

2007

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GONZALES V. OREGON AND PHYSICIAN-ASSISTED SUICIDE: ETHICAL AND POLICY ISSUES

Ken Levy*

I. INTRODUCTION

Since 1990, the United States Supreme Court has issued three major decisions on euthanasia:¹ *Cruzan v. Director, Missouri Department of Health*,² *Vacco v. Quill*,³ and *Washington v. Glucksberg*.⁴ Last term, the Court issued a decision, *Gonzales v. Oregon*,⁵ that discussed euthanasia but turned almost entirely on other issues, primarily statutory interpretation and the legitimate scope of the United States Attorney General's authority over medical policy among the fifty States. So *Gonzales* did not really advance the euthanasia debate very far. Still, the debate that it did provoke is interesting and worth further investigation, less for constitutional reasons and more for ethical and public policy reasons.

The incidental debate focused on whether or not physician-assisted suicide—i.e., “a physician[’s] facilitat[ing] a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act”⁶—serves a “legitimate medical purpose.”⁷ While the majority held that it *does* serve a legitimate medical

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1. Euthanasia is “commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy.” Council on Ethical & Jud. Affairs, American Medical Association (AMA), *Decisions near the End of Life*, 267 J. Am. Med. Assn. 2229, 2229 (1992).

2. 497 U.S. 261 (1990).

3. 521 U.S. 793 (1997).

4. 521 U.S. 702 (1997).

5. 126 S. Ct. 904 (2006).

6. *Physician-Assisted Suicide*, AMA Code of Ethics § E-2.211, <http://www.ama-assn.org/ama/pub/category/print/8459.html> (last updated Aug. 22, 2005); Council on Ethical & Jud. Affairs, *supra* n. 1, at 2229.

7. *Gonzales*, 126 S. Ct. at 915 (quoting 21 U.S.C. § 830(b)(3)(A)(ii) (2000) and 21 C.F.R. § 1306.04 (2005)). See also Kathleen Foley and Herbert Hendin, *Introduction: A Medical, Ethical, Legal, and Psychosocial Perspective*, in *The Case against Assisted Suicide: For the Right to End-of-Life Care* (Kathleen Foley and Herbert Hendin eds., Johns Hopkins U. Press 2002) (“In physician-assisted suicide, the patient self-administers the lethal dose that has been prescribed by a physician who knows the patient intends to use it to end his or her life.”)

purpose, Justices Scalia, Roberts, and Thomas took the opposite position in their dissent. Unfortunately, the majority did not indicate what this legitimate purpose is. So we are still left to fill in this blank ourselves. This article offers the most obvious way to fill in this blank—namely, alleviation of suffering.

This article will then survey—and reject—some ethical arguments against physician-assisted suicide. But the ultimate conclusion of this article is not that physician-assisted suicide should be legalized. Rather, the ultimate conclusion of this article is that States should think very long and hard before they follow Oregon's example and legalize physician-assisted suicide within their own borders. For even if there are no decisive ethical objections against physician-assisted suicide, it *does* raise serious policy worries. Perhaps the most important among them is that the very legalization of physician-assisted suicide would likely pressure too many terminally ill patients into exercising this option unnecessarily early and for the wrong reasons—not to alleviate their own suffering but to minimize the burden, inconvenience, and economic expense that they fear their continued existence would impose on others.⁸

II. THE ROAD TO *GONZALES V. OREGON*

The debate about whether or not physician-assisted suicide serves a legitimate medical purpose has hardly arisen in a vacuum. Rather, it has arisen directly out of the decisions issued in—and questions unresolved by—three previous cases dealing with the “right to die”: *Cruzan*, *Vacco*, and *Glucksberg*. This part summarizes the issues and arguments in these decisions, including the concurring and dissenting opinions, that are related closely enough to physician-assisted suicide.

A. *Cruzan*

1. The Majority

In *Cruzan*, the majority interpreted the central question to be whether or not Nancy Cruzan, who had been in an automobile accident that left her in a permanent vegetative state, had a constitutional right to refuse unwanted lifesaving medical treatment. Speaking for the majority, Chief Justice Rehnquist argued that she did. According to Rehnquist, Cruzan had a “constitutionally protected liberty interest” in refusing unwanted medical treatment, a liberty interest that derives from the Fourteenth Amendment’s Due Process Clause.⁹

This conclusion, however, raised a problem. Because Cruzan was in a vegetative state, it was impossible to ask her directly whether or not she wished to remain on life support. So her desires had to be ascertained in some other, less direct, way—namely, from evidence proffered by her family, friends, and *guardian ad litem*. Chief Justice

8. This article will discuss but not evaluate arguments for and against our having a constitutional right to physician-assisted suicide. For an eloquent defense of the proposition that a constitutional right to physician-assisted suicide should be recognized, see John Rawls et al., *Assisted Suicide: The Philosophers' Brief*, 44 N.Y. Rev. Bks. 41 (Mar. 27, 1997).

9. 497 U.S. at 278. The Due Process Clause provides that no State shall “deprive any person of life, liberty, or property, without due process of law.” U.S. Const. Amend. XIV, § 1.

Rehnquist argued that, in order to remove Cruzan's life support, this evidence had to establish to a "clear and convincing" degree that she wanted, or would have chosen in a conscious and competent state, to refuse lifesaving medical treatment. For only this high standard would lead to the correct distribution of the risk of error. On the one hand, if Cruzan's life support were removed against her wishes, then her right of self-determination would be *irreversibly* violated; once she was dead, there would be no bringing her back. If, on the other hand, Cruzan's life support continued against her wishes, then, while her right of self-determination would be violated, this violation would still be *reversible*. The possibility would remain that clear and convincing evidence that Cruzan (would have) wished to die would arrive. And if it did, the hospital could at *that* time fulfill Cruzan's wishes and remove her life support.¹⁰

2. Justice Scalia's Concurrence

In his concurrence, Justice Scalia pointed out that the petitioners, Cruzan's parents, had a difficult obstacle to overcome. States may clearly pass laws prohibiting suicide without violating the Due Process Clause. Yet the petitioners were trying to demonstrate that States like Missouri *were* violating the Due Process Clause by forbidding Cruzan's parents from withdrawing her life support. So petitioners had to demonstrate that there is a distinction between suicide and refusal of lifesaving medical treatment and that this distinction is constitutionally relevant. Accordingly, petitioners attempted to draw three distinctions that satisfied both of these criteria. The second of these distinctions, which only Justice Scalia discussed, was that refusal "would bring on [Cruzan's] death not by any affirmative act but by merely declining treatment that provides nourishment."¹¹ "Suicide, it is said, consists of an affirmative act to end one's life; refusing treatment is not an affirmative act 'causing' death, but merely a passive acceptance of the natural process of dying."¹²

Justice Scalia correctly identified this distinction as a species of the more general distinction between "action and inaction," which is more commonly known in philosophy, criminal law, and tort law as the distinction between positive action and *omission*. Justice Scalia then argued that this distinction between positive action and omission is morally—and therefore constitutionally—irrelevant. For, all else being equal, action and omission are both intention- and outcome-equivalent. They are merely different means to the same deliberately-sought end. For example, a parent is equally guilty of homicide whether she actively poisons her child or deliberately allows her child starve to death. It does not matter that the parent performs a positive action in one situation (administering poison) and performs no positive action in the other (stands idly by). Either way, the parent equally intends the child's death and the child equally dies.¹³

Rather than dismissing the positive action-omission distinction entirely, Justice

10. *Cruzan*, 497 U.S. at 283.

