
**TERMINAL AMBIGUITY:
LAW, ETHICS AND POLICY IN THE ASSISTED
DYING DEBATE**

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*Don't let us get sick
Don't let us get old
Don't let us get stupid, all right?
Just make us be brave
And make us play nice
And let us be together tonight*

Warren Zevon¹

I. INTRODUCTION

Dostoyevsky's Kirilov inhabits a solitary night-time world and dreams of becoming a god.² He will accomplish this by killing himself, the supreme act of free will that will deliver him from pain and fear.³ By conquering these demons, Kirilov will obliterate God, purveyor of the pain and fear of death.⁴ And, with God removed, nothing will restrain the triumph of free will in a world where men are so liberated that they care not whether they live or die.⁵ Spurning the after-life, Kirilov seeks only that present moment where time abruptly halts and becomes eternal.⁶ On his suicide note he wants to draw a face with a tongue sticking out.⁷

It is easy to dismiss Kirilov as unhinged, a minor player in one of the blackest of comedies. However, if his logic is not entirely persuasive, it is, at least, seductive. Many of us, stricken with painful, lingering illness, might seek to challenge God's hold and end the suffering on our own. To determine the time,

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¹ WARREN ZEVON, *Don't Let Us Get Sick, on LIFE'LL KILL YA* (Artemis Records 2000).

² FYODOR DOSTOYEVSKY, *THE POSSESSED* (Constance Garnett trans., Random House 1936) (1872).

³ *Id.* at 114-15.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.* at 630.

place, and manner of our death—to substitute our judgment for that of God and nature—is the ultimate act of taking life and death into our own hands. Whether or not we aspire to some brief flicker of omnipotence, we have led ourselves to believe that autonomy is good for us, even if we have to kill ourselves to prove it.

Modern medicine, with all of its blessings and curses, has taken the self-determination debate to new extremes. In many ways it has sparked the fight of our lives. For the past several decades, patients have clamored for various rights: the right of informed consent, the right to refuse medical treatment, the right to die, the right to enlist the aid of others in helping us die. Though some of these issues cannot be easily resolved philosophically, let alone legally, courts and the legislatures have been appointed to define and delimit the rights of the ill and the dying. Now, having achieved some measure of empowerment, we must ask ourselves: how much is enough? How much empowerment is too much before it overwhelms the boundaries of our understanding, our ability to act intelligently in our own interest and that of others?

Suicide, traditionally an intensely private act, has become a matter of public discourse. We recognize that life, once woefully short, can, largely through medical intervention, become intolerably long and burdensome. To wrest control from God and the doctors, we turn to assisted suicide and euthanasia and ask that these measures be legitimated. Some would respond by freely and willingly handing over the instrumentalities of our death. Others would do so only under extraordinary circumstances. Many would agree to let us die, by removing respirators and artificial nutrition and hydration, but would not affirmatively help us die. Depending on where we stand on this continuum, there is either a little, or a lot, of Kirilov in all of us.

This essay examines, and rejects, several closely-held notions in the discourse on assisted suicide and euthanasia.⁸ The concept of a legal right to end one's life must yield to the pragmatic assessment of medical factors affecting the dying and the treatment options available to them. The legal entitlement framework has fostered a misperception that we must choose between assisted dying and a drawn-out, painful demise. Rather, this essay posits that end-of-life decisions—including, but not limited to, assisted suicide and euthanasia—properly belong within the matrix of competent, compassionate medical care. Patients, aided by physicians and loved ones, can be helped to make informed medical choices based on a range of treatment and life alternatives. In presenting these options, we outline the central legal and ethical arguments for and against assisted dying, elaborating on the merits and inconsistencies of each position.

At the start of the twenty-first century, our society has taken the measure of several judicial and legislative responses to end-of-life questions. The experi-

⁸ For purposes of verbal economy we will occasionally combine both practices under the term “assisted dying.”

ence of officially-sanctioned aid in dying in Oregon and the Netherlands has furnished us with some understanding of how doctors and patients approach the desire for death under a facilitative legal regime. And, because these issues cannot breathe in a vacuum, we must consider them in light of current end-of-life medical practices. Insistence on the right to aid in dying creates a danger of prematurely ending the debate. In that sense, the Supreme Court, in denying us that right, may well have saved us from ourselves. Further, in authorizing assisted suicide, the Oregon legislature may have produced the most potent reasons to oppose it. Against the backdrop of gross deficiencies in medical end-of-life practice and education, the assisted dying debate is sorely in need of a re-framing of the issues and new principles to guide its resolution.

This essay is divided into four parts. Part II explores the extent to which disease, including mental illness, contributes to an individual's desire for death. Severe, debilitating infirmity strongly supposes a quest for relief, but does not inevitably lead to suicide as the means to achieve it. On the other hand, those who seek assistance in dying may be struggling to assert their true selves as their minds and bodies deteriorate beyond recognition. Part III examines ethical and legal perspectives on the death debate. Ethicists and judges have too narrowly constricted the dialogue, unduly limiting their own reasoning and the range of available options. This section further argues that the dominant paradigms must give way to an expanded consideration of complex social and medical realities in the life of each patient. Part IV analyzes the legislative response to the assisted dying debate. This section places in context some very disturbing aspects—from the individual patient's perspective—of the experiences of Oregon and the Netherlands with officially-sanctioned aid in dying. Overall, this section concludes that the legislative efforts to delineate the right to die have failed. Part V of this essay suggests that autonomy and compassion play a far more circumscribed role in end-of-life care than previously supposed. Moreover, reliance on questionable assumptions has produced untenable distinctions that further cloud the debate between assisted suicide and euthanasia, and between euthanasia and withdrawal of treatment. This essay concludes by calling for a reconceptualization of the dialogue, first by insisting on expanding the scope of medical school training to remedy deficiencies in end-of-life care and second, by proposing that assisted dying is only one of several solutions to end-of-life concerns. In this life-and-death debate, well trained doctors and their patients, not lawyers and judges, are the most appropriate arbiters.

II. DESIRING DEATH

Everyone struggles against despair, but it always wins in the end. It has to. It's the thing that lets us say goodbye.

JEFFREY EUGENIDES, MIDDLESEX⁹

⁹ JEFFREY EUGENIDES, MIDDLESEX 524 (2002).

I never had that irresistible hunger for oblivion, not the way some people do. Mine was a surmountable despair. I just didn't. Surmount it.

DAVID LONG, *THE INHABITED WORLD*¹⁰

A. *Suicide: A Brief Overview*

Nearly forty years ago, A. Alvarez noted an extraordinary increase in intentional death by drugs in Japan and parts of Europe.¹¹ Death by overdose had substantially displaced some of the more traditional and more violent means of suicide—shooting, knife wounds, hanging, jumping, and drowning.¹² People were choosing to forego the convulsive agonies brought on by ingestion of arsenic and strychnine and were swallowing sleeping pills instead.¹³ One could slip away in peace and oblivion and achieve a death so painless it appeared “magical.”¹⁴ Indeed, it is not uncommon for death by overdose to be mistaken for death by natural causes.¹⁵

Given the choice, when the time comes, we would all like to die in our sleep. This yearning for a gentle, permanent release from pain and suffering is a potent force behind support for assisted dying. After all, the right to orchestrate our own end would be of little comfort if we had to do serious violence to ourselves in order to exercise it. But this rosy ideal of a merciful end remains far removed from the shocking barbarity of so many self-inflicted deaths. Whatever the chosen method, suicide is, traditionally, the last refuge for people with decidedly unquiet minds.

The “logic of suicide,” according to Alvarez, is “the unanswerable logic of a nightmare.”¹⁶ His illumination of the suicidal mind is mesmerizing:

Once a man decides to take his own life he enters a shut-off, impregnable but wholly convincing world where every detail fits and each incident reinforces his decision. An argument with a stranger in a bar, an expected letter which doesn't arrive, the wrong voice on the telephone, the wrong knock at the door, even a change in the weather—all seem charged with special meaning; they all contribute. The world of suicide is superstitious, full of omens.¹⁷

For the suicidal, despair obscures the boundary between present and future,

¹⁰ DAVID LONG, *THE INHABITED WORLD* 268 (2006).

¹¹ A. ALVAREZ, *THE SAVAGE GOD: A STUDY OF SUICIDE* 158 (W.W. Norton & Co. 1990) (1970).

¹² *Id.* at 159.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ KAY REDFIELD JAMISON, *NIGHT FALLS FAST* 30-31 (1999).

¹⁶ ALVAREZ, *supra* note 11, at 144.

¹⁷ *Id.* at 121-22.

“and the present is painful beyond solace.”¹⁸ The individual who views his life as a chain of failures may resort to an act that, by its very finality, is an ironic testament to success. Like Kirilov, one can rise above the wreckage, exert the power of will and be free to dictate how and when one will die. Yet even this moment of glory can be equivocal. Alvarez suggests that Kirilov is motivated less by his desire to become God than by the realization that he is so wretchedly un-godlike.¹⁹

Whatever external meaning society struggles to attribute to it, suicide is rooted in a “terminal inner loneliness which no amount of social engineering will alleviate.”²⁰ At the time of death, ninety to ninety-five percent of those who commit suicide suffer from a diagnosable mental disorder.²¹ “[D]epression and manic depression . . . schizophrenia, borderline and antisocial personality disorders, alcoholism and drug abuse”²² comprise the principal psychopathological causes.²³ Suicide is the eighth leading cause of death for all men in the United States, and the eleventh leading cause overall.²⁴ Although women attempt suicide during their lifetimes about three times more frequently than men, men are four times more likely to succeed in the effort.²⁵

Suicide especially afflicts the young and the elderly. Of persons over sixty-five, one in seven suffers from depression but the great majority receives no treatment.²⁶ Elderly persons are apt to hide their symptoms out of shame or fear of seeming weak.²⁷ Doctors often fail to recognize the signs of depression in their older patients, or may believe that “nothing can be done for people with ample reason to be depressed.”²⁸ Brain injury caused by stroke may promote depression, as can many medications commonly taken by the elderly: “steroids, anticancer drugs, . . . drugs for Parkinson’s disease, high blood pressure, heart disease, rheumatoid arthritis and pain.”²⁹ Medical advances that have prolonged the lives of the chronically ill elderly have also elevated the rate of

¹⁸ JAMISON, *supra* note 15, at 93.

¹⁹ ALVAREZ, *supra* note 11, at 146.

²⁰ *Id.* at 121.

²¹ JAMISON, *supra* note 15, at 100.

²² *Id.* at 100.

²³ *Id.* at 100.

²⁴ National Institute of Mental Health, *Suicide in the U.S.: Statistics and Prevention*, <http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention.shtml> (last visited Oct. 12, 2007).

²⁵ Centers for Disease Control and Prevention, *Understanding Suicide Fact Sheet 2006*, <http://www.cdc.gov/ncipc/pub-res/Suicide%20Fact%20Sheet.pdf> (last visited Oct. 12, 2007).

²⁶ Jane E. Brody, *Age is No Barrier to Lifting Depression’s Heavy Veil*, N.Y. TIMES, May 30, 2006, at F7, available at <http://www.nytimes.com/2006/05/30/health/psychology/30brod.html?ex=1170997200&en=d5ed319e9ba99f01&ei=5070>.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

suicide among older persons.³⁰ And, while older women suffer serious depression at twice the rate of older men, elderly white males are eight times more likely to kill themselves than women of the same age.³¹ In 2001, firearms were used in seventy-three percent of suicides by adults over the age of sixty-five.³² So much for serene oblivion at the end of life.

B. *Illness and Suicide*

Several medical conditions, originating in or strongly impacting the brain and central nervous system, may contribute to a higher rate of suicide.³³ These disorders—Huntington’s disease, multiple sclerosis, temporal lobe epilepsy, spinal cord injury, head and neck cancer, HIV/AIDS—can cause severe mood swings and sometimes dementia.³⁴ Overall, however, most people who kill themselves are in good physical health, including an estimated two-thirds of older people who die by suicide.³⁵ Terminally ill individuals comprise only a small proportion of suicides, perhaps as little as two to four percent.³⁶ The great majority of patients suffering from severe pain, disfigurement or disability do not desire death by suicide.³⁷ It is important not to minimize the increased risk of suicide among the chronically and terminally ill. But, more often than not, these individuals are “resilient, and fight for life throughout their illness.”³⁸ In one retrospective study, researchers found that a group of cancer patients who had committed suicide had “fewer psychosocial resources and showed a poorer adjustment to their illness than a control group of cancer patients who did not commit suicide.”³⁹ In another study, of those terminally ill patients who did express a wish to die, all displayed the symptoms of major depression.⁴⁰ Treatment for depression may dramatically reduce a patient’s

³⁰ Patrick J. Meehan *et al.*, *Suicides Among Older United States Residents: Epidemiologic Characteristics and Trends*, 81 AM. J. PUB. HEALTH 1198, 1199-1200 (1991).

³¹ Rummana Hussain, *Report: Elderly White Males Have Top Suicide Rate*, CHICAGO SUN-TIMES, Aug. 18, 2006, available at http://findarticles.com/p/articles/mi_qn4155/is_20060818/ai_n16643166.

³² Centers for Disease Control and Prevention, National Center for Injury Prevention and Control Suicide: Fact Sheet, <http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/suicidefactsheet.pdf> (last visited Oct. 12, 2007).

³³ JAMISON, *supra* note 15, at 103.

³⁴ Brody, *supra* note 26, at F7.

³⁵ N.Y. STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 12-13 (1994) (hereinafter referred to as “N.Y. TASK FORCE”).

³⁶ *Id.* at 12.

³⁷ *Id.* at 13.

³⁸ *Id.*

³⁹ James Henderson Brown, *et al.*, *Is it Normal for Terminally Ill Patients to Desire Death?*, 14 AM. J. OF PSYCHIATRY 208 (1986).

