth, death as retaliatory abandonment, death as revenge, and death as self-punishment or atonement.”<sup>117</sup>

A recent study concludes that:

patients with unremitting pain . . . are not the patients most likely to request [euthanasia and assisted suicide]. . . . There is some concern that with legislation of euthanasia or physician-assisted suicide non-psychiatric physicians, who generally have a poor ability to detect and treat depression[,] may allow life-ending interventions when treatment of depression may be more appropriate.<sup>118</sup>

2. *Could Patients Accurately Perform the Utilitarian Calculus?* To work the utilitarian calculus, a patient would have to foresee the experiences that would be endured in the course of a voluntary death in the proximate future, and also the experiential consequences of the alternative.

One alternative may be to live but to experience pain. An important variable here is: how much pain, subject to what degree of medical palliation. Neither physicians nor patients always address the possibility of palliation successfully:

Undertreatment of pain is common, attributable to deficiencies in health professionals’ education about pain management as well as concerns about addiction among patients, family members, and clinicians. . . . In the Netherlands, an estimated 85% of patients withdraw their requests for hastened death after receiving better symptom palliation. More than 90% of patients with cancer pain

115. *Id.* at 451.

116. Hendin, *supra* note 30, at 1150.

117. *Id.*

118. Emanuel, *supra* note 71, at 1809.

respond to simple analgesic measures.<sup>119</sup>

Furthermore, suffering has consequences for personality development. These consequences are not always foreseeable and not always deleterious:

What is the nature of [the] patient's suffering such that death is preferable to loss of control and loss of an intact self? Exploration of these questions often identifies and highlights personality characteristics such as self-reliance, perfectionism, self-control, rigidity, and the tendency to respond judgmentally. These defensive styles may have been highly adaptive in many spheres of life. However, in the setting of terminal illness, self-reliance may be expressed as difficulty in trusting others, accepting help, and being dependent; perfectionism as frustration with personal weakness and neediness; self-control as intolerance of the noncontrollable vicissitudes and uncertainties of illness; and the tendency to be judgmental as self-criticism and self-blame over being ill and incapacitated. Giving up control, accepting dependency, and tolerating physical deterioration may be so intolerable that hastening death becomes a way to preserve the self. . . . Psychiatric intervention may help such patients reframe their experience; alternate expressions of control and of living up to high personal standards of behavior include forbearance in the face of uncertainty and difficulty, the capacity to model grace in confronting impending annihilation, and receiving help as a means of permitting others to master their feelings of loss.<sup>120</sup>

Medical afflictions may lead to fundamental personality developments, and even to a reconstruction of the character in which "the parts of the person are assembled in a new manner."<sup>121</sup> Patients may come to terms with their afflictions by "transcendence"—"[t]he sufferer is not isolated by pain but is brought closer to a transpersonal source of meaning and to the human community that shares that meaning. . . . [T]ranscendence locates the person in a far larger landscape."<sup>122</sup> Beforehand, can the patient really be expected to assess what such an experience would be like?<sup>123</sup>

119. Block & Billings, *supra* note 26, at 447.

120. *Id.*

121. CASSELL, *supra* note 105, at 44.

122. *Id.* at 45.

123. See BRODY, *supra* note 105, at 295-36 (making a similar point in the context of a preference-based consequentialist analysis). Some would argue that where the medical problem is severe the victim may eventually cease to be the same person, and that the

Another alternative may be natural death within six months. An important variable in the calculus, therefore, is the likelihood of death. The American Medical Association reports that “[p]rognostication of survival for the very seriously ill is imprecise”<sup>124</sup> and another authority raises concerns about how well and fairly relevant information is communicated to patients.<sup>125</sup>

And then there is the alternative offered under the Act: a demise that may be neither quick nor comfortable. Nearly a quarter of patients “who receive life-ending medication linger for several hours to four days before death occurs.”<sup>126</sup> Death by taking pills, for example, can take three hours or more.<sup>127</sup> “A patient can spill the medicine or choke or vomit or fall asleep before the full dose has been taken.”<sup>128</sup>

Entering these alternatives into the calculus involves appraising the experience of death. Not yet having experienced it, none of us is well positioned to predict what it will be like when we encounter what Henry James called, when he saw it approach, the Distinguished Thing.<sup>129</sup>

patient beforehand not only cannot well predict but also lacks moral standing to decide the fate of this “other person.” See Allen Buchanan, *Advance Directives and the Personal Identity Problem*, 17 PHIL. & PUB. AFF. 277 (1988), a work which relies heavily on PARFIT, *supra* note 108.

124. Council on Scientific Affairs, American Medical Association, *Council Report: Good Care of the Dying Patient*, 275 JAMA 474, 476 (1996) [hereinafter AMA Report, *Care of the Dying Patient*]. See Roy M. Poses, Carolyn Bekes, Fiore J. Copare, & William E. Scott, *The Answer to ‘What Are My Chances, Doctor?’ Depends on Whom is Asked: Prognostic Disagreement and Inaccuracy for Critically Ill Patients*, 17 CRITICAL CARE MED. 827 (1989).

Further complexity concerns the patient’s ability to influence the outcome by means of a do-not-resuscitate request. See Rosemarie B. Hakim, Joan M. Teno, Frank E. Harrell Jr., William A. Knaus, Neil Wenger, Russell S. Phillips, Peter Layde, Robert Califf, Alfred F. Connors Jr., & Joanne Lynn, *Factors Associated with Do-Not-Resuscitate Orders: Patients’ Preferences, Prognoses, and Physicians’ Judgments*, 125 ANNALS INTERNAL MED. 284, 291 (1996) (“Do-not-resuscitate orders were not written for almost half of the patients who wanted resuscitation withheld.”); Orentlicher, *supra* note 41, at 2102.

125. See Orentlicher, *supra* note 41, at 2102; see also Block & Billings, *supra* note 26, at 453 (“[P]atients have been shown to misunderstand information they receive about such emotionally loaded issues as cardiopulmonary resuscitation. Also, physicians’ concerns about upsetting or frightening patients in the course of discussions of wishes for care at the end of life may lead to euphemistic or incomplete discussions.” (citation omitted)).

126. Campbell, *supra* note 65, at 41 (reporting that in both the Netherlands and the United States, “20 to 25 percent of patients” suffer such lingering deaths).

127. See Simons, *supra* note 65, at A3.

128. *Id.* (quoting a physician who practices euthanasia in the Netherlands as saying, “This creates a lot more tension, also among others who accompany the patient. There are risks because people are terribly sick. . . . It is never simple.”).

129. See EDITH WHARTON, *A BACKWARD GLANCE* 367 (1934) (attributing to Henry James the statement, “So here it is at last, the distinguished thing!”).