11. *Id.* at 295. The two other distinctions were that Cruzan was "permanently incapacitated and in pain" and that "preventing her from effectuating her presumed wish to die requires violation of her bodily integrity." *Id.*

12. *Id.* at 296.

13. *Id.* at 296–97

Scalia made two positive suggestions. First, he suggested that the positive action-omission distinction was not *entirely* irrelevant, that it “has some bearing upon the legislative judgment of what ought to be prevented as suicide” and could be “discerned by logic or legal analysis.”¹⁴ Second, Justice Scalia suggested that the positive action-omission distinction was not far away from the more appropriate distinction. According to Justice Scalia, the line should be drawn not between positive action and omission but rather between “various forms” of omission—namely, omissions “that consist of abstaining from ‘ordinary’ care and [omissions] that consist of abstaining from ‘excessive’ or ‘heroic’ measures.”¹⁵

Curiously, however, Scalia’s second suggestion ended there. He did not explain why *this* distinction between omission of ordinary measures and omission of heroic measures is important or relevant. So it is difficult to see exactly what point Justice Scalia was making. Was he suggesting that withdrawal of life support *is* constitutionally protected when, and only when, it involves the omission of heroic measures? Was he suggesting that the distinction between omission of ordinary measures and omission of heroic measures *is* morally relevant but still constitutionally irrelevant? Or something else altogether? It is not clear.¹⁶

3. Justice Stevens’ Dissent

Two different dissenting opinions were offered, one by Justice Stevens¹⁷ and the other by Justice Brennan.¹⁸ Justice Brennan’s opinion was joined by Justices Marshall and Blackmun.

Justice Stevens argued that the majority should have assigned greater weight to Cruzan’s own best interests than to the State’s interest in preserving and protecting life.¹⁹ The main challenge for Justice Stevens was to demonstrate that withdrawal of life support was indeed in Cruzan’s best interests in the first place. He could not simply assume this point because it would beg the question against those who believe that life is always preferable to death and therefore that it is always in a person’s best interests to remain alive as long as possible, even if her life is impoverished to the level of a persistent vegetative state, than to die. Justice Stevens challenged this position with two arguments.

First, Justice Stevens argued that whether or not a person has an interest in

14. *Id.* at 296.

15. *Id.*

16. The distinction between “ordinary” and “extraordinary” treatments is sometimes thought to align with the distinction between treatment that ethically must be provided and treatment that morally may be withheld or withdrawn. See Council on Ethical & Jud. Affairs, *supra* n. 1, at 2230. But there are two problems with this position. First, the line between ordinary and extraordinary is difficult to draw. *Id.* at 2230–31. Second, the ordinary-extraordinary distinction seems to be non-moral; the determination of whether or not a given treatment is morally obligatory should be determined by moral, not (solely) non-moral, considerations. *Id.*

17. *Cruzan*, 497 U.S. at 330-57 (Stevens, J., dissenting).

18. *Id.* at 301-30 (Brennan, Marshall & Blackmun, JJ., dissenting).

19. See also Ronald Dworkin, *Life’s Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* 12–13 (Alfred A. Knopf 1993) (distinguishing between the “detached” claim that a person’s life should be preserved because human life is sacred and the “derivative” claim that a person’s life should be preserved because she has a right to continue, and interest in continuing, to live).

remaining alive depends on whether or not her life has value for her. And, life abstracted from the person has no value for her. Rather, a person's life has value for her only if it reaches, or has the potential to reach, a certain minimal degree of quality—namely, consciousness without inordinate suffering. So if a given person's life does not and cannot reach this level, such as in Cruzan's case, it does not have sufficient value for that person and that person therefore does not have an interest in remaining alive.²⁰

Second, Justice Stevens offered a two-part argument. First, even if Cruzan did have an interest in remaining alive, she had other interests that outweighed her interest in remaining alive. These other interests included how she would be remembered by "those whose opinions mattered to her," how she would *want* to be remembered, the integrity of her body, her dignity, and her personhood. Second, these other interests—which took precedence over Cruzan's purported interest in staying alive—were better served by withdrawal, rather than continuation, of life support.²¹

Justice Stevens' dissent focused on Cruzan's best interests, which are independent of her (prior) desires. And independence entails potential conflict. We often do not want what is in our best interests. For example, it is in a child's best interests to get certain vaccinations even if she would prefer not to be pricked with a needle. One problem with Justice Stevens' position is that he did not explore this possible difficulty. Justice Stevens' position arguably commits him to the position that a persistent vegetative patient's best interests trump her (prior-expressed) wishes, whatever they might be. So even if a patient in a persistent vegetative state previously expressed a desire to stay indefinitely on life support, Justice Stevens' position arguably entails that this desire is not dispositive, that the patient should still be terminated if it would better serve the memories of those close to her, the integrity of her body, her dignity, and her personhood. This conclusion seems a bit harsh and counterintuitive, no less inconsistent with the liberty interest protected by the Due Process Clause.²²

4. Justice Brennan's Dissent

Perhaps aware of this weakness in Justice Stevens' advocacy of a best-interests standard, Justice Brennan agreed with the majority that the standard should instead be Cruzan's autonomy, her self-determination, what she wanted or would have wanted in her current situation. He agreed with the majority that people like Cruzan have a constitutional "right to be free of unwanted artificial nutrition and hydration."²³

Still, Justice Brennan diverged from the majority on five main issues. First, he felt

20. *Cruzan*, 497 U.S. at 344–47, 356–57.

21. *Id.* at 344, 350–51, 355–56.

22. Of course, the potential conflict between autonomy and best interests may work in the opposite direction as well. It may be the case that the patient *wishes* to die, and this wish conflicts with her best interests. (Indeed, it is fear of this particular situation that motivates much, if not most, opposition to legalizing physician-assisted suicide.) Lois Shepherd makes a similar point about the potential conflict between autonomy and *dignity*. See Lois Shepherd, *Dignity and Autonomy after Washington v. Glucksberg: An Essay about Abortion, Death, and Crime*, 7 Cornell J.L. & Pub. Policy 431, 453–55 (1998).

23. *Cruzan*, 497 U.S. at 302. We have now come across three different considerations that are used in determining whether or not withdrawal of lifesaving medical treatment is constitutionally protected: the patient's autonomy, the patient's best interests, and the intrinsic value or sanctity of the patient's life. See Dworkin, *supra* n. 19, at 26, 190–98.

that the right to refuse unwanted medical treatment was not merely an important “liberty interest” but *fundamental*.²⁴ Second, he argued that Missouri’s interest in preserving life was *not* sufficiently important—at least not as important as Cruzan’s contrary wish to discontinue life support.²⁵ Third, Justice Brennan argued that, contrary to both the Missouri Supreme Court and the majority, the evidence that Cruzan wanted withdrawal of life support *was* clear and convincing.²⁶ Fourth, he argued that not only a decision to discontinue unwanted life support *but also* a decision to *continue* life support inflicted irreversible damage.²⁷ Fifth, he argued that if there is not clear and convincing evidence regarding what the patient wanted, the decision regarding what to do with the patient should not automatically “escheat” to the State but should instead be directed to “the person whom the patient himself would most likely have chosen as proxy or . . . the patient’s family.”²⁸

B. *Vacco*

In *Cruzan*, Chief Justice Rehnquist suggested that even *non*-terminally ill patients have the constitutional right to refuse *non*-lifesaving medical treatment because forced medical treatment, even though non-lifesaving, would violate their “liberty interest in refusing unwanted medical treatment” just as much as forced lifesaving medical treatment.²⁹ It goes without saying that there is an important distinction between the right to withdraw non-lifesaving medical treatment and physician-assisted suicide: only the latter will lead to death. So it would not be very convincing for proponents of physician-assisted suicide to argue that people have a constitutionally protected right to physician-assisted suicide because (a) withdrawal of *any* medical treatment is constitutionally protected and (b) there is no principled distinction between physician-assisted suicide and the withdrawal of any medical treatment. Rather, if this argument is to have any possibility of success, (a) and (b) should be restricted to *lifesaving* medical treatment.³⁰

In *Vacco*, it was precisely (b) that was at issue. The central question was whether or not there is a meaningful distinction between physician-assisted suicide and withdrawal of unwanted lifesaving medical treatment.³¹ (As discussed above, in his *Cruzan* concurrence, Justice Scalia had the foresight to confront this same issue.)