⁴⁰ *Id.* at 210.

wish to die, eliminating suicidal ideation in ninety percent of these cases.⁴¹

Patients with terminal illness face challenges in coping with conditions that are often progressive and debilitating.⁴² Treatment for depression may help them to strengthen their ability to adjust to these circumstances.⁴³ While many individuals with chronic or terminal illness may experience thoughts about suicide, most of them never act on those thoughts by committing suicide.⁴⁴ It is, apparently, a fallacy that terminal illness necessarily and normally contains a component of severe depression.⁴⁵ In fact, patients who become seriously ill sometimes undergo a phenomenon whereby the process of overcoming their fear of death “dissolves many other anxieties or neuroses.”⁴⁶ With these psychological distractions removed, patients are better able to appreciate the basic meaning of their lives.⁴⁷

Pain in varying levels of severity is a common symptom in dying patients, affecting a majority of those with cancer, AIDS, and at least half of those hospitalized with other diagnoses.⁴⁸ Pain can contribute to elevated levels of hormones that can induce stress to the heart and lungs.⁴⁹ It can also lead to heart attacks and strokes by causing blood pressure to spike, and can “consume so much of the body’s energy that the immune system degrades.”⁵⁰ When uncontrolled, pain can contribute to suicide and suicidal ideation.⁵¹ However, it is not generally an independent risk factor for suicide.⁵² Rather, the “significant variable in the relationship between pain and suicide is the interaction between pain and feelings of hopelessness and depression.”⁵³

Pain takes many forms and, because the experience is so subjective, it is not well understood. It may compound a patient’s problems by masking feelings of sadness and making depression harder to diagnose.⁵⁴ In addition, physical symptoms of chronic debilitating disease—appetite and weight loss, insomnia, fatigue and reduced concentration—often overlap with depressive symptoms, further complicating the diagnosis.⁵⁵ Patients with chronic, uncontrollable pain

⁴¹ N.Y. TASK FORCE, *supra* note 35, at 26.

⁴² *Id.* at 16.

⁴³ *Id.* at 26.

⁴⁴ *Id.* at 11.

⁴⁵ *Id.* at 16.

⁴⁶ *Id.* at 13.

⁴⁷ *Id.*

⁴⁸ Kathleen Foley, *Patients Need Better End-of-Life Care Rather Than Assisted Suicide*, in EUTHANASIA 190-91 (Loreta Medina ed., 2005).

⁴⁹ Tina Rosenberg, *Doctor or Drug Pusher?*, N.Y. TIMES MAG., June 17, 2007, at 50.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² N.Y. TASK FORCE, *supra* note 35, at 17.

⁵³ *Id.* at 17.

⁵⁴ Brown et al., *supra* note 39, at 209.

⁵⁵ *Id.* at 208-09.

may fall prey to feelings of anxiety, hopelessness and depression and see death as their only means of escape.⁵⁶ However, when used appropriately, “modern pain relief techniques can alleviate pain in all but extremely rare cases.”⁵⁷ When all else fails, terminal sedation can prevent the patient from experiencing the pain and suffering by producing a sleeplike state. This option is considered less than ideal because it robs the patient of consciousness but may be considered for the terminally ill in their last weeks or days of life.⁵⁸

Distinct from pain, suffering poisons a person’s spiritual and psychological state, often promoting “a sense of anguish, dread, foreboding, futility, meaninglessness” and loss of control.⁵⁹ Suffering also includes physical symptoms associated with severe or terminal illness—such as difficulty breathing, nausea, diarrhea, constipation and fatigue. Not all pain produces suffering, nor does suffering necessarily involve pain.⁶⁰ Neither is suffering confined to those with painful terminal illnesses. Patients with amyotrophic lateral sclerosis (ALS) and those who are quadriplegic due to spinal chord injury suffer intensely distressing disabilities and physical symptoms. In Brian Clark’s *Whose Life Is It Anyway?* the character of Ken Harrison, paralyzed from the neck down, tries to explain why his life is no longer worth living:

It’s a question of dignity. Look at me here. I can do nothing, not even the basic primitive functions. I cannot even urinate, I have a permanent catheter attached to me. Every few days my bowels are washed out. Every few hours two nurses have to turn me over or I would rot away from bedsores. Only my brain functions unimpaired but even that is futile, because I can’t act on any conclusions it comes to.⁶¹

Proponents of physician-assisted suicide hasten to distinguish it from acts of self-killing and self-destruction. For the severely ill and disabled, the greatest suffering arises from the loss of control, first of the body, then of the self, “borne downward by the illness.”⁶² Timothy Quill believes that those who seek a doctor’s help in dying are waging a battle *against* self-destruction.⁶³ Rather than the annihilation of the self, they seek death in order to salvage their personhood.⁶⁴ Death is the means by which they will re-assert and re-establish the

⁵⁶ N.Y. TASK FORCE, *supra* note 35, at 20-21.

⁵⁷ *Id.* at 40.

⁵⁸ *Id.*

⁵⁹ DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* 95 (1993).

⁶⁰ *Id.* Callahan noted that the pain experienced by a victorious long-distance runner may lead to pleasure and that the knowledge that one has Alzheimer’s disease produces a non-physical anguish.

⁶¹ BRIAN CLARK, *WHOSE LIFE IS IT ANYWAY?* 141-42 (1978).

⁶² CALLAHAN, *supra* note 59, at 133.

⁶³ Timothy E. Quill, *Dying Patients Should Have Access to Both Hospice Care and Assisted Suicide*, in *EUTHANASIA: OPPOSING VIEWPOINTS* 105, 110 (James D. Torr ed., 2000).

⁶⁴ *Id.* at 110.

essence of their being.⁶⁵ There is nothing like illness, disability and death to remind us that we are no more and no less than “embodied selves.”⁶⁶

III. DEBATING DEATH

But surely a wish to die is not *necessarily* a symptom of insanity? A man might wish to die for perfectly sane reasons.

BRIAN CLARK, WHOSE LIFE IS IT ANYWAY?⁶⁷

Life is the woman who loves you, the wind through your hair, the sun on your face, an evening stroll with a friend.

Life is also a woman who leaves you, a rainy day, a friend who deceives you. I am neither melancholic nor manic-depressive. I find the idea of dying horrible. But what is left to me is no longer life.

Piergiorgio Welby⁶⁸

A. *The Doctor-Patient Perspective*

In 1988 the Journal of the American Medical Association published an anonymous article, “It’s Over, Debbie.”⁶⁹ A resident in a large, private hospital receives a middle-of-the-night summons. He stumbles sleepily to the bedside of a young woman named Debbie who is dying of ovarian cancer. Except for some hurried details provided by a nurse and a quick look at her chart, the resident knows nothing about Debbie. The patient is emaciated, hollow-eyed, vomiting relentlessly, having difficulty breathing and has not responded to chemotherapy. Her only words to the resident are, “Let’s get this over with.” The resident withdraws to reflect briefly and concludes that, while he cannot cure her, he can “give her rest.” He injects her with a lethal dose of morphine

⁶⁵ *Id.* at 110. See generally Lois Shepherd, *Dignity And Autonomy after Washington v. Glucksberg: An Essay About Abortion, Death, And Crime*, 7 CORNELL J.L. & PUB. POL’Y 431, *passim* (1998) for discussion of the role of dignity and autonomy in this issue.

⁶⁶ CALLAHAN, *supra* note 59, at 146.

⁶⁷ CLARK, *supra* note 61, at 91.

⁶⁸ Ian Fisher, *A Poet Crusades for the Right to Die His Way*, N.Y. TIMES, Dec. 20, 2006, available at <http://www.nytimes.com/2006/12/20/world/europe/20welby.html> (quoting Piergiorgio Welby). Welby battled muscular dystrophy for forty years and spent his last nine years attached to a respirator. A well-known advocate of euthanasia, he authored a book, “Let Me Die,” and described his unwanted medical treatment as “unbearable torture.” An Italian court denied him permission for sedation and for a physician to remove him from the respirator. Shortly thereafter and without legal approval, an anesthesiologist sedated Welby and his respirator was disconnected. *Id.* After Welby’s death, his doctor was unanimously cleared by an Italian medical board. *No Disciplinary Action for Doctor in Right-to-Die Case*, N.Y. TIMES, Feb. 2, 2007, available at <http://query.nytimes.com/gst/fullpage.html?res=9F07E0DE123FF931A35751C0A9619C8B63>.

⁶⁹ Anon., 259 J. AM. MED. ASS’N 272 (1988).

and she dies, peacefully, within minutes.⁷⁰

The piece was greeted with storms of condemnation for the resident's having proceeded without consulting another physician and for committing what amounts to pre-meditated murder. Others questioned whether the article was a hoax, while fervent proponents of euthanasia like Derek Humphry approved of the result but not the young doctor's methods.⁷¹ Still others expressed relief that the anonymous author had "forced the fact that doctors did perform active euthanasia out into the open."⁷² Said one physician, "It makes no sense to hide our heads in the sand."⁷³

Doctors are often placed in the agonizing position of having to observe terrible suffering while, at the same time, having to filter their responses through complex moral, ethical and legal considerations. Some see physician-assisted suicide as too easy, a "flight from compassion."⁷⁴ Some support prohibition of aid in dying as a necessary safeguard against the arrogance of doctors—their willingness to apply entirely subjective criteria to the issue of "whether this life or that life is unworthy of continued existence."⁷⁵

The danger, however, comes not from the physician's belief that some lives are more worthy than others, but from the capacity to act on such judgments, especially "under the cloak of professional prestige and compassion."⁷⁶

In an era of scarce health resources, terminally ill patients, fearful of burdening their families, might interpret the right to die as "the duty to die."⁷⁷ Especially vulnerable are "the many individuals in our society whose autonomy and

⁷⁰ *Id.*

⁷¹ See IAN DOWBIGGIN, *A MERCIFUL END* 166 (2003). Derek Humphry is the author of *FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING*. First published in 1991, the book is now in a 3rd edition. Humphry founded the Hemlock Society, *Id.* at xvii, "committed to providing information regarding options for dignified death and legalized physician aid in dying." The Hemlock Society Home Page, <http://www.compassionandchoices.org/hemlock> (last visited Sept. 15, 2007). Humphry, believes that "[t]he right to choose to die when in advanced terminal or hopeless illness is the ultimate civil liberty." Who's Who and What's What: Derek Humphrey, <http://www.finalexit.org/dhumphry> (last visited Sept. 15, 2007). He is president of ERGO, Euthanasia Research and Guidance Organization, based in Oregon. About ERGO, <http://http://www.finalexit.org/about.html> (last visited Sept. 29, 2007).

⁷² DOWBIGGIN, *supra* note 71, at 166.

⁷³ *Id.* at 166.

⁷⁴ Robert McCormick, *Physician-Assisted Suicide: Flight from Compassion*, in *ARGUING EUTHANASIA* 135 (Jonathan Moreno ed., 1995).

⁷⁵ Leon R. Kass & Nelson Lund, *Physicians Should Not Be Legally Permitted to Assist in Suicide*, in *EUTHANASIA: OPPOSING VIEWPOINTS*, *supra* note 63 at 181, 187.

⁷⁶ *Id.*

⁷⁷ See ALAN MEISEL & KATHY L. CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* 1-4 to 1-5 (3d ed. 2004) (discussing the confusion of a right to die with a duty to do so among laypersons and health providers); Robert Misbin, *Physicians' Aid in Dying*, in *ARGUING EUTHANASIA*, *supra* note 74, at 125.

well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group.”⁷⁸ Thoughts about cost-effectiveness, however unbidden, hover around a generation at risk of sacrificing its financial future to the expense of caring for elderly parents.⁷⁹ Old age has never “lasted so long or been so costly.”⁸⁰ Medicare covers acute episodic illness, such as heart attack, cancer, or a broken hip and, therefore, provides little long-term help. Middle-aged children of the elderly exhaust their savings caring for parents and wonder whether they will ever be able to retire.⁸¹ Viewed in the context of such systemic inequities, insisting on access to physician aid in dying seems an irrational and counterproductive strategy. Referring to the movement to legitimize assisted dying, Yale Kamisar has noted that, “at a time when millions of Americans lack adequate health care and Congress has refused to do anything about it,” it seems ludicrous to argue that physician-assisted suicide is “the one health care right that deserves constitutional status.”⁸²

The most emphatic response to “It’s Over, Debbie” arose from a group of physicians who proclaimed the “very soul of medicine” to be on trial.⁸³ Invoking the Oath of Hippocrates, they declared the resident’s actions to be a clear violation of “one of the most hallowed canons of the medical ethic: doctors must not kill.”⁸⁴ On the one hand, it is difficult to quarrel with the unalloyed moral and ethical logic of such a statement. On the other hand, one wonders whether a strict construction of the Hippocratic Oath is, truly, the most valid or most helpful source of guidance on this issue. Doctors must not kill. Yet, in an untold number of instances, their ministrations are causing their patients to want to die. In a research project funded by the Robert Wood Johnson Foundation, 9,000 seriously ill patients in five major teaching hospitals were studied over the course of four years.⁸⁵ Viewed as “one of the most important studies on medical care for the dying,” it concluded that doctors “routinely subject

⁷⁸ N.Y. TASK FORCE, *supra* note 35, at 120.

⁷⁹ Jane Gross, *Elder-Care Costs Deplete the Savings of a Generation*, N.Y. TIMES, Dec. 30, 2006, available at <http://www.nytimes.com/2006/12/30/us/30support.html>.

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² Yale Kamisar, *Voluntary Euthanasia Should Not Be Legalized*, in EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 63, at 87.

⁸³ Willard Gaylin et al., *Doctors Must Not Kill*, in ARGUING EUTHANASIA, *supra* note 74, at 35.

⁸⁴ *Id.* at 34.

⁸⁵ See Joanne Lynn, *Unexpected Returns: Insights from SUPPORT*, in THE ROBERT WOOD JOHNSON FOUNDATION ANTHOLOGY, TO IMPROVE HEALTH AND HEALTH CARE, Vol. I (1997), http://www.rwjf.org/files/publications/books/1997/chapter_08.html (describing selected findings and lessons from SUPPORT, a large, multi-year research-and-demonstration project that investigated the care provided to critically ill hospitalized patients at the end of life).

their patients to futile medical treatment, ignore their specific instructions for care, and allow them to die in needless pain.”⁸⁶ This “plainly substandard”⁸⁷ care included the following: during the last three days of life, fifty-five percent of patients were conscious; of these, eighty percent endured pain, dyspnea, and fatigue. Forty percent of these patients suffered “severe pain”⁸⁸ “most of the time.”⁸⁹

Among the severely and terminally ill and those with prolonged unconsciousness or advanced dementia, infectious diseases such as pneumonia or urinary tract infection, if left untreated, might allow for a relatively peaceful death. Their “routine treatment,” however, extends the degenerative process, resulting in “death by inches” and robbing the patient of any prospect of peace.⁹⁰ Years ago, advanced cervical cancer caused death due to complications of kidney failure or urethral blockage, a comparatively merciful end. Now, patients can be kept alive by dialysis and other techniques until the tumor itself produces a “much more protracted and uncomfortable death.”⁹¹ The medical arsenal—including, but not limited to, chemotherapy, radiation therapy, artificial hydration and nutrition, immunotherapy, and palliative surgery—often extends life expectancy from a few months to many years. When the technology falters, however, the patient’s “prolonged remission” becomes “prolonged suffering.”⁹²

Of course medicine’s mission is to treat disease and illness and to prolong life. Patients fully, and rightfully, expect it to be so. At the same time, life-extending medications and techniques have transformed death into a “chronic, contrived, and manipulated phenomenon.”⁹³ Doctors find ample ethical justification to intervene at the treatment stage. Yet, when treatment finally fails and the patient is undergoing painful, protracted death, these very same ethics seem to justify abandonment. When the “ultimate price” for prolonging life “comes due,” doctors fall back on the tenets of their profession, shun euthanasia, and the patient assumes the cost.⁹⁴

Doctors must not kill. But their efforts at recognizing and alleviating pain

⁸⁶ Joe Loconte, *Hospice Care Can Make Assisted Suicide Unnecessary*, in EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 63, at 98.