Many critics of utilitarianism doubt the possibility of performing the utilitarian comparison where alternatives involve incommensurable outcomes.<sup>130</sup> The outcomes at issue here—life subject to pain; natural death; suicide—involve qualitative differences as extreme as can well be imagined.

3. *Are Pleasures and Pains Really the Proper Guides When Life is at Stake?* Many critics have noted as a defect of utilitarianism that it leads, in many circumstances, to an unacceptable willingness to sacrifice human life. Utilitarianism leads to the conclusions, for example, that it would be good to induce cancer in someone as a part of a research project that would eventually alleviate much suffering,<sup>131</sup> and that innocent victims must be executed when the populace believes they are guilty and will riot if they are freed.

Utilitarianism leads to these conclusions because human life has no independent weight in the system, no value other than as a bearer of pleasures and pains. In this respect utilitarianism contradicts universal common sense; most of us cling to our own lives even in adversity and stoutly condemn homicide whatever pleasure it may confer.

4. *Must Not the Utilitarian Calculus Include Effects on Other Individuals, such as Family Members?* Radical individualism is a besetting fault of the Act. The Commentary's allusions to "well-being" refer only to that of the patient. But of course the effects of a suicide on friends<sup>132</sup> and family members<sup>133</sup>—minor children, for example<sup>134</sup>—will be dramatic in most cases, and

130. See, e.g., JOHN FINNIS, *FUNDAMENTALS OF ETHICS* 86 *et seq.* (1983); JOHN FINNIS, *MORAL ABSOLUTES* 17-24 (1991); JOHN FINNIS, *NATURAL LAW AND NATURAL RIGHTS* 111-18 (1979); JOHN FINNIS, JOSEPH BOYLE, & GERMAIN GRISEZ, *NUCLEAR DETERRENCE, MORALITY AND REALISM* 238-72 (1987); Germain G. Grisez, *Against Consequentialism*, 23 *AM. J. JURISPRUDENCE* 21 (1978).

131. See Philippa Foot, *Utilitarianism and the Virtues*, in *CONSEQUENTIALISM AND ITS CRITICS* 224, 237 (Samuel Scheffler ed., 1988).

132. Friends may experience "major depression [and] post-traumatic stress disorder." David A. Brent, Joshua Perper, Grace Moritz, Chris Allman, Joy Schweers, Claudia Roth, Lisa Balach, Rebecca Canobbio, & Laura Liotus, *Psychiatric Sequelae to the Loss of an Adolescent Peer to Suicide*, 32 *J. AM. ACAD. CHILD & ADOLESC. PSYCHIATRY* 509 (1993).

133. See DANIEL HASSENFELD, *CALL OF THE SHOFAR* (1995) (presenting a sensitive and perceptive description of the effects of the death of a close relative); B.J. Smith, A.M. Mitchell, A.A. Bruno, & R.E. Constantino, *Exploring Widows' Experiences After the Suicide of Their Spouse*, 33 *J. PSYCHOSOCIAL NURSING & MENTAL HEALTH SERVICES* 10 (1995).

134. See J.A. Grossman, D.C. Clark, D. Gross, L. Halstead, & J. Pennington, *Child Bereavement After Paternal Suicide*, 8 *J. CHILD & ADOLESCENT PSYCHIATRIC NURSING* 5 (1995), abstract available in MEDLINE.

often much longer lasting than the pain that the patient may suffer.<sup>135</sup>

The pains of grief are not the half of it; far more telling are the effects on the relationship itself, which in a sense continues after death. As Proust wrote, "a sort of cutting taken from one person and grafted on the heart of another continues to carry on its existence, even when the person from whom it had been detached has perished."<sup>136</sup> What interpretation—surely often a devastating one—may a wife or a child put on the blotted signature at the bottom of the page of their love?

And here again pleasures and pains cannot be the only considerations. Wholly unnoticed in the Commentary is the presence of obligation: the marriage oath, the natural duty to support minor children, and the ties of friendship.

5. *Must Not the Calculus Include Consequences for the Relationship Between the Physician and the Patient?* Where the person the Act refers to as a "patient" really is a patient,<sup>137</sup> the doctor-patient relationship may be altered by the Act. Many physicians have expressed concern that discussion of physician-assisted suicide may undermine patients' confidence in their doctors.<sup>138</sup> Indeed, fifty-three percent of oncologists (but smaller percentages of patients and the general public) "thought that discussions between patients and physicians on 'end-of-life care that included explicit mention of euthanasia or physician-assisted

135. See generally *Compassion in Dying v. Washington*, 79 F.3d 790, 827 (9th Cir.) ("The state clearly has a legitimate interest in safeguarding the interests of innocent third parties such as minor children and other family members dependent on persons who wish to commit suicide."), cert. granted sub nom. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

136. 2 MARCEL PROUST, *REMEMBRANCE OF THINGS PAST* 750 (C.K. Scott Moncrieff trans., Random House 1932).

137. Assisted suicide under the Model Act would be available to someone who was not hospitalized or previously under medical care. See *supra* note 14 and accompanying text.

138. See, e.g., Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, *THE PUBLIC INTEREST*, Winter 1989, at 25, 35 ("The patient's trust in the doctor's wholehearted devotion to the patient's best interests will be hard to sustain once doctors are licensed to kill."); Orentlicher, *supra* note 31, at 1844-45.

If the physician appears sympathetic to the patient's interest in suicide, it may convey the impression that the physician feels assisted suicide is a desirable alternative. Such an impression may not be very comforting to the patient. Moreover, if the patient decides to reject suicide, will the patient have the same degree of confidence in the physician's commitment to his or her care as previously? In short, assisted suicide might seriously undermine an essential element of the physician-patient relationship, the patient's trust that the physician is wholeheartedly devoted to caring for the patient's health.

*Id.* (citation omitted).

suicide' would reduce patients' trust in the physician."<sup>139</sup>

This should be a special concern to those who reject one modern view of medicine—the highly individualistic view in which patient rights are central—and instead accept a relational account. One proponent of this relational ethic, Dr. Eric Cassell, urges physicians

to reach out to the suffering person to bring him or her back with the rest of us. You must communicate to the person that no matter what happens or how difficult it is, you are going to be there and help.

. . . .