Respondents offered the following argument for striking down New York State’s ban on physician-assisted suicide: (a) all else being equal, there is no meaningful difference between physician-assisted suicide and withdrawal of unwanted lifesaving

24. *Cruzan*, 497 U.S. at 304–05.

25. *Id.* at 312–14.

26. *Id.* at 319, 321–25.

27. *Id.* at 320–21; *see also* Dworkin, *supra* n. 19, at 196–98; Rawls et al., *supra* n. 8, at 46.

28. *Cruzan*, 497 U.S. at 328 (footnote omitted).

29. *Id.* at 277–79.

30. *See* David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 *New Eng. J. Med.* 663, 665 (1996) (noting irony of notion that while a young person depressed from the breakup of a romantic relationship has the constitutional right to withdrawal of ventilator treatment for her asthma, a very elderly terminally ill person in great pain does not have the constitutional right to physician-assisted suicide).

31. *Vacco*, 521 U.S. at 793 (1997).

medical treatment; (b) the Equal Protection Clause of the Fourteenth Amendment requires States to treat like cases alike;³² therefore, (c) physician-assisted suicide should receive the same constitutional protection that withdrawal of lifesaving medical treatment received in *Cruzan*. But the Court disagreed. Contrary to (a), Chief Justice Rehnquist's majority opinion held that there *are* meaningful differences between physician-assisted suicide and withdrawal of unwanted lifesaving medical treatment, differences that are both "widely recognized and endorsed in the medical profession and in our legal traditions" and "important and logical . . . certainly rational."³³

The first such distinction lies in intent. In both cases, the doctor expects or foresees that the patient will die sooner than she otherwise would. But in only one of these situations—physician-assisted suicide—is this result actually *intended*. The doctor does not intend this result if she merely withdraws life support. Instead, she intends "only" to respect her patient's wishes and thereby enable the patient to maintain her autonomy and dignity.³⁴ Chief Justice Rehnquist added that what applies to withdrawal of life support also applies to "aggressive palliative care."³⁵ Like the former, the latter may hasten the patient's death—i.e., may lead the patient to die earlier than she would have without the palliative medication³⁶—"but the physician's purpose and intent is, or may be, only to ease his patient's pain."³⁷ Rehnquist's theory here is commonly known as the "Doctrine of Double Effect." The Doctrine of Double Effect holds that actions producing certain negative outcomes are morally permissible, even if these outcomes were reasonably foreseeable, as long as the outcomes were unintended.³⁸

The second distinction lies in causation. Chief Justice Rehnquist argued that how the doctor helps her patient to die determines the actual cause of the patient's death. On the one hand, if the doctor helps her patient to commit suicide by prescribing a lethal medication, then the cause of the patient's death is the medication. On the other hand, if the doctor withdraws life support, then the cause of the patient's death is the "underlying fatal disease or pathology."³⁹ So the patient's death can be directly attributed to the doctor only in the case of physician-assisted suicide, not in the case of withdrawal of life support.⁴⁰

In his discussion of the second distinction—causation—Chief Justice Rehnquist

32. The Equal Protection Clause provides that no State shall "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1.

33. *Vacco*, 521 U.S. at 800-01 (footnote omitted).

34. *Id.* at 801-03.

35. *Id.* at 802.

36. See Leon R. Kass, 'I will Give No Deadly Drug': *Why Doctors Must Not Kill*, in Foley & Hendin, *supra* n. 7, at 34, 37; Thomas J. Marzen, "Out, Out Brief Candle": *Constitutionally Prescribed Suicide for the Terminally Ill*, 21 *Hastings Const. L.Q.* 799, 819 nn. 61, 62 (1994); Student Author, *Physician-Assisted Suicide*, 111 *Harv. L. Rev.* 237, 247 (1997); Shepherd, *supra* n. 22, at 465 n. 157.

37. *Vacco*, 521 U.S. at 802.

38. See Kass, *supra* n. 36, at 36-37; Yale Kamisar, *The Rise and Fall of the 'Right' to Assisted Suicide*, in Foley & Hendin, *supra* n. 7, at 81-82. *But see* Joan C. Callahan, *Acts, Omissions, and Euthanasia*, 2 *Pub. Affairs Q.* 21 (1988) (arguing that the Doctrine of Double Effect is conceptually and morally problematic).

39. *Vacco*, 521 U.S. at 801.

40. See also Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* 151 (Yale U. Press 1970) ("In omission no human agent causes the patient's death, directly or indirectly. He dies his own death from causes that it is no longer merciful or reasonable to fight by means of possible medical interventions.")

actually offered a third distinction: the consequences of prohibition. He argued that the *Cruzan* Court determined that patients have a constitutional right to refuse lifesaving medical treatment on the basis of “well-established, traditional rights to bodily integrity and freedom from unwanted touching.”⁴¹ A State that prohibited withdrawal of life support would effectively be forcing some patients to undergo unwanted lifesaving medical treatment, which is a form of battery. Rehnquist then implied that the same cannot be said of physician-assisted suicide. Presumably what he had in mind was that States’ prohibiting doctors from prescribing lethal medication does not force patients to suffer any violations to their “bodily integrity and freedom from unwanted touching.” It does not force patients to do anything. Instead, it exerts force only upon *doctors*.⁴²

C. *Glucksberg*

Vacco was the companion case to *Glucksberg*. Again, the *Vacco* Court held that New York State’s prohibition against physician-assisted suicide did not violate terminally ill patients’ Fourteenth Amendment Equal Protection rights.⁴³ In *Glucksberg*, Chief Justice Rehnquist held that the State of Washington’s prohibition against physician-assisted suicide did not violate terminally ill patients’ Fourteenth Amendment *Due Process* rights.

1. The Majority

Importantly, Chief Justice Rehnquist’s decision was *not* that physician-assisted suicide *violates* the Fourteenth Amendment Due Process Clause and therefore *must* be prohibited. It was only that physician-assisted suicide *is not protected by* the Due Process Clause and therefore *may* be prohibited. Naturally, *this* proposition is consistent with a State’s decision to *permit* physician-assisted suicide. As Chief Justice Rehnquist concluded, “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.”⁴⁴

Chief Justice Rehnquist offered several arguments for the majority’s conclusion that physician-assisted suicide is not protected by the Due Process Clause. First, he argued that while *Cruzan* held that patients have a constitutional right to refuse unwanted lifesaving medical treatment, this right does not entail or encompass a further right to receive assistance from a doctor in terminating their lives. As he did in *Vacco*, Rehnquist argued that, despite their superficial resemblance, the two practices are substantively distinct enough to warrant different legal treatment.⁴⁵

Second, Rehnquist argued that if people do not have a right to perform a certain

41. *Vacco*, 521 U.S. at 807 (citing *Cruzan*, 497 U.S. at 278–79, 287–88 (O’Connor, J., concurring)).