⁸⁷ W. Clay Jackson, *When All Else is Done: The Challenge of Improving Antemortem Care*, 1 J. CLIN. PSYCHIATRY 146, 148 (1999), available at <http://www.psychiatrist.com/pcc/pccpdf/v01n05/v01n0503.pdf>.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ CALLAHAN, *supra*, note 59, at 202.

⁹¹ Guy Benrubi, *Euthanasia—The Need for Procedural Safeguards*, in ARGUING EUTHANASIA, *supra* note 74, at 115-16.

⁹² *Id.* at 115.

⁹³ Kenneth Vaux, *Debbie’s Dying: Mercy Killing and the Good Death*, 259 J. AM. MED. ASS’N 2140, 2141 (1988).

⁹⁴ Benrubi, *supra* note 91, at 116.

are “grossly inadequate.”⁹⁵ Medical education regarding palliative care is deficient, or doctors often fail to offer pain relief until the latest stage of illness, or what they offer is simply not enough.⁹⁶ Even hospice patients, who should expect the highest level of palliative care, report severe pain and shortness of breath in the last week of life.⁹⁷ “Medical school and residency training programs have often failed to adequately address pain management and end-of-life care.”⁹⁸ Although pain is “the most common symptom in the dying,” insufficient palliative care especially afflicts women and minority AIDS and cancer patients, as well as thirty-six percent of nursing home residents with cancer and an appalling eighty-nine percent of children dying of cancer. Studies show that a majority of AIDS and cancer patients are provided with insufficient relief in the course of their terminal illness.⁹⁹ In a survey of 1,177 physicians who treated tens of thousands of cancer patients, “seventy-six percent reported that a lack of knowledge was a barrier to their ability to control pain.”¹⁰⁰ In another survey, only twelve percent of doctors viewed their medical school training in pain management as “excellent or good.”¹⁰¹

⁹⁵ N.Y. TASK FORCE, *supra* note 35, at 43; *see also* Melanie Thernstrom, *Pain, The Disease*, N.Y. TIMES, Dec. 16, 2001, available at <http://query.nytimes.com/gst/fullpage.html?sec=health&res=9C02E4DD163FF935A25751C1A9679C8B63> (“Pain treatment belongs primarily in the hands of ordinary physicians, most of whom know little about it.”); Robert D. Chen, M.D., *Training the Pain Physicians of Tomorrow*, AMER. SOC. OF ANESTHESIOLOGISTS NEWSLETTER, Oct. 1999, http://www.asahq.org/Newsletters/1999/10_99/train1099.html (“It is not unusual in an era of managed care medicine for primary care physicians to misdiagnose treatable acute pain conditions . . .”).

⁹⁶ Timothy E. Quill, *When Palliative Care Fails*, in EUTHANASIA 196, 200 (Loreta M. Medina ed., 2005); *see also* J. E. Mortimer and N.L. Bartlett, *Assessment of Knowledge about Cancer Pain Management by Physicians in Training*, 14 J. PAIN SYMPTOM MANAGE. 21, 21-28 (1997) (noting deficiencies in physician education on treating pain).

⁹⁷ Quill, *supra* note 96, at 201.

⁹⁸ Helen Thomson, *A New Law to Improve Pain Management and End-Of-Life Care*, 174 WEST. J. MED. 161, 162 (2001).

⁹⁹ Foley, *Patients Need Better End-of-Life Care Rather Than Assisted Suicide*, *supra* note 48, at 190-91.

¹⁰⁰ *Id.* at 191. The study is reported at Jamie H. Von Roenn et al., *Physician Attitudes and Practice in Cancer Pain Management: A Survey From the Eastern Cooperative Oncology Group*, 119 ANNALS OF INTERNAL MED. 121 (1993).

¹⁰¹ N.Y. TASK FORCE, *supra* note 35, at 43. The medical profession does not, of course, shoulder all the blame for the want of adequate pain medication. Our society is of two minds on several issues relating to pain management. One prime example relates to medical marijuana. A plethora of scientific studies and clinical experience showing the efficacy of marijuana to treat AIDS wasting syndrome, muscle spasticity, chronic pain, and other serious medical conditions. *See, e.g.*, OAKLEY RAY & CHARLES KSIR, *DRUGS, SOCIETY, AND HUMAN BEHAVIOR* (McGraw Hill 10th ed. 2004); D. I. Abrams, et al., *Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial*, 68 NEUROLOGY 515, 515-21 (2007) (“Smoked cannabis was well tolerated and effectively relieved

Severe, uncontrollable pain disrupts patients' sleep, and leads to further physical deterioration.¹⁰² It reduces the will to engage in physical activity, and to complete even the simplest of daily tasks.¹⁰³ Along with other physical symptoms, pain can "directly diminish a patient's quality of life."¹⁰⁴ As limned by one observer, "[a] modern chronicler of hell might look to the lives of chronic-pain patients for inspiration."¹⁰⁵ Furthermore, the patient's family and professional caregivers become distressed at witnessing pain and suffering. The interrelated nature of the distress serves to amplify it, contributing to feelings of helplessness and hopelessness and, perhaps, the belief that euthanasia or assisted suicide are the only paths to relief.¹⁰⁶

Doctors must not kill. But they do. In 1997, of a sample of physicians explicitly asked to assist in a patient's death, one quarter "provided patients with potentially lethal medication."¹⁰⁷ In Britain, one in seven of 36,000 general practitioners "has admitted that he or she has broken the law by helping patients to die at their request."¹⁰⁸ According to Kenneth Vaux, there are "numerous cases today in the medical and legal case files in which active euthanasia has been reluctantly allowed and the physicians involved have not been prosecuted."¹⁰⁹ As to assisted suicide, the scarcity of criminal prosecutions stems from "the private, consensual nature" of the act as well as the difficulty of proving intent on the part of the doctor—many of the prescribed substances are routinely employed to treat pain.¹¹⁰ Prosecutors are often unwilling to bring euthanasia cases in light of the "public sympathy they often arouse" and problems with securing indictments and convictions¹¹¹ In the words of one

chronic neuropathic pain from HIV-associated sensory neuropathy."); Stanley J. Watson et al., *Marijuana and Medicine: Assessing the Science Base*, 57 ARCH. GEN. PSYCHIATRY 547, 547-52 (2000). Nevertheless, this issue has become a political and cultural battleground. At least a dozen states have authorized exceptions to their drug possession laws for medicinal uses of marijuana. Curt Woodward, *Wash. to Set Medical Marijuana Limits*, WASH. POST, July 7, 2007. But federal law continues to criminalize all possession of marijuana, and the federal government law has trumped state efforts to allow doctors to prescribe this type of pain relief. See *Gonzales v. Raich*, 545 U.S. 1 (2005) (holding that the federal Controlled Substances Act was not an unconstitutional exercise of the Commerce Clause as applied to seriously ill patients who have been prescribed marijuana).

¹⁰² N.Y. TASK FORCE, *supra*, note 35 at 20.

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 21.

¹⁰⁵ Thernstrom, *supra* note 95, at 1.

¹⁰⁶ Foley, *Patients Need Better End-of-Life Care Than Assisted Suicide*, *supra* note 48, at 189.

¹⁰⁷ Quill, *When Palliative Care Fails*, *supra* note 96, at 203.

¹⁰⁸ David Pratt, *Too Many Physicians: Physician-Assisted Suicide After Quill/Gluck-sberg*, 9 ALB. L.J. SCI. & TECH. 161, 184 (1998-99).

¹⁰⁹ Vaux, *supra* note 93, at 2141.

¹¹⁰ N.Y. TASK FORCE, *supra* note 35, at 57.

¹¹¹ *Id.*

prosecutor, “A jury will not find somebody guilty for something they believe in their hearts was a blessing, no matter what a legal statute says.”¹¹²

Several years after the appearance of “It’s Over, Debbie,” Timothy Quill, a physician, published his own account of an assisted suicide.¹¹³ He told of a patient, Diane, stricken with leukemia and nearly out of treatment options.¹¹⁴ After extensive discussions with her, Dr. Quill acceded to her request and wrote her a prescription for barbiturates.¹¹⁵ Secure in knowing she could use them when and if the time came, Diane lived for several more months, said goodbye to friends and family, and took her life at home.¹¹⁶ Dr. Quill, who was not present at her death, later wondered “how many of the severely ill or dying patients secretly take their lives, dying alone in despair.”¹¹⁷ He also wondered how many physicians “secretly help patients over the edge into death” when confronted with such profound suffering.¹¹⁸

A grand jury refused to return an indictment after Dr. Quill admitted his role in Diane’s death.¹¹⁹ The New York State Health Department’s Board for Professional Medical Conduct also declined to pursue disciplinary proceedings.¹²⁰ But Dr. Quill continued to be disturbed by the legal and medical subterfuge compelled by prohibitions against assisted dying.¹²¹ He noted how the law’s restrictions “muddle clear thinking and discourage honesty,” how he and his colleagues “have learned how to hedge our intentions and to act in purposefully ambiguous ways.”¹²²

B. *The Legal Perspective*

Dr. Quill’s troubled conscience led him to the U.S. Supreme Court in 1997.¹²³ Acting for themselves and on behalf of three mentally competent,

¹¹² Esther B. Fein, *Decision Unlikely to Give Rise to More Prosecutions, Officials Say*, N.Y. TIMES, June 27, 1997, at A19 (quoting Frank Phillips, District Attorney for Orange County, N.Y.). For a discussion of euthanasia and assisted suicide prosecutions see Pratt, *supra* note 108, at 166-71.

¹¹³ Timothy Quill, *Death and Dignity—A Case of Individualized Decision Making*, in ARGUING EUTHANASIA, *supra* note 74, at 55-62.

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 59.

¹¹⁶ *Id.* at 60-62.

¹¹⁷ *Id.* at 62.

¹¹⁸ *Id.*

¹¹⁹ Lisa W. Foderaro, *New York Will Not Discipline Doctor for His Role in Suicide*, N.Y. TIMES, Aug. 17, 1991, at 125.

¹²⁰ *Id.* The Board reasoned that Dr. Quill himself “did not directly participate in any taking of life,” distinguishing him from Dr. Jack Kevorkian and his “suicide machine.” See *infra* text at note 206 for more on Dr. Kevorkian.

¹²¹ Quill, *When Palliative Care Fails*, *supra* note 96, at 203.

¹²² *Id.* at 203.

¹²³ *Vacco v. Quill*, 521 U.S. 793 (1997).

terminally ill patients, he and two other physicians challenged New York's prohibition against assisted suicide.¹²⁴ On the same day that the Supreme Court decided *Vacco v. Quill*,¹²⁵ it handed down its decision in *Washington v. Glucksberg*.¹²⁶ *Glucksberg*, also brought by physicians on behalf of themselves and competent, terminally ill patients, considered a constitutional challenge against Washington State's ban on assisted suicide.¹²⁷ That the petitioners in these cases viewed the judiciary as a "sympathetic partner" stemmed from prior court endorsement of the right to refuse medical treatment.¹²⁸ For a while, it did seem as though the courts were inclined to regard the issues as matters of self-determination. As Susan Channick has observed, "[i]n death and dying jurisprudence, the centerpiece of rights talk is personal autonomy."¹²⁹ In *Glucksberg* and *Quill*, however, the Supreme Court chose not to go down this path.¹³⁰ In fact, it virtually ignored autonomy as the critical element in the decision to end one's life.¹³¹ Ultimately, the concept of personal choice became lost in the depths of judicial reasoning and, to date, has not resurfaced.

In 1976, Joseph Quinlan, acting as guardian for his daughter, Karen Ann, sought court authorization to remove her from her respirator.¹³² The young woman had lapsed from a coma into a persistent vegetative state after prolonged oxygen deprivation.¹³³ Even before it reached the courts the Quinlan drama held the public riveted. 1970s culture had rediscovered mortality and found it fascinating.¹³⁴ Elisabeth Kubler-Ross published her groundbreaking work, *On Death and Dying*, in 1969.¹³⁵ Ernest Becker's *The Denial of Death*¹³⁶ won the Pulitzer Prize in 1974.¹³⁷ Furthermore, in Karen Ann Quinlan's plight, the public became aware of the very mixed blessings of emerging medical technologies. Karen's high school year-book picture became familiar world-wide, appearing on television screens and in newspapers and

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹²⁷ *Id.*

¹²⁸ Susan Channick, *The Myth of Autonomy at the End-of-Life: Questioning the Paradigm of Rights*, 44 VILL. L. REV. 577, 593-94 (1999).

¹²⁹ *Id.* at 581.

¹³⁰ *Glucksberg*, 521 U.S. at 702; *Quill*, 521 U.S. at 793.

¹³¹ *Id.*

¹³² *In re Quinlan*, 355 A.2d 647, 651 (N.J. 1976).

¹³³ *Id.* at 653-55.

¹³⁴ See Kingwood College Library, American Cultural History, 1970-1979, <http://kclibrary.nhmccd.edu/decade70.html> (last visited Oct. 5, 2007) ("Many of the books published in the 70's revolved around a general theme of man's alienation from his spiritual roots.").

¹³⁵ ELISABETH KUBLER-ROSS, *ON DEATH AND DYING* (Macmillan 1970) (1969).

¹³⁶ ERNEST BECKER, *THE DENIAL OF DEATH* (Free Press Paperbacks 1997) (1973).