. . . . Social contacts must be facilitated. Relationships within the family should be bolstered. Barriers to familial closeness erected during serious illness by, for example, untruths, false optimism, repugnance, and fear can usually be removed with little effort by teaching members of the family how to interact with a sick person.<sup>140</sup>

The case for this relational approach is especially compelling in respect to the terminally ill who begin to discuss suicide, because

[t]he vast majority of terminally ill patients who consider or discuss suicide do not kill themselves. For terminally ill patients, as for their non-terminally ill counterparts, talk of suicide is a signal to physicians and family that the patient's fears and needs have not been adequately addressed. Therefore, the first task for physicians . . . is to elicit the patient's concerns and try to relieve them. . . . Most terminally ill patients find reasons to continue to live after their concerns or symptoms are assuaged.<sup>141</sup>

These wise suggestions might not be universally taken after the adoption of the Act. Indeed, signs already exist that some doctors are considering that suggesting death to a patient might benefit the doctor as well. Two palliative care specialists recently

139. Emanuel, *supra* note 71, at 1808. As mentioned above, this study also found that "19.0% of patients and 26.5% of the general public thought they would change physicians if their physician told them he or she 'had provided euthanasia or assisted suicide for other patients.'" *Id.*

140. CASSELL, *supra* note 105, at 246-7.

141. Alpers & Lo, *supra* note 40, at 484. Cf. AMA Report, *Care of the Dying Patient*, *supra* note 124, at 475 (reporting that "many persons initiate a discussion about suicide to evaluate the degree to which others are concerned with their well-being and to evaluate their own self-worth").

expressed the apprehension that were euthanasia and assisted suicide to become legal, some physicians might come to hope for their patients to die:

An appropriate response of health care professionals [to a patient's request for euthanasia] is to listen carefully to patients' feelings of despair and to embark with them on a shared journey of exploration about meaning, all the while reinforcing that, as people, they are of value no matter how frail and ill. Skilled physical care must always be provided. . . . Can physicians continue to strive to better the lot of seriously ill and dying patients when a possible option is to act on their request to bring about death? At what point in care would death become a more attractive option to *both* parties?

Physicians and health care delivery systems face increased pressure to practise more efficiently and expediently and cost-effectively. It is doubtful that physicians could continue to care for seriously ill patients who are not likely to survive without developing a bias toward their patients' earlier death.<sup>142</sup>

Nowhere does the Commentary discuss this effect.<sup>143</sup>

142. Latimer & McGregor, *supra* note 65, at 1134-35 (emphasis added). For studies uncovering defects in physician communication with patients and in physician responsiveness to patient wishes in end-of-life situations, see note 125, *supra* and notes 154-56, *infra*. Leon Kass makes this point as well:

[L]egalized mercy killing . . .

. . . will make a world of psychic difference . . . for conscientious physicians. How easily will they be able to care wholeheartedly for patients when it is always possible to think of killing them as a "therapeutic option"? Shall it be penicillin and a respirator one more time, or perhaps just an overdose of morphine this time?

. . . . A physician friend who worked many years in a hospice caring for dying patients explained it to me . . . : "Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into to caring for them as they lay dying." The psychological burden of the license to kill (not to speak of the brutalization of the physician-killers) could very well be an intolerably high price to pay for physician-assisted euthanasia, especially if it also leads to greater remoteness, aloofness, and indifference as defenses against the guilt associated with harming those we care for.

Kass, *supra* note 138, at 35-36.

143. Similar points can be made about the chemistry of the patient's relationship with family and friends:

[T]he absolute fixed tabu against suicide . . . has served to make the patient's right to expect the care of her family or community fixed and unquestioned. As long as a human being's natural life exists the family and/or institutional caretakers are morally obligated to offer support and care. . . . When the option or choice to end a life is morally permitted, then the interpersonal situation changes. One must justify his or her choice to go on living and ask why one should voluntarily continue to exact care or be dependent on others.

Callahan, *supra* note 34, at 313.

6. *Must Not the Calculus Include Further Consequences to the Medical Professions?* Further consequences could be extensive. Studies suggest that a great many patients will request assisted suicide<sup>144</sup> and that a sizable percentage of physicians will receive such requests.<sup>145</sup> At issue is nothing less than a fundamental reorientation of the ethics of the health care professions.<sup>146</sup>

A physician who assisted in suicide would contravene the Hippocratic Oath, in which the physician pledges: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."<sup>147</sup> Regrettably, many graduating medical students these days are not asked to take the Hippocratic Oath. However, medical authorities continue to condemn assisting in suicide.<sup>148</sup> The AMA's Code of Medical Ethics states that "[p]hysician assisted suicide is fundamentally incompatible with the physician's role as healer."<sup>149</sup> A leading

144. See notes 184-86, *infra*, and accompanying text.

145. See Anthony L. Back, Jeffery I. Wallace, Helene E. Starks, & Robert A. Perlman, *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 923 (1996) ("Among our responding physicians, 26% had received an explicit request [for physician-assisted suicide or euthanasia] at some point in the past, and 13% had received an explicit request in the past year."); Emanuel, *supra* note 71, at 1808 ("More than 50% of oncologists [studied] had received requests for euthanasia or physician-assisted suicide."); cf. David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 NEW ENG. J. MED. 1374, 1375 (1996) (17% of critical care nurses reported receiving requests to engage in euthanasia or to assist in suicide). Asch's study is criticized in Colleen Scanlon, *Euthanasia and Nursing Practice—Right Question, Wrong Answer*, 334 NEW ENG. J. MED. 1401 (1996).

146. Cf. Miles J. Edwards & Susan W. Tolle, *Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish*, 117 ANNALS INTERNAL MED. 254, 256 (1992).

[W]e were struck by the gravity of what we had done. Doubts kept creeping into our minds. We each experienced a wave of disquieting emotion, feelings that we had killed this patient. . . . This anguish continued in both of us for several days. One of us sought counsel from a psychiatrist who reinforced our belief that we did the right thing.

*Id.* at 256.

147. LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION AND INTERPRETATION* 3 (1943). See also HIPPOCRATES, *OATH*, reprinted in 1 HIPPOCRATES 299 (W.H.S. Jones trans., 1923) ("Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.").

148. See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 226-27 (1994); Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229 (1992); Public Policy Committee, American Geriatrics Society, *Voluntary Active Euthanasia*, 39 J. AM. GERIATRICS SOC. 826 (1991); *U.S. Doctors Reaffirm Opposition to Euthanasia*, BRITISH MED. J., July 6, 1996, at 11; see also Latimer & McGregor, *supra* note 65, at 1135 (noting that experts in palliative medicine conclude that "assistance or counseling in suicide is not a supportable pattern of medical practice and cannot be considered as part of palliative care"); Orentlicher, *supra* note 41, at 1844, 1845.