42. See also New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 105, 113 (2d. ed., Jan. 2000); Orentlicher, *supra* n. 30, at 663 (describing a fourth possible distinction “between assisted suicide and the withdrawal of life-sustaining treatment . . . as a useful proxy, or substitute, for distinguishing between morally acceptable and morally unacceptable decisions by patients to end their lives.”).

43. *Vacco*, 521 U.S. at 797.

44. *Glucksberg*, 521 U.S. at 735.

45. *Id.* at 724–26.

action, then they certainly do not have a right to receive assistance in performing that action. As it turns out, people do not have a right to commit suicide.⁴⁶ Therefore people do not have a right to receive assistance in committing suicide. There are two main reasons that people do not have a right to commit suicide. The first reason: the prohibition against suicide is deeply rooted in “our Nation’s history, legal traditions, and practices.”⁴⁷ Similarly, most States, not to mention most Western democracies, have criminalized physician-assisted suicide.⁴⁸ While not dispositive, this fact certainly casts some doubt on the notion that physician-assisted suicide is a right, no less a fundamental right.⁴⁹ The second reason: the State has a compelling interest in prohibiting suicide—namely, the preservation of human life, especially life that does not necessarily involve a future of illness and suffering.⁵⁰

Third, Rehnquist argued that, in addition to the preservation of human life, the State has several other compelling interests that motivate prohibiting physician-assisted suicide. These other interests include “protecting the integrity and ethics of the medical profession”;⁵¹ “protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, . . . mistakes . . . coercion . . . prejudice, negative and inaccurate stereotypes, and ‘societal indifference’”;⁵² and protecting society against rolling down the slippery slope from physician-assisted suicide to “voluntary and perhaps even involuntary euthanasia.”⁵³ (These concerns will be discussed further in Part IV below.)

Regarding this last point, a doctor commits involuntary euthanasia when she performs euthanasia without the patient’s informed consent⁵⁴ and voluntary euthanasia when she performs euthanasia with the patient’s informed consent.⁵⁵ Because involuntary euthanasia “would never be ethically acceptable,”⁵⁶ we need no further explanation why Chief Justice Rehnquist rejected it. But why did he reject voluntary euthanasia as well? Although he did not give the reason, Rehnquist most likely had in mind scenarios in which a doctor, for her own ulterior reasons, helps suicidal patients to die unnecessarily early—i.e., when these patients are suffering not from terminal illnesses or incurable pain but rather from depression that might very well have been treated. *This* kind of euthanasia—though voluntary—would still be highly undesirable because it would lead to the deaths of patients who, had they resisted or been forced to resist their suicidal impulses, might very well have overcome their depression and gone

46. *Id.* at 711.

47. *Id.* at 710, 711–14.

48. *Id.* at 710–11, 714–18.

49. *Id.* at 723, 728; see also *Gonzales, Petr.’s Br.*, 2005 WL 1126079 at *24 (May 12, 2005) (indicating that “Congress passed a broad ban on the federal funding of assisted suicide” in 1997 and that “physician-assisted suicide is not eligible for reimbursement under Medicare because it is ‘not reasonable and necessary to the diagnosis and treatment of disease or injury’” (citation omitted)).

50. *Glucksberg*, 521 U.S. at 728–29.

51. *Id.* at 731.

52. *Id.* at 731–32 (citation omitted).

53. *Id.* at 732.

54. Council on Ethical & Jud. Affairs, *supra* n. 1, at 2229.

55. *Id.*

56. *Id.*

on to lead fulfilling and productive lives.⁵⁷

2. Concurring Opinions

Four Justices—Souter, Breyer, O'Connor, and Stevens—offered concurring opinions in *Glucksberg*. All of them drew attention to a third possibility “in between” physician-assisted suicide, which they agreed is not constitutionally protected, and refusal of lifesaving medical treatment, which is constitutionally protected.⁵⁸ This third possibility, which was already discussed in Part I.B above, was a doctor’s administering to terminally ill patients suffering excruciating pain palliative drugs that have the side effect of hastening death.⁵⁹ The point that all four Justices made with this third possibility is that it is legal, at least in New York and Washington, and therefore renders physician-assisted suicide unnecessary. Even if doctors do not have the option of prescribing lethal drugs for terminally ill patients, they may achieve a similar outcome by prescribing palliative but death-hastening treatment instead. Of course, this argument would fail for any State that decided to criminalize palliative but death-hastening treatment. But because no State has yet legislated any such prohibition, the Justices remained content with the status quo.⁶⁰

3. Justice Stevens’ Concurring Opinion

Justice Stevens was the only member of the Court to recognize that the very legality of palliative but death-hastening treatment has important implications for what would later become a central issue in *Gonzales*: the purpose of medicine. Justice Stevens stated:

The fear is that a rule permitting physicians to assist in suicide is inconsistent with the perception that they serve their patients solely as healers. But for some patients, it would be a physician’s refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role. . . . [B]ecause physicians are already involved in making decisions that hasten the death of terminally ill patients—through termination of life support, withholding of medical treatment, and

57. See also *Glucksberg*, 521 U.S. at 782–86 (Souter, J., concurring).

58. *Id.* at 737–38 (O’Connor, J., concurring), 751 (Stevens, J., concurring), 780 (Souter, J., concurring), 791–92 (Breyer, J., concurring).

59. But see New York State Task Force, *supra* n. 42, at 109 n. 115 (noting that the National Hospice Organization has adopted a resolution that “reaffirms the hospice philosophy that hospice care neither hastens nor postpones death”) (citation omitted).

60. But see *Vacco*, Respt.’s Br., 1996 WL 708912 at **8–9 (Dec. 10, 1996) (citations omitted):

Palliative medication is of course available to ease many patients’ physical pain. But it is undisputed that for others, especially those dying of some forms of cancer and those particularly near death, it may be impossible to relieve their excruciating pain or other physical symptoms. In addition, some patients may be unable to receive relief from pain because of their violent physical or psychological reactions to high doses of opiates. Palliative medication also has no effect on the suffering that may be brought on by a patient’s own anguish, physical degeneration and loss of dignity. Further, at levels at which it may be effective, such medication may have the effect of impairing mental acuity. Many patients find—especially near the end—that they cannot obtain the required level of pain relief before losing whatever clarity of mind is otherwise left to them for communicating with loved ones, praying, or coming to terms with their impending death. Although these patients may be prepared to die, they are confronted instead only with intolerable suffering—the suffering of their own pain or of opiate-induced oblivion.

terminal sedation—there is in fact significant tension between the traditional view of the physician’s role and the actual practice in a growing number of cases.⁶¹

Justice Stevens was groping toward a significant insight. The passage above suggests that palliative but death-hastening treatment is both consistent and in “significant tension” with a doctor’s “healing role.” This apparent opposition, however, can be dissolved. Justice Stevens’ point would have been more effective had he suggested that, in addition to healing, doctors serve another purpose as well: alleviation of suffering. For then Justice Stevens would not have had to try to fit the round peg of palliative but death-hastening treatment into the square hole of healing. Instead, he would have been able to fit this round peg into the equally round hole of alleviation. Moreover, as will be shown below, this suggestion would have had the fringe benefit of giving Justice Kennedy a strong point to use and Justice Scalia a compelling challenge to overcome in their respective *Gonzales* opinions.