¹³⁷ See The Pulitzer Prize Winners, <http://www.pulitzer.org/> (last visited Oct. 5, 2007).

magazines.¹³⁸ When *In re Quinlan*¹³⁹ was decided by the New Jersey Supreme Court it was hailed as “the Brown v. Board of Education of the right-to-die movement.”¹⁴⁰

In granting Joseph Quinlan’s request, the court accorded Karen a right to privacy, guaranteed by the Bill of Rights and previously recognized in *Griswold v. Connecticut* and *Roe v. Wade*.¹⁴¹ Balancing this right against asserted State interests, the court concluded that the latter weakens “and the individual’s right to privacy grows as the degree of bodily invasion increases and the prognosis dims.”¹⁴² Given Karen’s condition, and her inability to consciously exercise that right, the court allowed her father to act on her behalf.¹⁴³

Quinlan, consistent with his Catholic beliefs, sought detachment of the respirator (an extraordinary life-prolonging measure) but not the cessation of artificial nutrition and hydration (ordinary measures).¹⁴⁴ Years later, Karen’s mother, Julia, recalled how she and Joseph had hoped that, with the respirator removed, Karen would be “placed back in her natural state, and she would die on God’s time.”¹⁴⁵ It is apparent also, from the tone and language of its opinion, that the court expected Karen would die soon after the respirator’s removal. She lived for nine more years.¹⁴⁶

In 1990 the U.S. Supreme Court in *Cruzan v. Director, Mo. Dept. of Health*¹⁴⁷ declined to replicate *Quinlan*’s “right to privacy” reasoning as the basis for permitting refusal or withdrawal of medical treatment.¹⁴⁸ The Court

¹³⁸ Indeed, more than two decades after her death, the photograph is still readily viewable in her Wikipedia entry. See Wikipedia, http://en.wikipedia.org/wiki/Karen_Ann_Quinlan (last visited Oct. 19, 2007).

¹³⁹ *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

¹⁴⁰ DOWBIGGIN, *supra* note 71, at 147 (quoting PETER G. FILENE, *IN THE ARMS OF OTHERS: A CULTURAL HISTORY OF THE RIGHT-TO-DIE IN AMERICA* 73 (1998)).

¹⁴¹ *Quinlan*, 355 A.2d at 663; see *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹⁴² *Quinlan*, 355 A.2d at 664.

¹⁴³ *Id.*

¹⁴⁴ Ordinary means are defined as those that offer a reasonable hope of benefit and do not unduly burden the patient or family. Food and water and common medical treatments have traditionally been considered ordinary means. In contrast, extraordinary means are defined as those which offer no hope of reasonable benefit and which are unduly burdensome to the patient and family. The distinction between these two types of care is not always clear and often depends on the particular circumstance of the patient as well as the relevant medical technologies. See William Saunders, *What is the Church’s Teaching on Euthanasia?*, *ARLINGTON CATHOLIC HERALD*, Dec. 15, 1994, <http://www.catholicculture.org/library/view.cfm?id=307>.

¹⁴⁵ CNN Transcript, http://transcripts.cnn.com/TRANSCRIPTS/0503/23/i_ins.01.html (last visited Oct. 5, 2007).

¹⁴⁶ *Id.*

¹⁴⁷ *Cruzan v. Dir. Mo. Dept. of Health*, 497 U.S. 261 (1990).

¹⁴⁸ *Id.*

appeared to prefer grounding such right of refusal in common law rights to bodily integrity through informed consent.¹⁴⁹ In the course of its analysis, however, the Court did find that a competent person's right to refuse life-sustaining treatment arose from a constitutionally-protected liberty interest.¹⁵⁰ But it was never clear, as some euthanasia activists claimed, that the Court intended to recognize a broad "right to die."¹⁵¹

Nancy Beth Cruzan, like Karen Ann Quinlan, was the object of intense media attention.¹⁵² She was in her 20's when paramedics found her, unconscious and not breathing, following an automobile accident.¹⁵³ Severely oxygen-deprived, her breathing was restored but she required a permanent hydration and feeding tube.¹⁵⁴ By the time her case reached the Supreme Court, she had been hospitalized for seven years in a persistent vegetative state.¹⁵⁵ Regarding her wishes as to lifesaving medical procedures, she left no record except for a conversation with a roommate.¹⁵⁶ During this discussion, Nancy indicated that, if sick or injured, she would not want to go on living unless she could do so "halfway normally."¹⁵⁷ According to Missouri state law, clear and convincing evidence of an incompetent's wishes are required before medical treatment can be terminated.¹⁵⁸ Nancy's parents, acting as her surrogates, sought to discontinue artificial nutrition and hydration.¹⁵⁹ They had lost their battle in the state's highest court, unable to satisfy the law's requirement as to proof of Nancy's preferences.¹⁶⁰ They were left with no choice but to challenge the constitutionality of the statute.¹⁶¹

The Supreme Court, for purposes of weighing the constitutional merits of the law, assumed the existence of a "constitutionally protected right to refuse life-saving hydration and nutrition."¹⁶² However, when balanced against the protections offered by the Missouri statute, the right was deemed not strong enough to invalidate the law.¹⁶³ Weary yet persistent, the Cruzans returned to

¹⁴⁹ *Id.* at 271.

¹⁵⁰ *Id.* at 279.

¹⁵¹ See DOWBIGGIN, *supra* note 71, at 165.

¹⁵² See WILLIAM H. COLBY, LONG GOODBYE: THE DEATHS OF NANCY CRUZAN 118, 181-86, 221, 241, 243, 258-61, 267, 282, 342-43, 367 (2002).

¹⁵³ *Id.* at 3-9.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ *Cruzan v. Dir. Mo. Dept. of Health*, 497 U.S. 268 (1990).

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* at 280.

¹⁵⁹ *Id.* at 265.

¹⁶⁰ *Id.*

¹⁶¹ *Id.* at 279-280.

¹⁶² *Id.* at 279.

¹⁶³ See Louis M. Seidman, *Confusion at the Border: Cruzan, "The Right to Die," and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, 48 (1991) ("Cruzan presented the Court

state court.¹⁶⁴ There, they filed a motion of intent to offer evidence from three of Nancy's former co-workers as to her views on life-sustaining treatment.¹⁶⁵ The Attorney General's office withdrew from the case and Nancy's feeding tube was finally disconnected.¹⁶⁶ She died twelve days later.¹⁶⁷

The right to refuse life-sustaining treatment was crucial to the plaintiffs' arguments in *Vacco v. Quill*.¹⁶⁸ At issue was a New York statute making it a crime to aid another in committing or attempting to commit suicide.¹⁶⁹ The plaintiffs contended that, while New York permitted competent, terminally ill persons to hasten their deaths by refusing life-support measures, these same persons were prohibited from hastening death by ingesting drugs prescribed by a physician.¹⁷⁰ The distinction, they claimed, was arbitrary and irrational, a clear violation of the 14th amendment's Equal Protection clause.¹⁷¹ Furthermore, they argued, such unequal treatment bore no rational relation to legitimate state interests.¹⁷²

The Court of Appeals for the Second Circuit agreed, finding it impermissible for New York law to differentiate between two classes of persons in the final stages of terminal illness.¹⁷³ Those who are on life support are permitted to hasten death by directing the removal of life-prolonging treatment.¹⁷⁴ Those who are similarly situated but not on life support are barred from hastening death "by self-administering prescribed drugs."¹⁷⁵ In the Second Circuit's view, the withdrawal of life support, often accompanied by palliative drugs that may themselves contribute to death, requires an affirmative act by the physi-

with an excruciatingly difficult problem in drawing an appropriate boundary between realms of private and public decision making—between the private domain of individual rights and the public domain of community preferences.”).

¹⁶⁴ Lisa Belkin, *Missouri Seeks to Quit Case of Comatose Patient*, N.Y. TIMES, Oct. 12, 1990 at A15.

¹⁶⁵ *Id.*

¹⁶⁶ Andrew H. Malcolm, *Judge Allows Feeding-Tube Removal*, N.Y. TIMES, Dec. 15, 1990 at 110.

¹⁶⁷ Andrew H. Malcolm, *Nancy Cruzan: End to Long Goodbye*, N.Y. TIMES, Dec. 29, 1990 at 18. The year after Nancy's death, her father said, "I've wondered sometimes if we have finally accomplished for God what he set out to do. People say that's blasphemy, but I don't mean it that way. I mean it as, 'Where does God fit into the equation?'" The family's ordeal did not end with Nancy's death. Mr. Cruzan hanged himself in 1996. Eric Pace, *Lester Cruzan is Dead at 62; Fought to Let His Daughter Die*, N.Y. TIMES, Aug. 19, 1996, at B12.

¹⁶⁸ *Vacco v. Quill*, 521 U.S. 793, 797-98 (1997).

¹⁶⁹ *Id.* at 796.

¹⁷⁰ *Id.*

¹⁷¹ *Id.* at 807.

¹⁷² *Id.* at 793.

¹⁷³ *Quill v. Vacco*, 80 F. 3d 716, 729 (2d Cir. 1996).

¹⁷⁴ *Id.*

¹⁷⁵ *Id.*

cian.¹⁷⁶ Rather than resulting from the natural progression of the disease, the ensuing death is caused by dehydration or respiratory failure.¹⁷⁷ Thus, terminating life by withdrawing treatment is “nothing more nor less than assisted suicide.”¹⁷⁸ Further, in light of statutory and common law rights to refuse unwanted medical procedures, the preservation of the treatment withdrawal/assisted suicide distinction serves no state interest: “Physicians do not fulfill the role of ‘killer’ by prescribing drugs to hasten death any more than they do by disconnecting life support systems.”¹⁷⁹

The Supreme Court reversed, finding the distinction between treatment withdrawal and assisted suicide to be well grounded in medical and legal traditions: “When a patient refuses life-sustaining medical treatment, he dies from the underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”¹⁸⁰ The concept of intent was also important to the Court’s determination.¹⁸¹ A physician who complies with a request to terminate treatment intends only to honor his patient’s wishes and to discontinue futile or degrading measures.¹⁸² A physician who provides aggressive palliative care, drugs which may hasten a patient’s death, is acting to relieve the patient’s pain.¹⁸³ But “a patient who commits suicide with a doctor’s aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.”¹⁸⁴ Moreover, the Court of Appeals had incorrectly assumed that the right to refuse treatment arose from “a general and abstract ‘right to hasten death’”¹⁸⁵ rather than the “rights to bodily integrity and freedom from unwanted touching.”¹⁸⁶ Unlike the Second Circuit, the Supreme Court found the distinction between terminating treatment and aiding a suicide to be rationally related to valid public interests.¹⁸⁷ Among them was preserving life as well as the integrity of the medical profession, protecting the vulnerable from pressure to end their lives, and avoiding a “possible slide toward euthanasia.”¹⁸⁸ That the differentiation may be proper under an Equal Protection analysis, however, does not resolve the medical issues. Physicians and patients who perceive no meaningful differ-

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 730.

¹⁸⁰ *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

¹⁸¹ *Id.* at 801-02.

¹⁸² *Id.* at 801.

¹⁸³ *Id.* at 802.

¹⁸⁴ *Id.*

¹⁸⁵ *Id.* at 807.

¹⁸⁶ *Id.* (citing *Cruzan v. Dir. Mo. Dept. of Health*, 497 U.S. 268, 278-79 (1990)).

¹⁸⁷ *Vacco v. Quill*, 521 U.S. at 800-01.

¹⁸⁸ *Id.* at 808-09.

ence between withdrawal of treatment and assisted suicide will, most likely, fail to be persuaded or comforted by legal arguments to the contrary.

The plaintiffs in *Glucksberg* also had their moment of victory in the court below.¹⁸⁹ Sitting *en banc*, the U. S. Court of Appeals for the Ninth Circuit concluded that “the Constitution encompasses a due process liberty interest in controlling the time and manner of one’s death—that there is, in short, a constitutionally-recognized ‘right to die.’”¹⁹⁰ As in *Vacco v. Quill*, the Supreme Court upon review was forced to reiterate and clarify its holding in *Cruzan* as to the rationale for the right to refuse medical treatment.¹⁹¹ Further, in reversing the Ninth Circuit, the Court alluded to “our Nation’s history, legal traditions, and practices” embodied in the longstanding “commitment to the protection and preservation of all human life.”¹⁹² Despite its very clear language in *Planned Parenthood of Southeastern Pa. v. Casey* on liberty as “the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life,”¹⁹³ the Court in *Glucksberg* refused to extend due process protection to the right “to assistance in committing suicide.”¹⁹⁴

The lack of unanimity in the Court’s reasoning in *Glucksberg* and *Vacco v. Quill* is reflected in the six published opinions (one majority opinion in each case for the five-Justice majority, and four separate concurring opinions).¹⁹⁵ The complex nature of the problem engendered various legal rationales and no real consensus. None of the Justices considered autonomy a salient factor in his or her reasoning. Justice Souter preferred to rely on the analytical framework suggested in Justice Harlan’s dissent in *Poe v. Ullman*.¹⁹⁶ Specifically, Justice Souter viewed the issue as “whether the statute in question falls inside or outside the zone of what is reasonable in the way it resolves the conflict between the interests of state and individual.”¹⁹⁷ Justice O’Connor confined her discussion of rights to the observation that a terminally ill individual in great pain is not legally barred from obtaining medication to alleviate that pain, even “to the point of causing unconsciousness and hastening death.”¹⁹⁸

In the *Glucksberg* majority opinion, Chief Justice Rehnquist acknowledged

¹⁸⁹ *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁹⁰ *Compassion in Dying v. Washington*, 79 F. 3d 790, 816 (9th Cir.1996), *rev’d sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

¹⁹¹ *Vacco v. Quill*, 521 U.S. at 807.

¹⁹² *Glucksberg*, 521 U.S. at 710.

¹⁹³ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

¹⁹⁴ *Glucksberg*, 521 U.S. at 728.

¹⁹⁵ *See id.*; 521 U.S. at 736 (O’Connor, J., concurring); 521 U.S. at 752 (Souter, J., concurring in the judgment); 521 U.S. at 789 (Ginsburg, J., concurring in the judgments); 521 U.S. at 789 (Breyer, J., concurring in the judgments).

¹⁹⁶ *Id.* at 752, 756 (Souter, J., concurring in the judgment) (citing *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)).

¹⁹⁷ *Glucksberg*, 521 U.S. at 768 (Souter, J., concurring in the judgment).