149. Council on Ethical and Judicial Affairs, American Medical Association, *CODE OF*

treatise on medical ethics states that:

[The right to physician-assisted suicide] has almost never been recognized in law or in codes of medical ethics. The traditional belief is that we should altogether prohibit such forms of assistance in health care while authorizing letting die in a certain range of cases. Standards of health care ethics from the time of the Hippocratic oath to the present strictly prohibit direct assistance in death, even if a patient has good reasons for wanting to die. For example, in 1991, the American Geriatrics Society opposed all physician involvement in killing or assistance in suicide. In an influential statement passed in 1973 and revised in 1988 and 1991, the American Medical Association Council on Ethical and Judicial Affairs allowed forgoing life-sustaining treatments but prohibited any "intentional termination of the life of one human being by another—mercy killing." Whether letting particular patients die is morally acceptable depends on several factors in this policy, but if the deaths involve killing—even in circumstances identical to those in which a patient is allowed to die—they are never justifiable.<sup>150</sup>

Nurses' ethics are equally decisive:

The American Nurses Association . . . believes that the nurse should not participate in assisted suicide. Such an act is in violation of the *Code for Nurses* . . . and the ethical traditions of the profession.

....

The profession of nursing is built upon the Hippocratic tradition "do no harm" and an ethic of moral opposition to killing another human being. . . .

Nursing has a social contract with society that is based on trust and therefore patients must be able to trust that nurses will not actively take human life.<sup>151</sup>

A similar tradition guides the hospice movement, which was founded specifically because of objection to euthanasia and in an effort to provide an alternative to it. The National Hospice Organization has stated that euthanasia and assisted suicide

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MEDICAL ETHICS § 2.211 (1994) (the provision goes on to note that the practice "would be difficult or impossible to control, and would pose serious societal risks").

150. BEAUCHAMP & CHILDRESS, *supra* note 148, at 226-27.

151. AMERICAN NURSES ASSOCIATION, POSITION STATEMENT ON ASSISTED SUICIDE 1, 3 (1994).

violate “all aspects of medical ethics.”<sup>152</sup>

Medical ethics may already be in a somewhat fluid state, as standard practices are being changed by legal developments pertaining to managed care and withdrawal of life support.<sup>153</sup> Medical academics at Hebrew University in Jerusalem, in an analysis of American practice published last May, conclude that:

—“[d]uring the last few years, [American] physicians have become more concerned with societal needs than with their individual patient needs;”<sup>154</sup>

—it has become much more common in recent years for American physicians to withhold or withdraw treatment in critical-care units;<sup>155</sup> and

—“[u]p to 79% of deaths in the ICU have been shown to occur after the forgoing of life-prolonging therapies. Treatments such as CPR, which initially were mandatory in [sic] all patients in the ICU, have become optional and have ultimately become unavailable for some patients.”<sup>156</sup>

Medical ethics would be further changed by the Act. More accurately, medical ethics would be supplanted by statutes and regulations.<sup>157</sup> Such a development should be objectionable to

152. Campbell, *supra* 65, at 38 (quoting the National Hospice Organization).

153. See Steven H. Miles, *Physician-Assisted Suicide and the Profession's Gyrocompass*, HASTINGS CTR. REP., May-June 1995, at 17, 18-19.

A shift in the professional ethic about medical killing from a substantive conclusion against physician-assisted suicide or voluntary active euthanasia to one of nonjudgmental process, consent, and bureaucratic contracts signals a fundamental change in the moral boundaries and relationships between healers, patients, and society. Meanwhile, the United States is restructuring the clinician-patient relationship into new... configurations within powerful institutions in which clinicians are accountable for the health of both individuals and of populations on a finite budget. . . . The tide is running too fast to recalibrate this gyrocompass . . . .

*Id.*

154. Sprung, *supra* note 34, at 513 (“Health-care reform has emphasized cost containment . . . . [Physicians] have been told not to do everything that is in the best interests of their patient but rather to do as much as is reasonable.”) (references omitted); see also John M. Luce, *The Changing Physician-Patient Relationship in Critical Care Medicine Under Health Care Reform*, 150 AM. J. RESPIR. CRIT. CARE MED. 266 (1994) (urging physicians to embrace a communitarian ethic).

155. See Sprung, *supra* note 34, at 513. For similar observations, not specifically about critical care units, see Orentlicher, *supra* note 41, at 2103.

156. Sprung, *supra* note 34, at 513 (references omitted).

157. The Act affords an immunity from “professional sanction” for complying health care workers, see Model Act § 13(b). The Act also gives rule-making powers to the Department of Public Health, see Model Act § 9(b). Further, the Act provides that “[t]he Board of Registration in Medicine . . . may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the

physicians and other health care workers because it means further legal colonization of their professions. It also should be objectionable to anyone who believes that the historical traditions of the healing professions are a reliable guide to practices consistent with good medical care. It *will* be objectionable to many; as noted earlier, fifty-two percent of Michigan physicians in a recent survey said they would not participate in physician-assisted suicide even if it were legal.<sup>158</sup>

Because the attempt to induce drastic changes in medical ethics would be objectionable to many, its occurrence might result in a fragmentation of the medical profession. Fragmentation over assisted suicide is already afflicting the profession of hospice workers in Oregon:

[The Oregon Death with Dignity Act] permits providers and institutions to opt out of participation in the law. Yet to many hospice caregivers this provision for dissent and conscientious objection appears to permit abandonment of a patient. Thus, an important policy and practical question for the hospice community . . . concerns whether fidelity and nonabandonment of the hospice patient *requires* some level of participation by the hospice.

. . . [D]ifferences emerged not only among hospice programs, but also within them, with some caregivers expressing fervent opposition to participation and other hospice staff equally adamant in support of participation. Thus, the moral fallout of [the Oregon Act] . . . involved a collapse of the shared value framework that has guided hospice for the last two decades.

. . . .

. . . . At the very least, every hospice will undergo some internal discomfort, and, at the worst, complete upheaval and long-lasting injuries . . . .

. . . . [T]he nature and mission of hospice in Oregon will be irreversibly altered.<sup>159</sup>

The unity of a profession depends on its members'

Department" and must submit proposed rules to the Department for review. Model Act § 9(c).

158. See Bachman, *supra* note 61, at 306. For a discussion of the provisions of the Act aimed at protecting conscientiously objecting physicians and healthcare facilities, see Section II.B of this Article, *supra*.

159. Campbell, *supra* note 65, at 40, 43 (1995).

acceptance of common purposes and principles. When basic divergences develop over fundamental and recurrent matters, the profession stands to lose its coherence. The crisis among hospices in Oregon could engulf all the healing professions.