4. Justice Souter’s Concurring Opinion

In a part of his concurring opinion, Justice Souter strayed from the central constitutional questions to offer a public policy argument for the conclusion that criminalization of physician-assisted suicide is preferable to legalization. Justice Souter argued that some of the State interests mentioned by Chief Justice Rehnquist—namely, “protecting vulnerable groups” and protecting society against rolling down the slippery slope from physician-assisted suicide to “voluntary and perhaps even involuntary euthanasia”—were sufficient reasons for prohibiting physician-assisted suicide. Justice Souter based his argument on empirical evidence obtained from the Netherlands, one of the few countries that has legalized physician-assisted suicide. Studies showed that even Dutch laws permitting physician-assisted suicide that were layered with safeguards—laws “with teeth”—had been unable to prevent these interests from being impaired. Justice Souter concluded from this data that, until sufficient countervailing evidence becomes available, the safer course is for States to continue prohibiting physician-assisted suicide rather than passing laws, even “with teeth,” that permit this (potentially) dangerous practice.⁶²

D. Gonzales

The central issue in *Gonzales* was whether or not the Controlled Substances Act (CSA)⁶³ allowed “the United States Attorney General to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide, notwithstanding a state law permitting the procedure.”⁶⁴ The Court held that CSA did not grant the Attorney General this power. Most of its decision was based on the application of canons of statutory interpretation to the text of CSA.

61. *Glucksberg*, 521 U.S. at 748–49 (footnote omitted).

62. *Id.* at 782–87.

63. Pub. L. No. 91-513, 84 Stat. 1242, as amended, 21 U.S.C. §§ 801–971 (1994 & Supp. II 1996).

64. *Gonzales*, 126 S. Ct. at 911.

1. Case History

A brief history of *Gonzales* is in order. In 1994, Oregon became the first State to pass a ballot measure legalizing physician-assisted suicide.⁶⁵ The resulting Death with Dignity Act (DWDA)⁶⁶ exempts from criminal or civil liability state-licensed physicians who, in compliance with DWDA's safeguards, dispense or prescribe lethal doses of drugs to terminally ill patients who wish to die. In 1997, Oregon voters reaffirmed Oregon's DWDA by rejecting a ballot measure proposing to invalidate it.

On November 9, 2001, soon after Senator John Ashcroft had become the United States Attorney General, he issued a directive (the Ashcroft Directive) declaring that Oregon's DWDA conflicted with CSA and therefore was invalid.⁶⁷ CSA, which Congress passed in 1970, was designed to combat drug abuse and control the legitimate and illegitimate traffic in controlled substances by creating a comprehensive regulatory regime criminalizing the unauthorized manufacture, distribution, dispensation, and possession of substances that are questionable insofar as they have a potential for abuse or dependence, do not have an accepted medical use, or are not considered sufficiently safe for use under medical supervision. Attorney General Ashcroft declared that substances prescribed by doctors for the purpose of assisting terminally ill patients to end their lives violated CSA. Therefore, contrary to Oregon's DWDA, "appropriate administrative action" could still be taken against doctors who issued such prescriptions.

Attorney General Ashcroft based his interpretation of CSA on the application of two key concepts. The first came from a regulation issued in 1971 by then-Attorney General John Mitchell, which stated in part: "A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."⁶⁸ The second concept came from a 1984 congressional amendment to CSA, which authorized the Attorney General to revoke a physician's prescription privileges upon the determination that the physician has "committed such acts as would render his registration . . . inconsistent with the public interest."⁶⁹ According to the amendment, an act is "inconsistent with the public interest" if it, among other things, "threatens the public health and safety."⁷⁰ Attorney General Ashcroft held that substances prescribed for the purpose of assisting suicide fell within the scope of substances prohibited by CSA because physician-assisted suicide does not serve a "legitimate medical purpose" and is therefore "inconsistent with the public interest."⁷¹

On November 7, 2001, a doctor, a pharmacist, several terminally ill patients, and the State of Oregon challenged the Ashcroft Directive in the United States Court for the District of Oregon. On April 17, 2002, Judge Robert E. Jones entered a permanent

65. Similar ballot measures had previously been rejected by voters in California and Washington State and later rejected by voters in Michigan.

66. Or. Rev. Stat. §§ 127.800–127.995 (2005).

67. 66 Fed. Reg. 56607–56608 (Nov. 9, 2001).

68. 21 C.F.R. § 1306.04(a) (2005).

69. 21 U.S.C. § 824(a)(4).

70. *Id.* at § 823(f).

71. Ashcroft Directive, 66 Fed. Reg. at 56608; see also *Gonzales*, Petr.'s Reply Br., 2005 WL 2083964 at **2–3, 19–20 (Aug. 25, 2005); *Gonzales*, Petr.'s Br., *supra* n. 49, at **18–20.

injunction against enforcement of the Ashcroft Directive.⁷² On May 7, 2003, Attorney General Ashcroft appealed the injunction to the United States Court of Appeals for the Ninth Circuit. On May 26, 2004, a divided panel of the Court of Appeals affirmed the injunction on the ground that the Ashcroft Directive “interferes with Oregon’s authority to regulate medical care within its borders and therefore alter[s] the usual constitutional balance between the States and the Federal Government.”⁷³ On November 9, 2004, Attorney General Ashcroft, who was succeeded the next day by Alberto R. Gonzales, appealed the Court of Appeals’ decision to the United States Supreme Court.⁷⁴ On January 17, 2006, a divided Supreme Court affirmed the Court of Appeals’ decision.⁷⁵

2. The Majority

Justice Kennedy affirmed the Court of Appeals’ decision primarily on the ground that CSA, appropriately interpreted, did not extend to substances prescribed for the purpose of physician-assisted suicide. Justice Kennedy said very little about physician-assisted suicide itself. But the little he did say is noteworthy:

In the face of the CSA’s silence on the practice of medicine generally and its recognition of state regulation of the medical profession it is difficult to defend the Attorney General’s declaration that the statute impliedly criminalizes physician-assisted suicide. . . . A prescription, the Government argues, necessarily implies that the substance is being made available to a patient for a legitimate medical purpose. The statute, in this view, requires an anterior judgment about the term “medical” or “medicine.” The Government contends ordinary usage of these words ineluctably refers to a healing or curative art, which by these terms cannot embrace the intentional hastening of a patient’s death. It also points to the teachings of Hippocrates, the positions of prominent medical organizations, the Federal Government, and the judgment of the [forty-nine] States that have not legalized physician-assisted suicide as further support for the proposition that the practice is not legitimate medicine.

On its own, this understanding of medicine’s boundaries is at least reasonable. The primary problem with the Government’s argument, however, is its assumption that the CSA impliedly authorizes an Executive officer to bar a use simply because it may be inconsistent with one reasonable understanding of medical practice. Viewed alone, the prescription requirement may support such an understanding, but statutes “should not be read as a series of unrelated and isolated provisions.” The CSA’s substantive provisions and their arrangement undermine this assertion of an expansive federal authority to regulate medicine.⁷⁶

Justice Kennedy, then, conceded that one “reasonable” interpretation of the purpose of medicine is to heal, which includes preventing, curing, and curbing illness, disease, and injury. But implicit in Justice Kennedy’s expression “one reasonable understanding of

72. *Or. v. Ashcroft*, 192 F. Supp. 2d 1077, 1080 (D. Or. 2002).

73. *Id.* at 1124 (quoting *Gregory v. Ashcroft*, 501 U.S. 452, 461 (1985)) (internal quotation marks omitted) (brackets in original).

74. *Gonzales*, No. 04-623 (U.S. filed Nov. 9, 2004).

75. *Gonzales*, 126 S. Ct. at 926.

76. *Id.* at 924 (citations omitted).

medical practice” were the assumptions that, in addition to healing, medicine may serve another reasonable purpose, and physician-assisted suicide may be consistent with this other purpose. Unfortunately, Justice Kennedy failed to explain what this alternative legitimate medical purpose might be. Moreover, Justice Kennedy failed to explain how it might be the case that physician-assisted suicide does *not* threaten the public health and safety and is thereby *consistent* with the public interest.