¹⁹⁸ *Id.* at 733-37 (O’Connor, J., concurring).

that, although Due Process protections of rights and liberties “sound in personal autonomy,” that alone did not “warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected.”¹⁹⁹ That the patients in *Quill* and *Glucksberg*, all competent, had carefully and thoughtfully considered their decisions to hasten their deaths was simply not dispositive.²⁰⁰ Yet the real value of these Supreme Court decisions may well reside in their restraint. Chief Justice Rehnquist, writing for the Court in *Glucksberg*, concludes his opinion with the hope and expectation that end-of-life issues will continue to be discussed in other, perhaps more appropriate, forums: “Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society.”²⁰¹

In declining to usurp the role of the legislature, the Court “changed the focus of the discussion from rights talk to informing public policy.”²⁰² As the effects of decriminalizing assisted suicide were largely unknown, the question of rights may have been posed to the Court prematurely.²⁰³ Further, the Court was uncomfortable with “bootstrapping” the morality and desirability of assisted suicide onto *Cruzan*’s right to refuse life-sustaining treatment.²⁰⁴ Proponents of assisted suicide would have to find their own moral justification for hastening death.

IV. LEGISLATING DEATH

This is probably the first time that this august body has been addressed by someone under indictment on two counts of first-degree murder.²⁰⁵

Jack Kevorkian, acceptance speech for the 1994 Humanist Hero Award from the American Humanist Association.²⁰⁶

¹⁹⁹ *Id.* at 727 (majority opinion).

²⁰⁰ Channick, *supra* note 128, at 605.

²⁰¹ *Glucksberg*, 521 U.S. at 735.

²⁰² Channick, *supra* note 128, at 607.

²⁰³ *Id.* at 600.

²⁰⁴ *Id.* at 607.

²⁰⁵ Jack Kevorkian, Acceptance Speech for the 1994 Humanist Hero Award, in Jack Kevorkian, *A Modern Inquisition*, THE HUMANIST, Nov.-Dec. 1994, at 7, available at http://findarticles.com/p/articles/mi_m1374/is_n6_v54/ai_15922710.

²⁰⁶ A strident advocate of physician-assisted suicide, Dr. Kevorkian claimed to have helped more than 130 terminally ill people in their deaths. In the 1990s, he successfully evaded four prosecutorial attempts at a murder conviction. Pam Belluck, *Assisted-Suicide Advocates See Gains in Kevorkian Case*, N.Y. TIMES, Mar. 30, 1999, at A14. In 1999, however, Kevorkian was convicted of second-degree murder in Michigan and sentenced to ten to twenty-five years in prison. Monica Davey, *Kevorkian Freed After Years in Prison for Aiding Suicide*, N.Y. TIMES, June 2, 2007, at A8. He was released in 2007, having agreed as a condition of parole not to participate in future suicides. *Id.*

I bargained for salvation an' they gave me a lethal dose.²⁰⁷

Bob Dylan, *Shelter from the Storm*

A. *Obstacles to Statutory Development*

In his reticence about according constitutional remedies to the plaintiffs in *Glucksberg*, Chief Justice Rehnquist was acknowledging the need for objectivity and ongoing analysis in end-of-life matters.²⁰⁸ He was fully aware of the “subjective elements that are necessarily present in due-process judicial review.”²⁰⁹ In deferring to the functions of public debate and legislative action, Rehnquist ensured that judicial treatment of due process protections would not “be subtly transformed into the policy preferences of the Members of this Court.”²¹⁰ Perhaps the Justices had taken a lesson from *Roe v. Wade*,²¹¹ that imposing a constitutional right on a bitterly contested issue does not conclusively resolve it. The tension between public and private spheres may not be so easily resolved.²¹²

The outraged response of physicians to “It’s Over, Debbie”²¹³ was not necessarily echoed in the public’s reaction. In an editorial in *The Journal of the American Medical Association*, George Lundberg, MD observed that “many of our patients would want active euthanasia if needed, and they would want it performed by doctors.”²¹⁴ As he saw it, the medical profession could “ignore the pressure,” refuse to participate, even actively attempt to “repress the movement,” or it could begin to explore the development of medically ethical guidelines.²¹⁵ That such guidelines have not emerged may be due to the medical profession’s continued resistance and the public’s lack of consensus.²¹⁶

In 1985, New York’s Governor Mario Cuomo convened the Task Force on Life and the Law, a panel of doctors, nurses, lawyers, clergy, and medical ethicists.²¹⁷ The panel was given “a broad mandate to recommend public poli-

²⁰⁷ BOB DYLAN, *Shelter from the Storm*, on BLOOD ON THE TRACKS (Sony 1975).

²⁰⁸ *Washington v. Glucksberg*, 521 U.S. 702, 722, 735 (1997).

²⁰⁹ *Id.* at 722.

²¹⁰ *Id.* at 720 (citing *Moore v. City of E. Cleveland, Ohio*, 431 U.S. 494, 502 (1977)).

²¹¹ *Roe v. Wade*, 410 U.S. 113 (1973).

²¹² See Seidman, *supra* note 163, at 59 (“Most of constitutional law consists of an effort to delineate a boundary between [the public and private] spheres, and much of the modern critique of constitutional law consists of an attack on the coherence of this boundary.”).

²¹³ Anon., *supra* note 69.

²¹⁴ George D. Lundberg, ‘It’s Over, Debbie’ and the Euthanasia Debate, 259 J. AM. MED. ASS’N 2142, 2143 (1988).

²¹⁵ *Id.*

²¹⁶ See *infra* Section IV.B for a discussion of euthanasia in the Netherlands and physician-assisted suicide in Oregon.

²¹⁷ N.Y. TASK FORCE, *supra* note 35, at vii.

cy on issues raised by medical advances.”²¹⁸ In 1994, the Task Force produced an exhaustive report on matters pertaining to suicide, terminal illness, and end-of-life care, unanimously recommending that New York’s law not be changed to accommodate euthanasia or assisted suicide.²¹⁹ Donald McKinney, a Task Force member, proposed that, while the law should not sanction a deliberate act to aid someone in taking his or her own life, “it should be left a private act, with society able to be called in to judgment when and if the motive should be impugned.”²²⁰ While not an ideal system of justice, it was one that afforded “the least possibility of abuse.”²²¹

McKinney’s comments suggest that euthanasia was as ill-suited to a legislative solution as it was to a judicial one. In 1990, Washington State filed Ballot Initiative 119, the first state voter referendum on euthanasia and physician-assisted suicide.²²² Most of the state’s physicians opposed it, and the American Medical Association mailed out thousands of anti-119 brochures.²²³ Lavish amounts of money spent by pro-life organizations as well as rhetoric supplied by public figures like C. Everett Koop and Archbishop John Cardinal O’Connor helped sway voters and defeat the initiative.²²⁴ In California, the campaign for a ballot initiative on “aid-in-dying” began in 1988 and culminated in defeat by voters four years later.²²⁵ Subsequent attempts to legislate assisted suicide in California failed in 1995, 1999, 2005, 2006 and 2007.²²⁶ In 2000, voters in Maine defeated a ballot initiative by the extremely narrow margin of fifty-one percent to forty-nine percent.²²⁷ In Michigan, Dr. Kevorkian’s home state, voters rejected an assisted suicide initiative in 1998.²²⁸ The issue remains

²¹⁸ *Id.*

²¹⁹ *Id.* at 120. In 1997, while the U.S. Supreme Court decisions in *Quill* and *Glucksberg* were pending, the Task Force issued a supplemental report confirming its earlier recommendations. The panel also re-emphasized the distinction between physician-assisted suicide and treatment withdrawal and its opposition to the legalization of assisted dying. N.Y. TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT, SUPPLEMENT TO REPORT (April 1997), available at <http://www.health.state.ny.us/nysdoh/taskfce/sought.pdf>.

²²⁰ N.Y. TASK FORCE, *supra* note 35, at 102 (internal citation omitted).

²²¹ *Id.* at 103 (internal citation omitted).

²²² Kathi Hamlon, International Task Force on Euthanasia and Assisted Suicide, Failed Attempts to Legalize Euthanasia/Assisted-Suicide in the United States, www.internationaltaskforce.org/usa.htm (last visited Oct. 7, 2007).

²²³ DOWBIGGIN, *supra* note 71, at 170.

²²⁴ *Id.*

²²⁵ *Id.* at 171.

²²⁶ See Hamlon, *supra* note 222. On the failure to advance the California bill in 2007, see International Task Force on Euthanasia and Assisted Suicide, Assisted-Suicide Advocates Fail to Advance Bill in California, Update 2007, <http://www.internationaltaskforce.org/iua41.htm#1>.

²²⁷ Hamlon, *supra* note 222.

²²⁸ *Id.*

a contentious one in state legislatures: In 2007, bills legalizing euthanasia or assisted suicide were introduced, but not passed, in Arizona, California, Hawaii, Rhode Island, Vermont, and Wisconsin.²²⁹

Jack Kevorkian and his “mercitron” may have done much to raise the public’s consciousness as to euthanasia.²³⁰ He claimed to have helped more than 130 people die, not all of them terminally ill.²³¹ With his sinister and rather unsavory aspect and his overzealousness, Kevorkian alienated many who might otherwise have been sympathetic to his cause.²³² Kevorkian was most effective in portraying end-of-life illness as agonizing and untreatable.²³³ Having thus frightened the public, he then offered up his expedient brand of mercy.²³⁴ In 1991, Dr. Timothy Quill referred to Kevorkian and his antics as “a kind of sideshow.”²³⁵ Neither Kevorkian’s crusade nor the “news coming out of the Netherlands” could manage to dispel the cloud of uncertainty lingering over the euthanasia question.²³⁶

B. *Assisted Suicide Abroad and at Home: The Netherlands and Oregon*²³⁷

The Dutch have tolerated assisted dying for at least several dec-

²²⁹ International Task Force on Euthanasia and Assisted Suicide, *Euthanasia & Assisted-Suicide Measures Proposed* (2007), http://www.internationaltaskforce.org/us_bills.htm (last visited Oct. 9, 2007).

²³⁰ See International Task Force on Euthanasia and Assisted Suicide, *The Real Jack Kevorkian*, <http://www.internationaltaskforce.org/fctkev.htm> (last visited Oct. 9, 2007); see also Davey *supra* note 206, at A8.

²³¹ Belluck, *supra* note 206, at A14.

²³² *Id.*

²³³ See Foley, *supra* note 48, at 187.

²³⁴ *Id.*

²³⁵ Belluck, *supra* note 206, at A14.

²³⁶ DOWBIGGIN, *supra* note 71, at 169.

²³⁷ Belgium and Switzerland also have legalized euthanasia and/or assisted suicide. However, because the Dutch law came first and Dutch practice has been more extensively studied, this essay limits mention of the Belgian and Swiss laws and practice to the following summary: In 2002, Belgium passed a law allowing euthanasia and assisted suicide for patients who request it while suffering unbearably and for whom clinical treatment is considered hopeless. See Herman Nys, *Physician Assisted Suicide in Belgian Law*, 12 EUR. J. HEALTH L. 39 (2005). In the first two years under the new legislation, approximately 400 deaths by euthanasia were recorded. Expatica.com, *400 Belgian Euthanasia Cases in Two Years*, July 9, 2004, http://www.expatica.com/actual/article.asp?channel_id=3&story_id=9350. In 2005, the euthanasia rate doubled, as Belgian doctors reported 400 cases in that year. Expatica.com, *Euthanasia Cases Double Since Legalisation*, Feb. 7, 2006, http://www.expatica.com/actual/article.asp?channel_id=3&story_id=27432. The head of the Federal Control and Evaluation Commission for Euthanasia suspected, however, that the actual number of euthanasia deaths may be up to five times the official number. *Id.*; Expatica.com, *Belgian Euthanasia Cases ‘Exceed Official Reports,’* Sept. 5, 2005, http://www.expatica.com/actual/article.asp?channel_id=3&story_id=23437. Observing that euthanasia only ac-

ades.²³⁸ Beginning in the 1970s, a series of court cases effectively decriminalized euthanasia and conferred immunity from prosecution on euthanizing doctors.²³⁹ In 1990, the Dutch government appointed a commission to study how euthanasia was actually being practiced in the Netherlands.²⁴⁰ The resulting Rummelink report, issued the following year, revealed that in over 1000 of Holland's 130,000 annual deaths, "physicians admitted they actively caused or hastened death *without any request from the patient*."²⁴¹ In 25,000 cases, physicians made end-of-life decisions likely to result in death without consulting their patients.²⁴² Despite regulatory guidelines, physicians in 1990 reported patient euthanasia deaths to the authorities in only eighteen percent of the cases.²⁴³ By 1995, simplified notification procedures had improved the reporting rate to forty-one percent.²⁴⁴ A euthanasia study conducted in 1995 and 1996 reported that an average of ten percent of eligible physicians had declined to take part in the study.²⁴⁵ Observing that the incidence of underreporting and physician non-participation could compromise the study's accuracy, Dr. Sherwin Nuland posited the likelihood "that the physicians whose patients experienced the worst complications would be most reluctant to answer questions

counts for between three and four deaths out of every 1000, the Commission viewed the increased rate of euthanasia "as the result of progressive diffusion of information on euthanasia rather than [sic] a change in attitude." Expatica.com, *Belgium Keeps Tight Reins on Euthanasia Legislation*, Nov. 9, 2006, http://www.expatica.com/actual/article.asp?channel_id=3&story_id=34248.

In Switzerland, by contrast, assisted suicide has been effectively privatized; it is a crime only if those helping can be shown to have acted in self-interest. See Olivier Guillod & Aline Schmidt, *Assisted Suicide under Swiss Law*, 12 EUR. J. HEALTH L. 25 (2005); BBC News, *Family's Plea on Assisted Death*, June 2, 2006, http://news.bbc.co.uk/2/hi/uk_news/wales/5041306.stm; BBC News, *Dignitas: Swiss Suicide Helpers*, Jan. 20, 2003, <http://news.bbc.co.uk/2/hi/europe/2676837.stm>.

²³⁸ Herbert Hendin, *Legalized Euthanasia in the Netherlands Has Resulted in Many Deaths Without Consent*, in EUTHANASIA *supra* note 48, at 149 [hereinafter Hendin, *Legalized Euthanasia*].

²³⁹ *Id.* at 149-50.

²⁴⁰ *Id.* at 151.

²⁴¹ Herbert Hendin, *Safeguards Cannot Prevent Abuse of Legalized Euthanasia*, in EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 63, at 145 (emphasis added) [hereinafter Hendin, *Safeguards Cannot Prevent Abuse*]; see also Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 169 (2000) ("All empirical studies of the Dutch experience show that some percentage of euthanasia acts are performed on incompetent patients despite the ostensible impermissibility of such acts under Dutch law.").

²⁴² Hendin, *Safeguards Cannot Prevent Abuse*, *supra* note 241, at 145.

²⁴³ *Id.* at 154.

²⁴⁴ *Id.* at 154.