These alterations could only grow deeper during the months and years after the adoption of the Act. Some people profess contempt for slippery slope arguments,<sup>160</sup> but there is nothing foolish about fear of a slope when powerful ideological groups—internationally organized under the umbrella of the World Federation of Right-to-Die Societies<sup>161</sup>—are standing nearby waiting to give people a push. Here in the United States, suicide-assistance legislation was proposed in at least eleven States in 1995;<sup>162</sup> the Act is the next (more permissive) wave of this same assault. Were it to be enacted, efforts to broaden it would undoubtedly follow soon after.

Some efforts to legalize assisted suicide may succeed through challenges to the constitutionality of legal restrictions. A State has a well-recognized interest in “the protection and preservation of human life.”<sup>163</sup> However, once it has vitiated that protection in an important way it may find it hard to defend “technical” limitations against assertions of irrationality, arbitrariness, discrimination, vagueness, and infringement on the right to privacy.<sup>164</sup> It may become difficult to defend the

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160. For a recent defense of slippery slope arguments and citations to authorities for and against them, see Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 749-53 (1995).

161. See Rita L. Marker, Joseph R. Stanton, Mark E. Recznik, & Keith A. Fournier, *Euthanasia: A Historical Overview*, 2 MD. J. CONTEMP. LEGAL ISSUES 257 (1991).

162. In addition to the Oregon Death with Dignity Act, *supra* note 4, see, for example, A.B. 1080, 1995-96 Reg. Sess. (Cal. 1995); H.R. 1308, 60th Leg., 1st Sess. (Colo. 1995); S. 334, 1995 Leg., Reg. Sess. (Conn. 1995); H.R. 552, 117th Leg., 1st Sess. (Me. 1995); H.R. 933, 1995 Leg. Sess. (Md. 1995); H.R. 3173, 179th Leg., 1st Sess. (Mass. 1995); H.R. 4134, 88th Leg., 1995 Sess. (Mich. 1995); H.R. 339, 1995 Reg. Sess. (N.H. 1995); S. 446, 42d Leg., 1st Sess. (N.M. 1995); S. 5596, 54th Leg., 1996 Sess. (Wash. 1995).

163. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 282 (1990) (concluding that “a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.”); *Compassion in Dying v. Washington*, 79 F.3d 790, 817 (9th Cir.) (en banc) (concluding that “[t]he state may assert its interest in preserving life in all cases, including those of terminally ill, competent adults who wish to hasten their deaths”), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

164. See *Compassion in Dying*, 79 F.3d at 839 n. 140; *Lee v. Oregon*, 869 F. Supp. 1491, 1499 (D. Or. 1994), *criticized in Compassion in Dying*, 79 F.3d at 838. See generally Kamisar, *supra* note 160, at 749-53 (1995); Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CTR. REP., May-June 1993, at 32; Powell & Cohen, *supra* note 99.

requirement that the assistance in suicide be rendered by a physician. Why not nurses or family members?<sup>165</sup> It may become difficult to defend the competence requirement against challenges brought "on behalf of" incompetent patients who "seek" death by proxy consent. Thus it may become legally permissible (even under certain circumstances legally mandatory)<sup>166</sup> to terminate the lives of the mentally ill and other incapacitated persons.<sup>167</sup>

It may become difficult to defend the requirements that ensure that the actual killing will be done by the patient rather than the physician. Proponents of assisted suicide will argue, as some have already argued in the *New England Journal of Medicine*, that such requirements are unfair to patients who are physically unable to commit suicide.<sup>168</sup> Thus it may become legally permissible, and perhaps in some circumstances even

Washington permits adults to have 'life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconsciousness'. . . . In adopting the statute, the Washington legislature necessarily determined that the state's interest in preserving life is not so weighty that it ought to thwart the informed desire of a terminally ill, competent adult to refuse medical treatment.

*Compassion in Dying*, 79 F.3d at 839 n.140.

165. See *Compassion in Dying*, 79 F.3d 790, 817.

We would add that those whose services are essential to help the terminally ill patient obtain and take that medication and who act under the supervision or direction of a physician are necessarily covered by our ruling. That includes the pharmacist who fills the prescription; the health care worker who facilitates the process; the family member or loved one who opens the bottle, places the pills in the patient's hand, advises him how many pills to take, and provides the necessary tea, water or other liquids; or the persons who help the patient to his death bed and provide the love and comfort so essential to a peaceful death.

*Id.*

166. See the discussion in Section II.B of this Article, *supra*, of the ways in which the Act may mandate cooperation in assisted suicide.

167. See *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987), *amended*, 757 P.2d 534 (1988); *In the Matter of the Welfare of Colyer*, 99 Wash.2d 114, 660 P.2d 738 (1983). These cases extend a right to refuse treatment to instances where the refusal is made by a second party "on behalf of" an incapacitated person. They are cited with apparent approval in *Compassion in Dying*, 79 F.3d at 851.

168. See Christopher J. Ryan & Miranda Kaye, *Sounding Board: Euthanasia in Australia—The Northern Territory Rights of the Terminally Ill Act*, 334 NEW ENG. J. MED. 326, 327 (1996):

The ethical distinction, if any, between physician-assisted suicide and voluntary euthanasia has been debated extensively. Allowing voluntary euthanasia means that in many cases it will be easier to administer substances intravenously and thus improve the reliability of absorption, the rapidity of death, and the ability to titrate the dose to obtain the effect. Disallowing euthanasia would make physician-assisted death unavailable to patients who are competent to request assistance but physically unable to administer the necessary substances themselves. (references omitted).

mandatory, to commit euthanasia. A leading treatise on medical ethics states that "[i]t seems likely that assisted suicide will be the driving force behind efforts to alter rules against killing in medicine."<sup>169</sup> A similar strategy is being pursued in Germany, where the German Society for Humane Dying takes the view that legalizing assisted suicide is a necessary step towards legalizing euthanasia.<sup>170</sup>

Things have got to the point in the Netherlands where, owing to the leniency of the authorities,<sup>171</sup> the rate of voluntary, active euthanasia has increased rapidly in recent years; that practice accounted for at least 2.3% of all deaths in 1995.<sup>172</sup> Half of all Dutch doctors have performed euthanasia.<sup>173</sup> And,

169. BEAUCHAMP & CHILDRESS, *supra* note 148, at 227.

170. See MARGARET P. BATTIN, *THE LEAST WORST DEATH: ESSAYS IN BIOETHICS ON THE END OF LIFE* 257-58 (1994). There is also a body of pro-euthanasia opinion in China. See Peicheng Hu, *The Acceptability of Active Euthanasia in China*, 12 *MED. & L.* 47 (1993).

[I]n China, there has always been the practice of 'filial piety' in order to allow the aged to live happily in their remaining years. . . .