3. The Dissent

Justice Scalia’s dissent, which was joined by Chief Justice Roberts and Justice Thomas, capitalized on these omissions.⁷⁷ The majority’s failure to offer a legitimate medical purpose other than healing or an explanation of how physician-assisted suicide might not threaten the public health and safety left Justice Scalia free to claim victory for the Attorney General’s unchallenged interpretations:

[E]ven if [the Attorney General’s] interpretation of [“legitimate medical purpose”] is entitled to lesser deference or no deference at all, it is by far the most natural interpretation of [this phrase]—whose validity is not challenged here. This interpretation is thus correct even upon *de novo* review. [And] even if that interpretation of [“legitimate medical purpose”] were incorrect, the Attorney General’s independent interpretation of the *statutory* phrase “public interest” in 21 U.S.C. §§ 824(a) and 823(f), and his implicit interpretation of the statutory phrase “public health and safety” in § 823(f)(5), are entitled to deference . . . and they are valid.⁷⁸

Justice Scalia spent most of his opinion explaining why deference should be given to the Attorney General’s interpretation of CSA and of its incompatibility with physician-assisted suicide. For the most part, he argued that deference was owed to the Attorney General not necessarily because his interpretations were correct but because both the text of CSA and prior cases—namely *Auer v. Robbins*⁷⁹ and *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*⁸⁰—mandated this deference.⁸¹

Still, Justice Scalia *did* maintain that, regardless of deference issues, the Attorney General’s interpretations *were* correct. In particular, Justice Scalia offered three quick arguments—or, more precisely, one argument and two assertions—in defense of the Attorney General’s thesis that the only legitimate medical purpose is healing and therefore that CSA clearly ruled out physician-assisted suicide. Justice Scalia’s only *argument* was to reiterate the Attorney General’s own appeal to authority. Justice Scalia stated that “[v]irtually every relevant source of authoritative meaning,” including “virtually every medical authority from Hippocrates to the current American Medical

77. *Gonzales*, 126 S. Ct. at 926 (Roberts, C.J., Scalia & Thomas, JJ., dissenting).

78. *Id.* at 926 (citations omitted).

79. 519 U.S. 452 (1997).

80. 467 U.S. 837 (1984).

81. In his separate dissent, Justice Thomas also argued that deference should be given to the Attorney General’s interpretations of CSA. Like Justice Scalia, Justice Thomas argued that this deference was mandated by CSA. *Id.* at 940 (Thomas, J. dissenting). But Justice Thomas also argued that the Supreme Court’s decision in *Gonzales v. Raich*, 545 U.S. 1 (2005)—a case that entailed the Attorney General’s interpretations of CSA—was inconsistent with the majority’s decision in *Gonzales*. *Id.* at 939–41.

Association (AMA),” suggests that the sole purpose of medicine is to heal.⁸² The first of Justice Scalia’s *assertions* was that “[n]ot even those of our Eighth Amendment cases most generous in discerning an ‘evolution’ of national standards would have found, on this record, that the concept of ‘legitimate medicine’ has evolved so far.”⁸³ The second of Justice Scalia’s *assertions* was that healing is the only meaning that “legitimate medical purpose” could have, and this meaning “surely excludes the prescription of drugs to produce death.”⁸⁴

III. ETHICAL ISSUES

It is not clear whether or not there is a larger significance to Justice Kennedy’s point in *Gonzales* that there may be legitimate medical purposes other than healing. At the very least, Justice Kennedy is suggesting that the worry that physician-assisted suicide is incompatible with a doctor’s role as healer is not dispositive, that States may still permit physician-assisted suicide without necessarily violating the fundamental purposes of medicine. But is this point also meant to reopen the very door that *Vacco* and *Glucksberg* apparently closed? Again, *Vacco* and *Glucksberg* both held that terminally ill patients do not have a constitutional right to physician-assisted suicide. Is *Gonzales* meant to be the first step in undoing *Vacco* and *Glucksberg* and revisiting this question?

Of course, we can only speculate as to what the Court’s underlying motivations are and how it will decide future cases questioning the constitutionality of laws either permitting or prohibiting physician-assisted suicide. This article does not attempt to engage in any such psychoanalysis or palm reading. Instead, it remains on the safer ground of argument and textual interpretation. The thesis of this part is that, whether or not the Court intends to reconsider if terminally ill patients have a constitutional right to physician-assisted suicide, it has not offered theoretically satisfying answers to two critical questions. The first question: does physician-assisted suicide have a legitimate medical purpose? The second question: is there a meaningful morally relevant distinction between physician-assisted suicide, which the Court stated in *Vacco* and *Glucksberg* may be criminalized, and withdrawal of lifesaving medical treatment, which the Court stated in *Cruzan* is a constitutionally protected right?

A. Does Physician-Assisted Suicide Have a Legitimate Medical Purpose?

In *Glucksberg*, there was a scuffle between Justices Kennedy and Scalia over whether or not physician-assisted suicide serves a legitimate medical purpose. Justice Kennedy suggested that it may but failed to mention what this legitimate medical purpose might be. And Justice Scalia suggested that the only legitimate medical purpose is healing and therefore that physician-assisted suicide, which is designed not to heal but to do the very opposite—kill—falls outside the legitimate boundaries of medicine.

82. *Gonzales*, 126 S. Ct. at 932; see also *Physician-Assisted Suicide*, *supra* n. 6; New York State Task Force, *supra* n. 42, at 105–08.

83. *Gonzales*, 126 S. Ct. at 932 (Roberts, C.J., Scalia & Thomas, JJ., dissenting).

84. *Id.* at 939.

1. The Hippocratic Oath

Justice Scalia based his position that physician-assisted suicide does not serve a legitimate medical purpose largely on a June 27, 2001 memorandum from the Office of Legal Counsel at the U.S. Department of Justice to Attorney General Ashcroft (OLC Memorandum).⁸⁵ The OLC Memorandum derived this position from a number of sources, including the AMA and the American Nurses Association.⁸⁶ These agencies themselves relied largely on the Hippocratic Oath.

There are two versions of the Hippocratic Oath—ancient and modern. The ancient version, which was written in the fifth century B.C. by Hippocrates, states in part that “[n]either will I administer a poison to anybody when asked to do so, nor will I suggest such a course.”⁸⁷ The modern version, written by Dr. Louis Lasagna in 1964, states in part:

Most especially must I tread with care in matters of life and death. If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.⁸⁸

The ancient version directly conflicts with physician-assisted suicide. But there are several reasons why the ancient version does not present a very strong basis for current opposition to physician-assisted suicide. First, candidates for the license to practice medicine no longer recite, or need to recite, the ancient version.⁸⁹ Rather, they generally recite the modern version.⁹⁰ Second, Hippocrates inserted the clause above (“[n]either will I . . . such a course”) into the oath largely to “prevent[] physicians from participating in political intrigues.”⁹¹ This concern is no longer relevant. Third, there is

85. Memo. from U.S. Dept. of Just., Off. of Leg. Counsel, to Atty. Gen. John Ashcroft, *Whether Physician-Assisted Suicide Serves a “Legitimate Medical Purpose” under the Drug Enforcement Administration’s Regulations Implementing the Controlled Substances Act* (June 27, 2001). Others who base their opposition to physician-assisted suicide at least in part on the Hippocratic Oath include the Council on Ethical & Jud. Affairs, *Physician-Assisted Suicide*, 10 Issues L. & Med. 91 (1994); Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino & Mark Siegler, “Doctors Must Not Kill”, 259 J. Am. Med. Assn. 2139 (1988); John C. Harvey, *Doctors Must Not Kill*, Am. J. Ethics & Med. 9 (1993); Leon R. Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, 94 Pub. Interest 25 (1989); Kass, *supra* n. 36, at 31-32; Charles L. Sprung, *Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments*, 263 J. Am. Med. Assn. 2211 (1990); Avraham Steinberg, *The Terminally Ill—Secular and Jewish Ethical Aspects*, 30 Isr. J. Med. Sci. 130 (1994); see also Stephen Jamison, *Assisted Suicide: A Decision-Making Guide for Health Professionals* 20 (Jossey-Bass 1997); Ernlé W.D. Young, *Physician-Assisted Suicide: Overview of the Ethical Debate*, 166 W. J. Med. 402, 403-04 (1997).