²⁴⁵ Johanna H. Groenewoud et al., *Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands*, 342 NEW ENG. J. MED. 551, 552 (2000).

about untoward events.”²⁴⁶

The Dutch, apparently undeterred by these findings, officially legalized assisted suicide and voluntary active euthanasia in 2001.²⁴⁷ Eligible candidates now include those suffering from psychological distress as well as chronic and terminal illness, children, and individuals with mental retardation or brain damage.²⁴⁸ At least one critic of euthanasia in the Netherlands has claimed that, because it is easier, euthanasia has replaced the use of palliative and hospice care for the chronically sick and dying.²⁴⁹

Opponents of the “Dutch cure” were especially repelled by the specter of involuntary euthanasia.²⁵⁰

The failed initiatives in California and Washington in the early 1990s would have allowed euthanasia by lethal injection as well as assisted suicide.²⁵¹ In contrast, physician-assisted suicide, limited to competent, terminally ill adults, seemed a more respectable, moderate alternative.²⁵² The state of Oregon, with its political culture of “libertarianism, progressive populism, and the lowest rate of churchgoing” in the nation, proved highly hospitable to assisted suicide.²⁵³ In 1994, the state’s voters approved the Oregon Death with Dignity Act (ODWDA).²⁵⁴ However, implementation was delayed by a federal court ruling that the statute violated the Fourteenth Amendment.²⁵⁵ After this decision was vacated on procedural grounds,²⁵⁶ the Act was held in further abeyance pending the Supreme Court’s decisions in *Glucksberg* and *Quill*.²⁵⁷ In 1997, Oregon voters defeated a measure to repeal the Act by an even greater margin than the majority originally supporting it in 1994.²⁵⁸

²⁴⁶ Sherwin B. Nuland, *Physician-Assisted Suicide and Euthanasia in Practice*, 342 *NEW ENG. J. MED.* 583, 583 (2000).

²⁴⁷ DOWBIGGIN, *supra* note 71, at 169.

²⁴⁸ Hendin, *Safeguards Cannot Prevent Abuse*, *supra* note 241, at 144; *see also* Rita L. Marker, International Task Force on Euthanasia and Assisted Suicide, *Euthanasia, Assisted Suicide & Health Care Decisions: Protecting Yourself & Your Family*, 2006, http://www.internationaltaskforce.org/rpt2006_1.htm#108.

²⁴⁹ Hendin, *Legalized Euthanasia*, *supra* note 238, at 159.

²⁵⁰ Hendin, *Safeguards Cannot Prevent Abuse*, *supra* note 241, at 145.

²⁵¹ Marker, *supra* note 248.

²⁵² *Id.*

²⁵³ DOWBIGGIN, *supra* note 71, at 171.

²⁵⁴ OR. REV. STAT. § 127.800 (2000).

²⁵⁵ *Lee v. Oregon*, 891 F. Supp. 1429, 1438 (D. Or. 1995) (holding that the Act violated the Fourteenth Amendment’s Equal Protection Clause because it “singles out terminally ill persons who want to commit suicide and excludes them from protection of Oregon laws that apply to others.”), *vacated and remanded*, 107 F.3d 1382 (9th Cir. 1997).

²⁵⁶ *Lee v. Oregon*, 107 F.3d 1382 (9th Cir. 1997) (holding that the plaintiffs, doctors, patients, and residential care facilities challenging the facial validity of the Act failed to establish actual injury, as required for standing).

²⁵⁷ Pratt, *supra* note 108, at 187.

²⁵⁸ *Id.*

The federal government responded by seizing on the Controlled Substances Act (“CSA”)²⁵⁹ as a means to obstruct operation of the Oregon statute. In November 2001, United States Attorney General John Ashcroft issued an interpretive rule declaring that physicians who prescribe lethal substances to assist in suicide are in violation of the CSA.²⁶⁰ An Oregon federal district judge issued a permanent injunction against enforcement of Ashcroft’s rule and was upheld by the U.S. Court of Appeals for the Ninth Circuit.²⁶¹ The Supreme Court agreed, concluding that the CSA did not authorize the Attorney General to prohibit doctors from prescribing regulated drugs in accordance with the ODWDA.²⁶² As of this writing, the Act remains in effect.

Somewhat strangely, the facilitation of suicide contemplated by the ODWDA is legislatively determined not to constitute “assisted suicide, mercy killing or homicide, under the law.”²⁶³ The statute further forbids the use of “lethal injection, mercy killing or active euthanasia” to end a patient’s life.²⁶⁴ To qualify for death with dignity under the law, one must be an adult Oregon resident, mentally competent, terminally ill and, within reasonable medical judgment, likely to die within six months.²⁶⁵ The patient’s request for life-ending medication must be voluntary and in writing.²⁶⁶ Upon receipt of such request, the attending physician must determine whether the patient is terminally ill, refer the patient to a consulting physician for confirmation of the diagnosis, and ensure that the patient is making an informed decision.²⁶⁷ If, in the attending physician’s opinion, the patient’s judgment is impaired by a psychiatric or psychological illness or depression, the physician shall refrain from prescribing the medication and refer the patient for counseling.²⁶⁸ If the counselor determines the patient’s judgment is not impaired, the physician may prescribe the medication.²⁶⁹ Once a physician deems it appropriate to prescribe the medication, there is no further obligation to follow up with the patient or to be present when the drugs are ingested.²⁷⁰

Oregon’s Department of Human Services (“DHS”) issues yearly reports on physician compliance and the characteristics of those who have died pursuant

²⁵⁹ 21 U.S.C. §§ 801-802, 811-814, 821-830, 841-844a, 846-848, 850-856, 858-864, 871-890, 901-904 (2000).

²⁶⁰ *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1078-79 (D. Or. 2002), *aff’d*, 368 F.3d 1118 (9th Cir. 2004), *aff’d sub nom. Gonzales v. Oregon*, 546 U.S. 243 (2006).

²⁶¹ *Id.*

²⁶² *Gonzales*, 546 U.S. at 274-75.

²⁶³ OR. REV. STAT. § 127.880 (2000).

²⁶⁴ *Id.*

²⁶⁵ *Id.*

²⁶⁶ *Id.*

²⁶⁷ *Id.* at § 127.815.

²⁶⁸ *Id.* at §§ 127.815, 127.825.

²⁶⁹ *Id.* at § 127.825.

²⁷⁰ *Id.* at § 127.815.

to the Act. According to the DHS, from the passage of the ODWDA in 1997 to 2006, 292 people died from ingesting lethal medication.²⁷¹ Most of them were white, between the ages of sixty-five and eighty-four, and suffering from cancer, ALS, or HIV/AIDS.²⁷² Only nine percent of participants had less than a high school education, while forty-one percent had a college degree or higher.²⁷³ Almost without exception, they were medically insured, either privately or through Medicare or Medicaid.²⁷⁴ The vast majority died at home (ninety-three percent), with seventy-six percent enrolled in hospice care.²⁷⁵

The principal end of life concerns motivating these patients were “loss of autonomy,” “loss of dignity,” and the feeling of being less able to engage in activities that make life enjoyable.²⁷⁶ More than half were distressed at losing control of bodily functions, while more than a third feared they had become a burden on family, friends or caregivers.²⁷⁷ Less prominent among the participants’ concerns was the financial implications of treatment (seven percent).²⁷⁸ During 2006, a far greater number of participants was concerned about inadequate pain control than in previous years, an increase from twenty-two percent to forty-eight percent.²⁷⁹ During 2006, a far greater number of “participants were concerned about inadequate pain control . . . than in previous years . . .” an increase of twenty-two percent to forty-eight percent.²⁸⁰

These statistics seem to undermine the assertion that poor, uninsured and uneducated persons who are ill are especially at risk of pressure to commit suicide. Furthermore, the factors of intolerable pain or fear of inadequate pain control, while certainly significant, appear not as paramount as one might expect.²⁸¹ This does not mean, however, that, in general, relief of pain for many patients is adequate or even acceptable.²⁸² Nor does it mean that the 292 Oregon patients who opted for death might not have benefited, whatever their ultimate choice, from decent palliative care.²⁸³

The ODWDA requires physicians to document compliance with the statute

²⁷¹ OR. DEP’T OF HUMAN SERVS., SUMMARY OF OREGON’S DEATH WITH DIGNITY ACT—2006 1 (2006), available at <http://oregon.gov/DHS/ph/pas/docs/year9.pdf>.

²⁷² OR. DEP’T OF HUMAN SERVS., EIGHTH ANNUAL REPORT ON OREGON’S DEATH WITH DIGNITY ACT 12, Table 1 (March 9, 2006) [hereinafter cited as “DHS Report”].

²⁷³ *Id.* at Table 1.

²⁷⁴ *Id.* at Table 4.

²⁷⁵ OR. DEP’T OF HUMAN SERVS., *supra* note 271.

²⁷⁶ *Id.*

²⁷⁷ DHS Report, *supra* note 272, at 23.

²⁷⁸ *Id.*

²⁷⁹ *Id.* at 2.

²⁸⁰ *Id.* at 2.

²⁸¹ *Id.* at 2.

²⁸² See Marker, *supra* note 248.

²⁸³ SUMMARY OF OREGON’S DEATH WITH DIGNITY ACT—2006, *supra* note 271, at 1.

in the patient's medical record.²⁸⁴ These records are then submitted to the DHS for preparation of its annual review.²⁸⁵ As physicians are essentially self-reporting, there is no way to know how many prescriptions went unreported or to confirm the accuracy of the physician's documentation. Upon completion of each year's report, the DHS destroys all pertinent patient records, thus preventing any examination of each doctor's compliance from year to year.²⁸⁶ In fact, the DHS has neither the regulatory authority nor the resources to ensure that physicians are acting in accordance with the law.²⁸⁷

Almost entirely absent from these annual reviews is data concerning the doctor-patient relationship. According to one report, two-thirds of patients seeking assistance under OWDWA could not get a prescription from the first physician they contacted.²⁸⁸ Nearly half asked two or three other physicians.²⁸⁹ DHS reported that, in 2005, the median length of the doctor-patient relationship was eight weeks.²⁹⁰ This statistic does not indicate how often the patient was seen or the nature and extent of the doctor-patient discussions. Although the great majority of patients were enrolled in hospice care, there is no information as to whether hospice personnel were consulted or any way involved in the patient's decision to end his or her life.

That Oregon physicians so frequently and unilaterally deemed their patients mentally competent is also troubling, given the well-established link between mental illness and suicide.²⁹¹ Since 1998, only fourteen percent of patients have been referred for psychiatric evaluation, a mere five percent in 2005.²⁹² The ODWDA does not require an initial psychiatric evaluation, nor is the physician required to treat depression or any other mental illness if one is found.²⁹³ Most doctors are inadequately trained in diagnosing depression, particularly in complex cases where the patient is terminally ill.²⁹⁴ Medical illness "may obscure indicia of depression, rendering the diagnosis difficult."²⁹⁵ According to one large-scale study, terminally ill patients requesting suicide "all suffered

²⁸⁴ *Id.* at 9.

²⁸⁵ Or. Rev. Stat. 127.855 § 3.09 (1999) & 127.865 § 3.11 (1999).

²⁸⁶ Marker, *supra* note 248.

²⁸⁷ See Linda Prager, *Details Emerge on Oregon's First Assisted Suicides*, AM. MED. NEWS, Sept. 1998, at 10.

²⁸⁸ Amy D. Sullivan *et al.*, *Legalized Physician-Assisted Suicide in Oregon—The Second Year*, 342 New Eng. J. Med. 598, 601 (2000).

²⁸⁹ *Id.* at 603.

²⁹⁰ DHS Report, *supra* note 272 at 24, Table 4.

²⁹¹ See *supra* text accompanying notes 20-31.

²⁹² DHS Report, *supra* note 272, at 23.

²⁹³ See N. Gregory Hamilton & Catherine Hamilton, *Competing Paradigms of Response to Assisted Suicide Requests in Oregon*, 162:6 AM. J. PSYCHIATRY 1060, 1061 (2005).

²⁹⁴ N.Y. TASK FORCE, *supra* note 35, at 127.

²⁹⁵ *Id.*

from symptoms of depression or irrational hopelessness.”²⁹⁶ Under the traditional clinical model these patients would be treated for their symptoms.²⁹⁷ Under the OWDWA, they may well be given prescriptions for lethal drugs.²⁹⁸ Moreover, even if a patient is initially deemed mentally competent, there is no further physician follow-up to ensure that the patient remained competent to the time when he or she actually took the fatal overdose.²⁹⁹

Proponents of assisted dying often claim that merely possessing the means and the knowledge of how to end their lives brings solace to the terminally ill.³⁰⁰ Thus, “[o]ne woman had purchased poison more than a decade before she died, when her cancer was first diagnosed, so that she would never be without the means of controlling the end of her life, should it become unbearable.”³⁰¹ Some doctors even believe that this sense of control may prolong a patient’s life.³⁰² This view, while well-intentioned, conflicts with the well-established psychiatric practice of removing lethal instrumentalities from the proximity of suicidal individuals.³⁰³ As depression so often accompanies suicide, it is difficult to be certain that the decision to use lethal drugs is based on a rational determination to end one’s life, free of the distorting overlay of mental illness.

Another suspect entry in the DHS Report for 2006 is its finding that patients who ingested the medication suffered complications only five percent of the time.³⁰⁴ From 1998 to 2005, prescribing physicians were present when thirty five percent of their patients ingested the lethal medication.³⁰⁵ The other sixty-five percent were, evidently, not present to witness their patient’s deaths and may be providing information based on “secondhand accounts” or “guesswork.”³⁰⁶ The authors of the DHS report acknowledge that accounts by “family members, friends or other health professionals” attending the patient’s death are often the source of the physician’s narrative.³⁰⁷

The most common complications associated with assisted suicide are vomiting, spasm and difficulties with completion (“longer-than-expected interval be-

²⁹⁶ Hamilton & Hamilton, *supra* note 293, at 1060.

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ Marker, *supra* note 248.

³⁰⁰ See Derek Humphry, *Voluntary Euthanasia is Ethical*, in EUTHANASIA: OPPOSING VIEWPOINTS, *supra* note 63, at 22.

³⁰¹ Sullivan *et al.*, *supra* note 288, at 603.

³⁰² Hamilton & Hamilton, *supra* note 293, at 1063.

³⁰³ *Id.*

³⁰⁴ DHS Report, *supra* note 272 at 24, Table 4.

³⁰⁵ DHS Report, *supra* note 272, at 23-24, Table 4. According to the DHS Report, “other” health care providers were present in 54 percent of the cases. DHS Report, *supra* note 272, at 23.