But the epoch has changed, and ideas are changing. With the development of human society there has come new cultural thought—the life value theory. It says that hopeless life can only bring about suffering, so it is not valuable. . . .

. . . .

. . . . One hopes that by the efforts of the experts in medicine, ethics and law and the public, active euthanasia will become acceptable to the people of the world.

*Id.* at 50-52; see also Shi Da Pu, *Euthanasia in China: A Report*, 16 *J. MED. PHIL.* 131 (1991) (reporting physicians' acceptance of the practice).

171. See CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* (1991); Richard Fenigsen, *The Netherlands: New Regulations Concerning Euthanasia*, 9 *ISSUES L. & MED.* 167 (1993); John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, 9 *NOTRE DAME J.L. ETHICS & PUB. POL'Y* 407 (1995) [hereinafter Keown, *Slippery Slope*]; John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 *L.Q. REV.* 51 (1992); Alan D. Ogilvie & S.G. Potts, *Assisted Suicide for Depression: The Slippery Slope in Action?*, 309 *BRITISH MED. J.* 492 (1994); Johannes J. M. van Delden, Loes Pijnenborg, & Pual J. van der Maas, *The Rimmelink Study Two Years Later*, *HASTINGS CTR. REP.*, Nov.-Dec. 1993, at 24; van der Maas, *supra* note 28, at 669 (1991). See generally Simons, *supra* note 65.

172. See Paul J. van der Maas, Gerrit van der Wal, Ilinka Haverkate, Carmen L.M. de Graaff, John G.C. Kester, Bregje D. Onwuteaka-Philipsen, Agnes van der Heide, Jacqueline M. Bosma, & Dick L. Willems, *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 *NEW ENG. J. MED.* 1699 (1996).

In the interview study 2.3 percent of all deaths resulted from euthanasia, as compared with 2.4 percent in the death-certificate study. In 1990 the rates were 1.9 and 1.7 percent, respectively. Assisted suicide occurred in 0.4 percent of deaths in the interview study and 0.2 percent of deaths in the death-certificate study, as compared with 0.3 and 0.2 percent, respectively, in 1990.

*Id.* at 1700.

173. G.H. Blijham, *The Person from Porlock. Ethical Issues in Terminal Care: The Dutch Perspective*, 3 *SUPPORT. CARE CANCER* 61 (1995); see also van der Maas, *supra* note 172, at

demonstrating that Holland has descended to the next level of horror, many euthanasia deaths are involuntary or not based on sufficient consent.<sup>174</sup> Fully 0.7% of deaths involved ending the patient's life without the patient's explicit, concurrent request.<sup>175</sup> In 48% of these "no explicit, concurrent request" cases the physician had no information establishing that the patient had expressed a wish for euthanasia.<sup>176</sup> It appears that in some such cases the physician omitted to discuss the matter with the patient's family and even with colleagues and nurses.<sup>177</sup>

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1701 (reporting that 53% of Dutch physicians interviewed said they had performed euthanasia, and that 29% confirmed that they had done so in the previous 24 months).

174. See Keown, *Slippery Slope*, *supra* note 171, at 426-32.

If one includes cases in which the patient's death is referred to as part of what the doctor aimed to achieve, then the total number of intentional killings by doctors [in the Netherlands in 1990] may not be far short of 26,350, in 15,258 (58%) of which the patient had not explicitly asked for death to be hastened.

*Id.* at 431-32. See also Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 ISSUES L. & MED. 123, 155 (1994); van Delden, *supra* note 171, at 24; Gerrit van der Wal, *Unrequested Termination of Life: Is It Permissible?* 7 BIOETHICS 330 (1993).

For authorities raising similar concerns about American practice, see note 177, *infra*; Asch, *supra* note 145, at 1376 (noting that "it could be calculated that" at least 7% of critical care nurses surveyed had on at least one occasion performed euthanasia or assisted in suicide without a request from either a patient or a surrogate). Asch's study is criticized in Scanlon, *supra* note 145. See also Lee, *supra* note 34, at 311 (reporting that 29% of respondents "thought that legalizing physician-assisted suicide could result in lethal overdoses being given to patients without their consent").

175. See van der Maas, *supra* note 172, at 1700.

176. *Id.* at 1701, 1704; see also Loes Pijnenborg, Paul J. van der Maas, Johannes J.M. van Delden, & C.W.N. Looman, *Life-Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1196 (1993).

177. See van der Maas, *supra* note 172, at 1701-02; see also van Delden, *supra* note 171, at 25. Compare the following findings about American practice in the area of withdrawal of treatment:

Despite physicians being incorrect about patient preferences for resuscitation and continued life, they often present information based on their own views and preferences, which alters patient decisions. They may make the decision themselves because they believe the patient or the family cannot understand the medical complexity of the situation or because they believe it is a medical decision. Physicians may simply override the patient-family decision because they disagree.

Sprung, *supra* note 34, at 513 (references omitted). See also David A. Asch, John Hansen-Flaschen, & P.N. Lanken, *Decisions to Limit or Continue Life-Sustaining Treatment by Critical-Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes*, 151 AM. J. RESPIR. CRIT. CARE MED. 288, 288 (1995) (finding that 82-83% of U.S. physicians unilaterally withhold or withdraw therapies they believe are futile). "Many physicians reported withholding or withdrawing life-sustaining treatment without the consent of the patient or family or without their knowledge, and some reported doing so over patients' or family members' objections." *Id.* at 290. The authors state that their findings "may be a disturbing sign of paternalism" on the part of doctors. *Id.* at 291. Cf. AMA Report, *Care of the Dying Patient*, *supra* note 124, at 476 ("Physicians' predictions of patients' preferences for resuscitation were no better than random."); Orentlicher, *supra* note 41, at 2101.

According to leading Dutch authorities, "once one accepts euthanasia and assisted suicide, the principle of universalizability forces one to accept termination of life without explicit request."<sup>178</sup> Among Dutch physicians interviewed in a recent study, "23 percent said that at some time they had ended a patient's life without his or her explicit request, and 32 percent said that they had never done so but that they could conceive of a situation in which they would."<sup>179</sup> A substantial body of Dutch medical opinion now favors terminating the lives of babies when "quality of life" considerations suggest it.<sup>180</sup> This may in fact have been done in some cases.<sup>181</sup>

7. *Must Not the Calculus Include Implications for the Law?* While more and more of Anglo-American law has become plasticized, "fact-sensitive," malleable according to the circumstances, until recently the law of homicide has not acquired such characteristics.<sup>182</sup> Although more and more of the law has become both "economic," accepting utility as a guide, and libertarian, accepting preferences and consents of affected parties as prime determinants, the law of homicide has generally remained firmly nonconsequentialist and moralistic. Anglo-American courts have not, for example, embraced the principle that appears in Dutch euthanasia cases accepting that a *force majeure* or necessity defense is established by patient suffering.<sup>183</sup> Anglo-American law has traditionally been uncompromising

178. van Delden, *supra* note 171, at 24. See also Keown, *Slippery Slope*, *supra* note 171, at 439 (reporting that "some of the legal authorities in the Netherlands now openly condone non-voluntary euthanasia in certain circumstances").