86. OLC Memorandum, *supra* n. 85, at 11-13. The AMA stated its position in *Glucksberg*, Amicus Br., 1996 WL 656263 (Nov. 12, 1996), and in H.R. Subcomm. on Const. of the H. Comm. on the Jud., *Assisted Suicide in the United States*, 104th Cong. 521-66 (Apr. 29, 1996) (testimony of Lonnie L. Bristow, M.D., Pres., AMA) (available at 1996 WL 226114). The American Nurses Association stated its position at the same hearing and in its *Position Statement on Assisted Suicide*, <http://www.nursingworld.org/readroom/position/ethics/prtetsuic.htm> (Dec. 8, 1994).

87. *Ethics in Medicine: Historical Perspectives and Contemporary Concerns* 5 (Stanley Joel Reiser, Arthur J. Dyck & William J. Curran eds., student ed., MIT Press 1977).

88. Nova Online, *Hippocratic Oath—Modern Version*, http://www.pbs.org/wgbh/nova/doctors/oath_modern.html (updated Mar. 2001).

89. Nova Online, *The Hippocratic Oath Today: Meaningless Relic or Invaluable Moral Guide*, http://www.pbs.org/wgbh/nova/doctors/oath_today.html (updated Mar. 2001).

90. *Id.*

91. Erich H. Loewy, *Textbook of Medical Ethics* 146 (Plenum Publ. Corp. 1989).

no good reason to think that Hippocrates is a definitive, authoritative source on the fundamental principles of medical ethics. His view is just as contestable as any other medical ethicist's view.⁹² Fourth, the principles of medical ethics are not necessarily timeless but rather vary with context, society, and technology. These three things have dramatically changed since Hippocrates' time.

Unlike the ancient version, the modern version does not clearly rule out physician-assisted suicide. First, to suggest that a physician must "tread with care in matters of life and death" still leaves open the possibility of a physician's *carefully* terminating her patient's life. Second, the suggestion that the "awesome responsibility" of "tak[ing] a life" "must be faced with great humbleness and awareness of my own frailty" directly suggests that the physician must sometimes decide whether or not to take a patient's life, which itself implies that the physician is sometimes morally permitted to decide in favor of termination. Third, if the statement that the physician "must not play at God" were taken to be a categorical ban on physician-assisted suicide, then it would contradict the previous statements' implications, which have just been noted above.⁹³ Given the previous statements, a more plausible interpretation of this last statement is that the physician should not make the decision based solely on her own judgment. Rather, she should also take into account the wishes, interests, and circumstances of the patient and the patient's family. Finally, many physicians who have subscribed to the principles embodied by the Hippocratic Oath believe that physician-assisted suicide is morally permissible.⁹⁴ And it would be both highly cynical and arrogant to think that any, no

92. This third argument applies not merely to modern society but also to the ancient Greeks themselves. According to Erich H. Loewy and Roberta Springer Loewy, *The Ethics of Terminal Care: Orchestrating the End of Life* 107 (Kluwer Academic/Plenum Publishers 2000), many physicians in ancient times did not subscribe to Hippocrates' medical ethical principles. See also Darrel W. Amundsen, *The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide*, in *Physician-Assisted Suicide* 3, 25–26 (Robert F. Weir ed., Ind. U. Press 1997) (maintaining that the early Christians did not categorically reject the practices of euthanasia, suicide, and physician-assisted suicide but instead barely discussed or considered them).

93. Jean Davies makes a very interesting observation in this context:

The emptiness of [assertions like "[o]nly God can give or take life" and "[w]e cannot play God"] in relation to actual medical practice can be seen in the determined (and laudable) attempts that are made to restore to health those hovering on the brink of death by reason of accident or treatable infection. In fact the whole practice of medicine could be defined as one long struggle to prevent "Nature taking its course."

Jean Davies, *The Case for Legalizing Voluntary Euthanasia*, in *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* 83, 90 (John Keown ed., Cambridge U. Press 1995).

94. Physicians who support physician-assisted suicide include Lofty L. Basta & Carole Post, *A Graceful Exit: Life and Death on Your Own Terms* (Insight Bks. 1996); Loewy & Loewy, *supra* n. 92. Orentlicher, *supra* n. 30, at 666, offers evidence that there is widespread support for physician-assisted suicide among modern physicians. See also Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: The Silver Lining*, 124 *Annals Internal Med.* 267 (1996). Harold Y. Vanderpool, *Doctors and the Dying of Patients in American History*, in *Physician-Assisted Suicide* 33, 37 (Robert F. Weir ed., Ind. U. Press 1997), points out that, far from uniformly opposing euthanasia and physician-assisted suicide, the medical community has hotly contested these issues since at least the 1870s. Vanderpool also offers the names of many physicians and medically related organizations that have practiced or advocated euthanasia and physician-assisted suicide since that time. In more or less chronological order, they include Samuel D. Williams, T.T. Robertson, the American Association of Progressive Medicine, Alfred Worcester, William Sperry, Walter C. Alvarez, Joseph Fletcher, Edward H. Rynearson, Frank J. Ayd, Paul Ramsey, Norman L. Cantor, Thomas W. Furlow, Jr., the 1983 Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Sisella Bok, Derek Humphry, the Hemlock Society, and the Unitarian Universalist Association.

less all, of these physicians are guilty of either unwitting self-contradiction or false consciousness.

2. The Fundamental Purposes of Medicine

When they are not appealing to the Hippocratic Oath, the sources that Justice Scalia cites in favor of the proposition that healing is the only purpose of medicine appeal to something even weaker—bald assertion. They merely assert that the only purpose of medicine is to heal—to prevent, cure, or curb illness, disease, and injury.⁹⁵ This objective clearly conflicts with physician-assisted suicide, which is designed to do the very opposite—not heal the patient but end her life.

This perspective, however, is myopic. In addition to healing, medicine has at least one other main purpose: to alleviate physical or emotional suffering. One need merely consider the universal acceptance of palliative care (e.g., hospice treatment).⁹⁶ And when it comes to terminally ill patients who suffer excruciating pain and wish to die, the “healing purpose” may conflict with the “alleviation purpose.” That is, a physician treating a terminally ill patient who is suffering excruciating pain and wishes to die may not be able to satisfy both purposes. In this limiting case, she may just have to choose between them. She may just have to violate a fundamental purpose of medicine. On the one hand, if she opts for healing the patient, she may thereby prolong or intensify the patient’s physical and emotional suffering. On the other hand, the only way in which the physician may be able to alleviate the patient’s suffering is by terminating her life. So it is disingenuous for opponents of physician-assisted suicide to suggest that it violates a fundamental purpose of medicine. In certain situations, *failing* to terminate the patient’s life might also violate a fundamental purpose of medicine.⁹⁷

Non-physicians who also support physician-assisted suicide include Margaret Pabst Battin, *The Least Worst Death: Essays in Bioethics on the End of Life* (Oxford U. Press 1994); Raphael Cohen-Almagor, *The Right to Die with Dignity: An Argument in Ethics, Medicine, and Law* (Rutgers U. Press 2001); Davies, *supra* n. 93.