³⁰⁶ Marker, *supra* note 248.

³⁰⁷ DHS Report, *supra* note 272, at 9.

tween administration of medications and death.”).³⁰⁸ In the Netherlands, the Royal Dutch Medical Association advises doctors to be present when their patients undergo assisted suicide or euthanasia.³⁰⁹ A physician who elects not to be present, perhaps at the patient’s request, must arrange to be available if the complications develop.³¹⁰ One Dutch study examined problems arising in 114 assisted suicide cases (roughly half the number of all 246 patients dying pursuant to ODWDA since 1998), and found complications in seven percent of these cases.³¹¹ In some instances, physicians had to step in and administer a lethal injection.³¹² In Oregon, since nearly two-thirds of physicians are not present when their patients ingest the lethal medication, they are not there to witness any complications which might occur. Those in attendance are constrained by statute from ending a patient’s life by lethal injection, mercy killing or active euthanasia.³¹³ Thus, they are barred from interventions which, in the event of complications, might end the patient’s nightmare.

If the “Dutch cure” arouses some medical and ethical alarms, the “Oregon cure” should too. Questions regarding physician reporting, follow-up and lack of presence at the patient’s death, along with cursory attention to mental health concerns, all seem to mock the statute’s stated intent to deliver death with dignity. At the beginning of the 21st century, no other state has followed Oregon’s example in enacting legislation to permit assisted suicide. But the story is far from over.

V. LESSONS ON DYING

The elders of the tribe meet and decide to propitiate Nature by sacrificing a young girl. A maiden is selected. . . . She is ordered by the elders to dance herself to death. She pleads pathetically, telling them that she is not that good a dancer.

Woody Allen, *A Guide to Some of the Lesser Ballets*³¹⁴

I am no coward, but I am so strong, [it is] so hard to die.

Meriwether Lewis³¹⁵

³⁰⁸ Groenewoud *et al.*, *supra* note 245, at 554.

³⁰⁹ *Id.* at 556.

³¹⁰ *Id.*

³¹¹ *Id.* at 555.

³¹² *Id.* at 554.

³¹³ OR. REV. STAT. 127.880 § 3.14 (1999).

³¹⁴ WOODY ALLEN, *A Guide to Some of the Lesser Ballets*, in *WITHOUT FEATHERS* 17 (Random House 1972) (1975).

³¹⁵ STEPHEN AMBROSE, *UNDAUNTED COURAGE* 456 (1996). Ambrose provides a poignant account of Lewis’s suicide. *Id.* at 465.

A. *The Limited Uses of Autonomy*

Two words crop up often in the dialogue on assisted dying: autonomy and compassion. Depending on where one stands on the euthanasia and assisted suicide question, these terms have different operative meanings. During the latter part of the 20th century, patients fought vigorously for the right of informed consent and self-determination in their medical care decisions. They achieved the right to refuse treatment, even if to do so would result in their deaths.³¹⁶ Aiming even higher on the autonomy scale, they petitioned for the right to determine the time and manner of their deaths.³¹⁷ When the Supreme Court denied them,³¹⁸ it put an end, at least temporarily, to “rights talk.”³¹⁹ It also neutralized autonomy as the “guiding principle” behind the debate.³²⁰ Now that assisted dying has entered the realms of ethics, medical practice and public policy, the role of autonomy is only one of the many factors for consideration. As for compassion, when it comes to the dying, we preach a great deal and practice very little. If nothing else, the euthanasia debate has highlighted serious deficiencies in end-of-life care.

Legalizing assisted dying would probably do little or nothing to improve the lot of “the 2.3 million Americans who die each year.”³²¹ But just thinking about it might help us to re-focus our priorities. The remainder of this essay explores some of these priorities.

One of the legacies of the *Cruzan* decision was a concerted effort, at both the state and federal levels, to expand the use of advance care directives and health care proxies.³²² Despite such efforts, only twenty-nine percent of Americans

³¹⁶ In re Quinlan, 355 A.2d 647, 663 (N.J. 1976).

³¹⁷ Compassion in Dying v. Washington, 79 F.3d 790, 816 (9th Cir. 1996), *rev'd sub nom* Washington v. Glucksberg, 521 U.S. 702 (1997).

³¹⁸ *Glucksberg*, 521 U.S. at 734.

³¹⁹ See Ezekiel Emanuel, *The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy*, 82 MINN. L. REV. 983, 983 (1998) (“the majority holdings [in *Washington v. Glucksberg* and *Vacco v. Quill*] permanently shifted the forum, the arguments, the perspective, and the justifications in the debate over PAS and euthanasia. The forum is no longer the courts, but the legislatures and public squares. The arguments are no longer about constitutional rights, but ethics and prudent policies.”); see also MEISEL & CERMINARA, *supra* note 77, at 1-4 (“The language of ‘rights’ denotes to many an adversarial relationship between patients and health care professionals and perhaps, consciously or unconsciously, conjures up images of the two most dreaded of all legal phenomena: the criminal prosecution and the malpractice lawsuit.”) Of course, in the American legal polity “rights talk” never ends for long. See, e.g., John B. Mitchell, *My Father, John Locke, and Assisted Suicide: The Real Constitutional Right*, 3 IND. HEALTH L. REV. 43 (2006).

³²⁰ Channick, *supra* note 128, at 609, 617.

³²¹ Emanuel, *supra* note 319, at 985.

³²² Channick, *supra* note 128, at 591-92. On advance directives and related documents generally, see MEISEL & CERMINARA, *supra* note 77, chap. 7, *Advance Directives*.

have executed living wills and, among them, relatively few young people.³²³ Worse, patients who do express their preferences in writing have no blanket assurance that their wishes will be honored. In one study of living wills, “physicians overrode a patient’s treatment preference twenty-five percent of the time and, in three-quarters of those overrides, the physician withheld treatment desired by the patient.”³²⁴ The drive to promote autonomy through the creation and implementation of advance directives has “essentially failed.”³²⁵

The assumption that autonomy is paramount among patient concerns is mistaken. In a study conducted by SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), a group of patients were given intensive medical staff intervention and information designed to promote informed decision-making.³²⁶ Surprisingly, these autonomy-enhancing measures had no significant impact on patient treatment choices, nor did they increase patient satisfaction.³²⁷

When thrust upon the unwilling and confused, autonomy can be frightening

³²³ National Hospice and Palliative Care Association, *Advance Care Planning is Critical*, (March 13th, 2006) available at <http://www.nhpco.org/i4a/pages/Index.cfm?pageID=4818>; Channick, *supra* note 128, at 628.

³²⁴ David Orentlicher, *The Alleged Distinction Between Euthanasia and Withdrawal of Life-Sustaining Treatment: Conceptually Incoherent and Impossible to Maintain*, 1998 U. ILL. L. REV. 837, 844-45 (1998) (Part of the dissonance between the intent manifest in advance directives and the results so at odds with that intent may be due to the resistance in some quarters to the “precommitment” concept in end-of-life medical care). See, e.g., Rebecca Dresser, *Precommitment: A Misguided Strategy for Securing Death with Dignity*, 81 TEX. L. REV. 1823, 1823 (2003) (arguing that reliance on advanced treatment directives is “misguided and morally troubling.”); Joanne Lynn, *Why I Don’t Have a Living Will*, 19 MEDICINE & HEALTH CARE 101, 103 (1991) (arguing in favor of “family choice over the opportunity to make our own choices in advance”) (emphasis in original).

³²⁵ Robert Burt, *The End of Autonomy*, in IMPROVING END OF LIFE CARE: WHY HAS IT BEEN SO DIFFICULT?, HASTINGS CENTER REPORT SPECIAL REPORT 35, no.6, S9-S13, at S9 (2005); see Jackson, *supra* note 87 at 149 (reporting that “the completion of a living will alone has been repeatedly demonstrated to fail to improve compliance with the wishes of patients and their families”).

³²⁶ Burt, *supra* note 325, at S9.

³²⁷ Channick, *supra* note 128, at 592-93. A more recent study of a short course designed to improve physician’s communication skills with patients on end-of-life issues reported mixed results:

Residents attending the course demonstrated statistically significant increases in their overall skill ratings in the delivery of bad news, with improvement in the specific areas of information giving and responding to emotional cues. Although cumulative scores for discussions about patient preferences for treatment did not increase residents demonstrated enhanced specific skills including discussing probability, presenting clinical scenarios, and asking about prior experience with end-of-life decision making. Stewart C. Alexander, et al., *A Controlled Trial of a Short Course to Improve Residents’ Communication with Patients at the End of Life*, 81 ACADEMIC MEDICINE 1008, 1008 (2006).

and burdensome. Modern patients, already overwhelmed by coordinating doctors and medical procedures and negotiating with insurance companies, must also choose among various treatment alternatives.³²⁸ When faced with multiple treatment options, especially experimental procedures, patients are told by doctors to perform their own research and decide according to their values.³²⁹ One exasperated patient remarked, “At 57, it’s a little late to be starting medical school.”³³⁰ Patients do benefit from being better-informed about their health, but, left to filter all the data on their own, they often feel abandoned. Physicians who provide continuous support and guidance throughout the treatment process help to improve patient survival rates and lower medical costs: “It is impossible to overestimate the bracing impact of that old-fashioned guide, the doctor who can be a patient’s constant, her Pole Star.”³³¹ In the words of one discouraged patient, “[i]t’s patchwork, and frustrating, that there is not one person taking care of me who I can look to as my champion.”³³² Yet, in 2003, less than a fifth of first-year medical students intended to pursue careers in primary care medicine.³³³ The “discrete and episodic” nature of the new doctor-patient relationship de-emphasizes autonomy and is plainly antithetical to notions of informed consent.³³⁴

The SUPPORT data further reveal that most patients and families don’t want to be responsible for end-of-life care decisions.³³⁵ Patients are often too ill and frail to meaningfully assess their treatment options. Further, according to Robert Burt, cognitive difficulties limit the ability of all patients to comprehend the reality of death, especially their own.³³⁶ One argument against assisted suicide is the fear that patients will be taxed with the responsibility for ending their own pain and suffering.³³⁷ Whatever they choose to do, the “blame will attach only to the dying person, and will be attached by the dying person to himself.”³³⁸ One can imagine that, to avoid these dilemmas, patients might willing-

³²⁸ Jan Hoffman, *Awash in Information, Patients Face a Lonely, Uncertain Road*, N.Y. TIMES, Aug. 14, 2005, available at <http://www.nytimes.com/2005/08/14/health/14patient.html>.

³²⁹ *Id.*

³³⁰ *Id.*

³³¹ *Id.*; see also NATIONAL QUALITY FORUM, A NATIONAL FRAMEWORK AND PREFERRED PRACTICES FOR PALLIATIVE AND HOSPICE CARE QUALITY, Table 1 at vii-viii (2006) (detailing 38 “preferred practices” of palliative care), available at <http://www.rwjf.org/files/research/txPHreportPUBLIC01-29-07.pdf>.

³³² Denise Grady, *Cancer Patients, Lost in a Maze of Uneven Care*, N.Y. TIMES, July 29, 2007, at A1 (quoting Karen Pasqualetto).

³³³ See Hoffman, *supra* note 328.

³³⁴ Channick, *supra* note 128, at 625.

³³⁵ Burt, *supra* note 325, at S9.

³³⁶ *Id.* at S10.

³³⁷ Ezekiel Emanuel, *Whose Right to Die?*, ATLANTIC MONTHLY, Mar. 1997.

³³⁸ Burt, *supra* note 325, at S11.

ly sacrifice autonomy for humane medical care. The question is whether, in assessing the best end of life options, they should have to.

B. *The Myths of Compassion*

Whatever our position on assisted dying, our calls for compassion must acknowledge that we treat the dying rather badly. We marginalize them and, whether through inadequate pain control or overly aggressive treatment, we cause them “needless suffering.”³³⁹ As of 2002, only five of 126 American medical schools required a separate course in end-of-life care.³⁴⁰ Despite the training opportunities available in hospice programs, only seventeen percent of residency programs offered a hospice rotation.³⁴¹ Yet, when surveyed, medical school students, residents and faculty expressed near-universal endorsement of the importance of end-of-life care.³⁴² Approximately one-third of those students and one-fifth of those residents have not been taught basic pain management.³⁴³ In clinical programs, “students are systematically protected from, or deprived of, opportunities to learn” about care of the dying.³⁴⁴ Even when they do participate in clinical programs, students lack role models with sufficient expertise and experience to provide leadership.³⁴⁵ Less than twenty percent of students surveyed had taken a course in end-of-life care.³⁴⁶ Further educational deficiencies were noted in “treatment of depression, bereavement care, and attention to the fears and concerns of dying patients.”³⁴⁷ Opponents of euthanasia refuse to countenance a response to suffering that involves “kill[ing] the sufferer.”³⁴⁸ But while good palliative care is an undeniably worthy goal, pain control is not always the principal issue in end-of-life dilemmas. Patients facing imminent death often require a range of services to guide and assist them as well as their families.

Hospice care would seem to offer some promise of relief, with its medical care, social work services and supportive counseling for the terminally ill and their families.³⁴⁹ Over the past decade, however, the median length of hospice has been a mere twenty-two days, with one-third of patients dying within seven

³³⁹ Foley, *supra* note 48, at 194.

³⁴⁰ *Id.* at 192.

³⁴¹ *Id.* at 192-93.

³⁴² Amy Sullivan et al., *The Status of Medical Education in End-of-life Care*, 18 J. GEN. INTERN MED. 685, 688 (2003).

³⁴³ *Id.* at 691.

³⁴⁴ *Id.*

³⁴⁵ *Id.*

³⁴⁶ *Id.* at 688.

³⁴⁷ *Id.* at 691.

³⁴⁸ See generally Foley, *supra* note 48, at 187.