179. van der Maas, *supra* note 172, at 1701.

180. Zier Versluys & Richard de Leeuw, *A Dutch Report on the Ethics of Neonatal Care*, 21 J. MED. ETHICS 14 (1995).

The Dutch Paediatric Association reports consensus among its members regarding the necessity to take the future quality of life into account when reaching decisions regarding the continuation or dis-continuation of life-prolonging treatment. The paramount importance of the discussion with the parents is stressed. Dissension exists regarding active euthanasia in the newborn, both opinions being respected. If dissension exists within the profession parents should be informed and if necessary referred to a doctor who shares their moral views.

*Id.* at 14.

181. See Simons, *supra* note 65 (referring to "incidents [of euthanasia] when people have not explicitly asked for death, like those involving a comatose patient or severely deformed newborn babies").

182. See John M. Finnis, Bland: *Crossing the Rubicon?*, 109 L.Q. REV. 329 (1993).

183. See generally Keown, *Slippery Slope*, *supra* note 171; Johan Legemaate, *Legal Aspects of Euthanasia and Assisted Suicide in The Netherlands, 1973-1994*, 4 CAM. Q. HEALTH CARE ETHICS 112 (1995).

about the defense of innocent human life. It has not accepted consent as a defense to the crime of homicide. It has not accepted consent as a defense to charges of mutilating assault. It has not accepted explanations that a person's life is painful or meaningless as justifications for destroying it.

In the wake of the Holocaust, it was largely uncompromising Anglo-American legal doctrines that justified the Nuremberg trials and the international conventions which followed.

We undermine these doctrines at our peril.

8. *Must Not the Calculus Take Account of Wider Social and Political Implications?* Perhaps a very large population would come to take advantage of the services contemplated by the Act.<sup>184</sup> A recent study found that fifty-five percent of HIV-infected patients had considered physician-assisted suicide for themselves,<sup>185</sup> and substantial desire for death or interest in suicide has also been reported among cancer patients.<sup>186</sup>

The Commentary offers us not the slightest reflection on the changes that may be wrought on the larger communities affected: on a town, for example, by the practice of suicide among its residents. Some communities have reported the occurrence of "copy-cat" suicides.<sup>187</sup>

And what of the effects on our public morality, and on our sense of what we owe one another and what we stand for as a national community and as a wider civilization? The

184. See Jay A. Jacobson, Evelyn M. Kasworm, Margaret P. Battin, Jeffrey R. Botkin, Leslie P. Francis, & David Green, *Decedents' Reported Preferences for Physician-Assisted Death: A Survey of Informants Listed on Death Certificates in Utah*, 6 J. CLINICAL ETHICS 149, 150 (1995) (reporting that "about 16 percent of decedents reportedly would have wanted either physician-assisted suicide or euthanasia"). A large increase in the numbers of patients seeking active euthanasia or physician-assisted suicide in the Netherlands is reported in van der Maas, *supra* note 172, at 1700.

185. See Breitbart, Rosenfeld, & Passik, *supra* note 28, at 239. Cf. H-M. Laane, *Euthanasia, Assisted Suicide and AIDS*, 7 AIDS CARE S163 (1995) ("The calculated overall incidence of euthanasia/assisted suicide among [persons with AIDS] in Amsterdam is about 26%.").

186. See Chochinov, *supra* note 28; Emanuel, *supra* note 71, at 1808.

187. See Block & Billings, *supra* note 26, at 446-47.

Practitioners report anecdotally that recent attention to legislative proposals for legalization of euthanasia, the publication of *Final Exit*, and widely reported cases of assisted suicide appear to be associated with increased frequency of such requests. This impressionistic data are reinforced by the evidence of recent increase in suicide rates among Danish patients and by a study that documented an increase in the frequency of suicide by asphyxiation, as recommended in *Final Exit*, following the book's publication.

*Id.* (reference omitted). But see Brent, *supra* note 132, at 509 (unable to detect a copy-cat or similar effect).

understanding that "any man's death diminishes me,"<sup>188</sup> that human life is sacred, and that social and political institutions have a trust looking toward the preservation of life, has been hard-won in history, yet in this century has been subjected to both violent assault and quiet vitiation. Alter practice as regards preserving life, and one goes a long way towards altering the principle that life ought to be preserved.

The poor, the vulnerable, and the elderly are notoriously neglected in many parts of the health-care system. An important American Medical Association study released earlier this year underlines this concern as applied to dying patients:

Hospice is mostly available to adults with . . . families with enough wealth to provide unpaid care indefinitely . . . [The] homeless, [or] isolated, . . . are regularly excluded . . .

....

. . . Expertise in pain management is often not available to patients, and comprehensive and enduring care is the exception. . . .

....

. . . In the current system of care, many dying persons suffer needlessly, burden their families, and die isolated from family and community.<sup>189</sup>

An increasingly uncaring attitude toward the poor and the elderly can be detected today in many quarters. If assisted suicide were legalized, it is not unlikely that we would eventually encounter the following arguments: "If the poor and elderly are so badly off, they can always get a physician-assisted suicide;"<sup>190</sup> "Why respond to calls for better palliative care and pain management when people can choose suicide;" and, "Why spend money for hospices? They are uneconomical because they

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188. JOHN DONNE, *Meditation XVII, DEVOTIONS UPON EMERGENT OCCASIONS* 87 (Anthony Raspa ed., McGill-Queen's University Press 1975) (1624).

189. AMA Report, *Care of the Dying Patient*, *supra* note 124, at 476, 477. The report also notes that terminally ill patients "with serious pain might be effectively treated for an intent to commit suicide by having effective pain treatment." *Id.* at 475.

190. See also *Compassion in Dying v. Washington*, 79 F.3d 790, 826 (9th Cir. 1996) ("[w]e are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration"), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

will only diminish the number of people choosing suicide."<sup>191</sup>

Such consequences are especially likely where, as under this Act, the medical profession is recruited into the projects of death. A policy generally applied by doctors, in the hospitals to which we entrust our sick friends, and where we have our babies, will come to be wrapped with the authority of the physician's prestige as a minister to the body and an anciently recognized guardian of health.