³⁴⁹ Kathleen M. Foley, *The Past and Future of Palliative Care*, 35 HASTINGS CENTER REPORT (SPECIAL REPORT: IMPROVING END OF LIFE CARE: WHY HAS IT BEEN SO DIFFICULT?) S42, S43 n.6 Supplement (2005).

days of admission.³⁵⁰ Such “brink of death” care deprives patients of the opportunity, over the course of several months, to prepare for death.³⁵¹

To be eligible for hospice care, terminally ill patients traditionally had to abandon advanced or more aggressive medical treatment.³⁵² Recently, some private insurers and hospice programs have begun to offer more creative options.³⁵³ Patients may avail themselves of hospice’s supportive services while, at the same time receiving “sophisticated medical treatments that may slow or even halt their disease.”³⁵⁴ This new approach, called “open access” hospice, attracts patients who elect to continue curative or life-prolonging care.³⁵⁵ Some even improve enough to leave the program.³⁵⁶ Rather than spend their last weeks in a “last rites” atmosphere, patients can receive assistance through their final six, or even twelve, months of life.³⁵⁷

This approach, while encouraging, is not universally available and does not appeal to all terminally ill patients.³⁵⁸ There will still be those who express a desire for death. When they do, it is essential that physicians recognize that “medically ill suicidal individuals are no different from other suicidal individuals.”³⁵⁹ As A. Alvarez has chillingly described, the world of the suicidal is infested with omens.³⁶⁰ A depressed patient may interpret a physician’s willingness to assist in suicide as validating the decision to die, confirming that the choice is correct.³⁶¹ In reality, the patient may be pleading for a very different kind of reassurance.³⁶²

There is a type of discomfort known as “existential” suffering that afflicts the severely ill³⁶³ It encompasses the more spiritual and cultural aspects of suffering, such as fear of dependence and fear of becoming a burden to one’s family

³⁵⁰ *Id.* at S45.

³⁵¹ *Id.*

³⁵² Reed Abelson, *A Chance to Pick Hospice, and Still Hope to Live*, N.Y. TIMES, Feb. 10, 2007, at A1.

³⁵³ *Id.*

³⁵⁴ *Id.*

³⁵⁵ *Id.* at C4; *see, e.g.*, Continuum Hospice Care, Open Access, <http://www.hospicenyc.org/access.html> (last visited Sept. 27, 2007) (“In Open Access hospice, eligibility for hospice services is determined solely by the regulatory requirements: appropriate prognosis certified by a licensed physician and election of the benefit by patient or proxy. The patient’s Plan of Care may include any potential treatment, including life-prolonging treatments, and as long as the patient remains eligible, he or she will receive hospice care.”).

³⁵⁶ *Id.*

³⁵⁷ *Id.*

³⁵⁸ Foley, *supra* note 48, at 191-92.

³⁵⁹ Hamilton & Hamilton, *supra* note 293, at 1060.

³⁶⁰ ALVAREZ, *supra* note 11, at 144.

³⁶¹ N.Y. TASK FORCE, *supra* note 35, at 95.

³⁶² *Id.*

³⁶³ Foley, *supra* note 48, at 191-92.

as well as to oneself.³⁶⁴ It accompanies the disintegration of one's personality and the loss of a role in society.³⁶⁵ In its 2006 Summary of Oregon's Death with Dignity Act, the Oregon DHS reported that ninety-six percent of the state's death-with-dignity participants cited loss of autonomy as a principal concern.³⁶⁶ Given the questionable power of autonomy to ease the souls of the sick and dying, one can only speculate as to what the participants truly meant. Perhaps they were referring to these existential factors, or perhaps they simply wanted to die. Whatever their motivation, one wonders at the degree of compassion expended by a doctor who writes a prescription for lethal drugs and then bows out of the patient's life.

Oregon's incremental "arm's length" solution seeks to legitimate physician-assisted suicide by distinguishing it from active euthanasia.³⁶⁷ The distinction, says Ezekiel Emanuel, is a "charade"³⁶⁸ and "impossible to operationalize."³⁶⁹ Doctors, in a self-protective stratagem, "frequently label actions as PAS [physician-assisted suicide] when in fact the actions are euthanasia."³⁷⁰ Thus, a doctor may provide assistance with ingesting drugs to a patient who has difficulty swallowing. The physician tries to mitigate his own discomfort by classifying the action as one thing but certainly not another. Some competent patients are unable to end their lives on their own, whether because of weakness, neurologic disease or difficulty using their hands.³⁷¹ One Netherlands study found that, because of physical limitations affecting numerous patients seeking death, "general practitioners and nursing home physicians preferred euthanasia to assisted suicide."³⁷² Emanuel estimates that as many as twenty percent of physician-assisted suicide attempts result in failure to end the patient's life.³⁷³ He doubts that the state would prosecute physicians who, in these instances, step in to provide humane medical assistance.³⁷⁴ As a matter of social policy, "[t]he real choice is to legalize both PAS and euthanasia, or to legalize neither."³⁷⁵

In the realm of assisted dying, this is not the only distinction that "obfuscates

³⁶⁴ *Id.*

³⁶⁵ *Id.* at 192.

³⁶⁶ OR. DEP'T OF HUMAN SERVS., *supra* note 271 at 2.

³⁶⁷ Emanuel, *supra* note 319, at 1001 n.63.

³⁶⁸ *Id.* at 1003.

³⁶⁹ *Id.* at 1001. Emanuel refers to "[t]he myth of separation[,] . . . the notion that we can separate physician-assisted suicide from euthanasia." *Id.* at 984 n.4. He adds that "[a]lthough this distinction can be made conceptually, in practical terms it is extremely difficult." *Id.*

³⁷⁰ *Id.* at 1001.

³⁷¹ Groenewoud *et al.*, *supra* note 245, at 555.

³⁷² *Id.* at 555-56.

³⁷³ Emanuel, *supra* note 319, at 1002.

³⁷⁴ *Id.* at 1003.

³⁷⁵ *Id.*

rather than illuminates.”³⁷⁶ David Orentlicher argues that the “bright-line” separation between withdrawal of treatment and euthanasia/assisted suicide is equally untenable.³⁷⁷ When a patient refuses life-sustaining treatment, he does so because he no longer wishes to live.³⁷⁸ When a physician acts to discontinue that treatment, she is facilitating an “intent to die.”³⁷⁹ When a doctor, at the patient’s request, places him under terminal sedation, the patient will most likely refuse food and water.³⁸⁰ The combination of medically induced coma and withdrawal of nutrition and hydration will inevitably result in death and therefore constitutes euthanasia.³⁸¹ If a patient may legally refuse treatment and cannot be forced to remain alive, whether because of intolerable suffering or because he has made a competent, reasoned decision to end his life, “we are left with an argument that does not distinguish between treatment withdrawal and euthanasia/assisted suicide.”³⁸²

On the other hand, Robert Burt maintains that this distinction, though illogical, prevents us from becoming tolerant of actions that are “socially dangerous.”³⁸³ Preserving the myth of separation is “in the service of promoting conscious awareness of moral discomfort.”³⁸⁴ At first, this view seems reasonable. A little moral discomfort can go a long way in preventing a holocaust. Yet, a morality that rests on highly impeachable logic is easily attacked and easily overcome. Truly unsettling are distinctions promoting superficial or minimal compliance with arbitrary rules. Physicians may escape with their ethics and reputations intact. But whether the difference between treatment withdrawal and euthanasia is clear, patients are left with the less philosophical chore of dying.

In his concurring opinion in *Glucksberg*, Justice Souter cautioned against the recognition of unenumerated rights which effectively displace “the legislative ordering of things.”³⁸⁵ Emanuel interprets this to mean that, rather than “declare the existence of such unenumerated rights,” the Supreme Court should “ratify a social process that creates and accepts these rights.”³⁸⁶ Moral dicta such as “doctors must not kill” and invocations of the sanctity of life do little to unravel the complexity of the assisted-dying debate. As Ronald Dworkin observed, “the crucial question is not whether to respect the sanctity of life, but

³⁷⁶ Channick, *supra* note 128, at 619.

³⁷⁷ Orentlicher, *supra* note 324, at 846.

³⁷⁸ *Id.*

³⁷⁹ *Id.*

³⁸⁰ *Id.* at 855.

³⁸¹ *Id.* at 855-56.

³⁸² *Id.* at 846.

³⁸³ Burt, *supra* note 325, at S12.

³⁸⁴ *Id.*

³⁸⁵ *Washington v. Glucksberg*, 521 U.S. 702, 788-89 (1997) (Souter, J., concurring).

³⁸⁶ Emanuel, *supra* note 319, at 994.

which decision best respects it.”³⁸⁷ Sound public policy relies on experimentation and the testing of various assumptions. The resolution of assisted-dying issues will evolve, not from slogans or unsubstantiated beliefs, but from “a new paradigm of bioethics,” based on empiricism and facts.³⁸⁸ Improving and studying palliative and end-of-life care is the first step, along with proper diagnosis and treatment of depression in the seriously ill. As we learn more about the process of dying, we are better able to evaluate the boundaries of treatment and to recognize that, in some cases, assisted-dying may well be the most humane response. With so much yet to know, we must ask ourselves whether, in a compassionate society, the seemingly cold and peremptory practices the Oregon statute risks engendering are the best we can do. It may be impossible to effectively legislate and regulate assisted dying. Even the most painstakingly crafted safeguards, approved by the courts and the medical profession, do not guarantee adherence.³⁸⁹ The Dutch experience has taught us that safeguards are often violated and, due to physician underreporting, it is difficult to ascertain the frequency and extent of those violations.³⁹⁰

Leon Kass abjures the legalization of euthanasia, “[f]or the choice for death is not one option among many, but an option to end all options.”³⁹¹ Given the gross inadequacy of medical care for the dying, the rush to assisted suicide and euthanasia does seem precipitate. But, for some time now, doctors have been engaged in furthering the process of dying, through pain medications that hasten death, as well as by terminal sedation. Moreover, as many as seventy percent of hospital deaths result from the decision to withdraw or withhold treatment.³⁹² Reporting and documentation of medical decisions to terminate treatment or hasten death would provide valuable data on actual, current end-

³⁸⁷ Ronald Dworkin, *Life is Sacred: That's the Easy Part*, in ARGUING EUTHANASIA, *supra* note 74, at 250.

³⁸⁸ Channick, *supra* note 128, at 612; *see also* Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1100 (1998) (The assisted suicide debate requires a larger discussion that has not yet occurred on the role of data and empiricism in the constitutional and policy questions. In the absence of that discussion, the debate too often veers into ungrounded abstraction. But the data tell an important story. They show that patients need not choose between agony and assisted suicide; numerous techniques for pain relief and palliative care are available, including sedation to unconsciousness. When patients do seek assisted suicide, it is usually because untreated depression or inadequate pain relief drives them. These patients are not independent agents freely choosing an uncoerced option, as in a commercial transaction. And termination of life-sustaining treatment, high-dose pain relief, and sedation to unconsciousness are distinct practices with significant therapeutic uses, each one distinguishable from assisted suicide.)

³⁸⁹ Emanuel, *supra* note 319, at 1011.

³⁹⁰ *Id.* at 1009, 1011.

³⁹¹ Leon R. Kass, *Death with Dignity and the Sanctity of Life*, in ARGUING EUTHANASIA, *supra* note 74, at 232.

³⁹² N.Y. TASK FORCE, *supra* note 35, at 147.

of-life practices. These mechanisms would further assist in the development of ethics and guidelines in care for the dying, including determining those circumstances where euthanasia might be appropriate. It is time to penetrate the veil of calculated ambiguity and subterfuge preventing forthright discussion of these issues.³⁹³ The threat of criminal prosecution is diminished when factual distinctions between euthanasia and withholding treatment are so difficult to prove. It is also unlikely that prosecutors and judges would want to assume the unenviable role of second-guessing the decisions of trained, competent professionals who routinely care for the dying and gravely ill.

Emanuel estimates that, of the 2.32 million Americans who die each year, there are 5,000 to 25,000 people who suffer unendurable pain and would choose physician-assisted suicide or euthanasia as a means of ending this pain.³⁹⁴ That these individuals might benefit from life-ending procedures does not obviate the urgent necessity of improving palliative care for all of us. That this group is comparatively small also calls into question the wisdom of a broad, legislative response. Donald McKinney's observation that assisted dying is best envisioned as a "private act"³⁹⁵ seems far more apt and persuasive than partisan arguments about legalization. The decision to end one's life is profoundly personal and properly resides within a secure, knowledgeable and unhindered doctor-patient relationship.³⁹⁶

In an era when life-prolonging measures "force some patients to outlive their deaths,"³⁹⁷ we require physicians to be more than staunch defenders of life. Medicine is essentially "a pastoral art, especially when a good physician, like a good shepherd," helps to guide the patient through illness and, when the time comes, from life into death.³⁹⁸ Undoubtedly, one risk of tolerating euthanasia is that the practice will expand to include an ever-widening array of candidates. While this risk should not be underestimated, it seems arbitrary and even heartless to exclude all but the terminally ill from the prospect of release. Terribly injured victims of accidents and war, and sufferers of degenerative diseases such as ALS might also wish for a permanent end to their ordeal. To categorically deny them relief implies that we are somehow qualified to judge the merits of their claims.

Assisted dying, however humanely practiced, is the taking of life. We cling to life, even in the most unimaginable circumstances. Indeed, A. Alvarez has

³⁹³ Quill, *supra* note 96, at 203.

³⁹⁴ Emanuel, *supra* note 319, at 1008.

³⁹⁵ N.Y. TASK FORCE, *supra* note 35, at 102-103.

³⁹⁶ See Jackson, *supra* note 87, at 149 ("What is wanted is a commitment by physicians to a *process* of engaging patients regarding antemortem care issues, not a reliance on a 'one-shot' conversation that leaves a vaguely worded document tucked deep in the recesses of the patient's clinic record.").

³⁹⁷ Vaux, *supra* note 93, at 2141.

³⁹⁸ *Id.* at 2141; see Jackson, *supra* note 87, at 152 ("When all else is done, comfort the dying.").

written that the best counterargument to suicide “is life itself.”³⁹⁹

You pause and attend: the heart beats in you chest, outside the trees are thick with new leaves, a swallow dips over them, the light moves, people are going about their business.⁴⁰⁰

For those for whom life is no longer enough, who are weak and exhausted, immobilized and imprisoned in their bodies, longing for a death that is tantalizingly out of reach, one can only hope that they find their good shepherds.

VI. CONCLUSION

We have much more to learn about the care of the ill and the dying and about compassion in all of its contexts. Without more research and analysis, we cannot yet condemn or discard any practice that may help to alleviate suffering. Zealous devotion to the sanctity of life is not, and perhaps never has been, the cardinal rule in end-of-life care. Palliative treatment for the dying and severely ill is an emerging specialty. We must allow it to evolve unhampered by extremist sentiment and discredited notions of legal entitlement.

Yet, officially sanctioned assisted dying in the Netherlands and Oregon has produced mixed and problematic results. Until the medical profession willingly accepts an unambiguous role in end-of-life ethics and policy, legislative solutions will continue to be incremental, partially informed and perhaps even injurious to the dying.

³⁹⁹ ALVAREZ, *supra* note 11, at 152.

⁴⁰⁰ *Id.*