This prestige helped the Nazis conceal and legitimize the Holocaust:

The key word in the healing-killing reversal [at Auschwitz] is *Sonderbehandlung*, or "special treatment" . . . We have seen how this euphemism for killing insinuated something on the order of medical therapy, along with a standing that was "more legal than legal." In general bureaucratic usage, "special" [the prefix] was the opposite of "regular": special trains and regular trains, special courts and regular courts, etc. Special procedures were deemed necessary because of special conditions. The word not only detoxified killing and aided in its routinization but, at the same time, infused that killing with a near-mystical priority for the "Auschwitz self" in carrying it out. Killing assumed a certain feeling of necessity and appropriateness, enhanced by the medical, as well as the military, aura surrounding it.<sup>192</sup>

## VI. BEYOND AUTONOMY AND UTILITY

A more fundamental point is that the ethics and anthropology of autonomy (in the sense understood by the drafters)<sup>193</sup> and of utilitarianism are limited and partial. They emphasize only the shell of a moral human act or a satisfactory human life—its edges. They recognize one of its conditions (the absence of restraint) and one of its usual outcomes (pleasure) but omit

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191. See AMERICAN NURSES ASSOCIATION, *supra* note 151, at 3 (concluding that "[t]he availability of assisted suicide could foreseeably weaken the goal of providing quality care for the dying").

Under the Model Act, the "responsible physician" must "offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness or alleviating symptoms." Model Act § 4(a). If the patient cannot afford it, it need not be offered. See Commentary, *supra* note 2, at 20.

192. ROBERT JAY LIFTON, *THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE* 150-51 (1986) (the brackets around "the prefix" are also present in the original).

193. See Section IV of this Article.

much of its substance.

But the roots of our law and much of our civilization reach into another moral tradition, informed not by Hume and Hobbes and Smith and Bentham and Mill but by Aristotle, by Judaism, and by Christianity.<sup>194</sup> This tradition locates the good of the human life not in autonomy or pleasure but in virtue; in a life's projects and in its intentions—for example, in friendship, philosophy, and faith. In the Stoic tradition, the good is identified with the person's status as a "spark of the Divine." In the Jewish and Christian traditions, the sacred quality of human lives arises from their creation in the image of God, with a standing divinely conferred:

When I behold Your heavens, the work of Your fingers,  
the moon and stars that You set in place,  
what is man that You have been mindful of him,  
mortal man that You have taken note of him,  
that You have made him little less than divine . . . .<sup>195</sup>

The drafters make no allusion to these traditions, nor even to modern versions of humanism that look beyond rights and autonomy.<sup>196</sup> Nor do the drafters discuss the fiduciary duty of the

194. For a close analysis and a review of several traditions, see JOHN KLEINIG, *VALUING LIFE* (1991). For a valuable criticism of euthanasia from a nonconsequentialist point of view, see John Finnis, *A Philosophical Case Against Euthanasia*, in *EUTHANASIA EXAMINED*, *supra* note 35, at 23; see also John Finnis, *The Fragile Case for Euthanasia: A Reply to John Harris*, in *EUTHANASIA EXAMINED*, *supra* note 35, at 46; John Finnis, *Misunderstanding the Case Against Euthanasia: Response to Harris's First Reply*, in *EUTHANASIA EXAMINED*, *supra* note 35, at 62.

195. Psalm 8, in TANAKH: JEWISH PUBLICATION SOCIETY TRANSLATION OF THE HOLY SCRIPTURES ACCORDING TO THE TRADITIONAL HEBREW TEXT 1115 (Jewish Publication Society trans., 1985); see also *EUTHANASIA AND CLINICAL PRACTICE: TRENDS, PRINCIPLES AND ALTERNATIVES: A WORKING PARTY REPORT* (1982), reprinted in *EUTHANASIA, CLINICAL PRACTICE AND THE LAW* 1, *supra* note 102, at 51-58 (describing the Christian and especially the Roman Catholic condemnation of euthanasia); *EVANGELIUM VITAE* (Encyclical of Pope John Paul II, March 25, 1995) (discussing the condemnation of killing in the Christian tradition); Damien Keown & John Keown, *Killing, Karma and Caring: Euthanasia in Buddhism and Christianity*, 21 *J. MED. ETHICS* 265 (1995) (describing the sanctity-of-life objection to killing in the Christian and Buddhist traditions).

196. See, e.g., BRODY, *supra* note 105, at 32-33 (advancing the view that respect for personhood goes beyond respecting people's rights, and that therefore physicians must try to save the lives of any people who have tried to kill themselves); Callahan, *supra* note 34.

physician, the Hippocratic tradition, or the profound horror that our culture directs towards an act of homicide. Nowhere in the Act, nor in the highly footnoted Commentary, do we find the ghost of a reference to this set of ethical traditions.

These omissions can come as no surprise to someone who inhabits today's academic world, where entire stretches of terrain have been systematically defoliated of classical and theistic thought. These omissions are no surprise, but still a disgrace. The disgrace is worse in light of the fact that this legislation is proposed to govern the conduct of a population not composed entirely of politically-correct teaching assistants and graduate students, but also including, for example, professionals in the many religiously-affiliated medical institutions of this country. How can these authors claim authority for drafting legislation intended to govern people without taking the slightest account of the their major moral traditions?

Omit these central traditions, disregard their insights into the human good, limit one's anthropology to the shells of autonomy and pleasure, and you will be driven to an equally limited view of the value of human beings; you will be led, like Hume in his essay *On Suicide*, to compare them to oysters.<sup>197</sup> Limit your anthropology in these ways and you limit the conditions under which you see any sense in many peoples' survival. You will say, with Nietzsche:

In a certain state it is indecent to go on living. To vegetate on in cowardly dependence on physicians and medicaments after the meaning of life, the *right* to life, has been lost ought to entail the profound contempt of society.<sup>198</sup>

You will be led to reconstruct our jurisprudence in a way that makes it possible to put an end to such people.

197. See David Hume, *On Suicide*, in DAVID HUME, *ESSAYS ON SUICIDE, AND THE IMMORTALITY OF THE SOUL* 1, 11 (Thoemmes Press 1992) (1783) ("the life of a man is of no greater importance to the universe than that of an oyster"); see also RICHARD POSNER, *THE PROBLEMS OF JURISPRUDENCE* 382 (1990) ("Economic man' is . . . a person whose behavior is completely determined by incentives; his rationality is no different from that of a pigeon or a rat."). Judge Posner seems not to be agreeing with this anthropology but merely to be reporting it.

198. FRIEDRICH NIETZSCHE, *TWILIGHT OF THE IDOLS AND THE ANTICHRIST* 88 (R.J. Hollindale trans., Penguin Books 1968) (1889 & 1895).