95. *Gonzales*, 126 S. Ct. at 931–32 (Roberts, C.J., Scalia & Thomas, JJ., dissenting).

96. Even the Ashcroft Directive, 66 Fed. Reg. at 56608, recognizes this point: “Pain management . . . has long been recognized as a legitimate medical purpose justifying physicians’ dispensing of controlled substances.” See also Daniel Callahan, *Reason, Self-determination, and Physician-Assisted Suicide*, in Foley & Hendin, *supra* n. 7, at 59 (“What [medicine] can do is relieve pain and bring comfort to those who psychologically suffer because of illness.”); Kass, *supra* n. 36, at 21 (“[T]he physician is called to serve the high and universal goal of health while also ministering to the needs and relieving the sufferings of the frail and particular patient.”).

97. See Cohen-Almagor, *supra* n. 94, at 184–85, 186; Jamison, *supra* n. 85, at 19–20, 24–25; Loewy & Loewy, *supra* n. 92, at 113–14; Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 *New Engl. J. Med.* 1384 (1992); Council on Ethical & Jud. Affairs, *supra* n. 1, at 2230; Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empiric Perspectives*, 154 *Archives Internal Med.* 1890, 1893 (1994); *Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death*, 336 *Lancet* 610, 613 (1990); Winston Nesbitt, *Euthanasia and the Distinction between Acts and Omissions*, 10 *J. Applied Phil.* 253 (1993); Orentlicher, *supra* n. 30, at 664; Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 *L., Med. & Health Care* 116, 123 (1992). *But see* Kass, *supra* n. 36, at 34–35 (challenging the notion that medicine serves the goal, among others, of “helping patients achieve a peaceful death”).

B. *Is There a Morally Relevant Distinction between Physician-Assisted Suicide and Withdrawal of Lifesaving Medical Treatment?*

The *Vacco* Court held that there is a significant moral (and constitutional) difference between a doctor's withdrawing lifesaving medical treatment from a terminally ill patient and a doctor's prescribing lethal drugs for a terminally ill patient. Is this decision correct? Is there really a difference? If so, what is it?⁹⁸

We have already come across three proposed answers to these questions from Chief Justice Rehnquist in his *Vacco* opinion. First, while a doctor who prescribes lethal drugs to her patient intends to help her die, a doctor who withdraws life support from her patient intends only to respect the patient's autonomy and dignity. Second, while physician-assisted suicide involves the patient's dying from the drug prescribed by her doctor, withdrawal involves the patient's dying from the underlying illness. Third, only prohibiting withdrawal, not prohibiting physician-assisted suicide, violates the patient's Fourteenth Amendment liberty interest.

1. The First Distinction: Intent

The first two distinctions are quite weak. Regarding intent, a physician who prescribes lethal drugs to her patient is not necessarily, or usually, some evildoer who rubs her hands together with glee at the prospect that her patient might soon be dead. And even if we assume that she is, we have no reason not to assume the same about the doctor who withdraws her patient from life support, in which case this practice should be illegal as well. If, however, we assume what we should—namely, that the doctor who fulfills her patient's wishes to remove life support does so almost invariably not from some evil motive but simply out of a respect and concern for her patient's autonomy—then we have no reason not to assume the very same about the doctor who prescribes lethal drugs for her patient. We have no reason not to assume that she prescribes lethal drugs out of the very same respect and concern for her patient's autonomy. But if we may—and should—make these assumptions, then Chief Justice Rehnquist's first distinction fails. All else being equal, there is no difference between the intent of a doctor who removes unwanted lifesaving medical treatment from her patient and the intent of a doctor who prescribes lethal drugs for her patient.⁹⁹

2. The Second Distinction: Causation

Regarding causation, Chief Justice Rehnquist stated what is undeniable—namely, that the cause of the death of a patient from whom lifesaving medical treatment is

98. See Dworkin, *supra* n. 19, at 184 (footnote omitted):

[T]he law produces the apparently irrational result that people can choose to die lingering deaths by refusing to eat, by refusing treatment that keeps them alive, or by being disconnected from respirators and suffocating, but they cannot choose a quick, painless death that their doctors could easily provide. Many people, including many doctors, think that this distinction is not irrational but, on the contrary, essential. They think that doctors should in no circumstances be killers. But to many other people, that principle seems cruelly abstract.

99. David Lavalley makes a similar point about the *patient's* intent. David Lavalley, *Physician-Assisted Suicide: Is There a Right to Die?* 31 *Suffolk U. L. Rev.* 945, 973 (1998).

withdrawn is her underlying illness. Where Rehnquist went wrong was in assuming that the cause of such a patient's death must be confined to only one causal factor. In fact, there is another—quite obvious—factor that equally contributed to this patient's death: removal of her life support. Once we acknowledge this second, equally important, causal factor, the purported distinction that Chief Justice Rehnquist drew between causation by physician-assisted suicide and causation by withdrawal breaks down entirely. For just as it is misleading to say that the cause of the death of a patient from whom life support has been removed is her underlying illness, it is equally misleading to say that the cause of the death of a patient who has administered to herself a lethal drug prescribed by that doctor is the lethal drug. Clearly, her terminal illness also plays a causal role. It causes her the great suffering that motivates her to take the drug in the first place.¹⁰⁰

Opponents of physician-assisted suicide might argue that this description overlooks an obvious temporal distinction between the two cases. On the one hand, when the doctor removes life support, the patient normally does not die immediately. There is some gap of time, however small, between the removal of life support and the patient's death. What intervenes in that gap is the patient's illness. So it is more precise to say that the patient's illness is the *immediate* cause of her death, removal of life support "only" the *distant* cause. And in *this* sense, *the* cause of the patient's death is her illness. The same, however, cannot be said of the patient who commits suicide by means of a lethal drug prescribed by her doctor. The immediate cause—and therefore *the* cause—of her death is the drug itself, *not* her illness.

But this is a distinction without a difference. The point of Rehnquist's distinction between causation-of-death in the physician-assisted suicide scenario and causation-of-death in the withdrawal scenario is that the latter is somehow more benign, and therefore more tolerable, than the former. But it is arbitrary to make this normative judgment about benignity or tolerability on the basis of the immediate cause alone. There is no good reason to think that the immediate cause alone carries such importance. On the contrary, if causation is to be considered at all, this normative judgment should instead be based not merely on the immediate cause but on the larger process or causal history or chain of events behind this immediate cause. Once we take this larger chain of events into consideration, we see that the two scenarios should be judged equally. For both chains of events share two key features—both of which are sufficient to determine our normative judgments. First, the patient's wishes initiate both chains of events. It is the patient who asks her doctor to remove life support or to prescribe lethal drugs. Second, in both chains of events, the doctor serves as merely a means to the end of fulfilling the patient's wishes. It does not matter *how* she fulfills the patient's wishes, whether by removing life support or by prescribing lethal drugs. This is merely a technical issue, not a moral issue.¹⁰¹

100. *Id.* at 973.

101. It might be objected that it *does* matter how the doctor fulfills the patient's wishes. Clearly, if the patient wishes to die, the doctor may not fire a pistol at her. And this is so even if the patient *wishes* to be shot to death. But this objection requires only a simple qualification. The doctor must use *non-violent* means to achieve the end of fulfilling her patient's wish to die. Prescribing a lethal drug clearly qualifies as non-violent

Opponents of physician-assisted suicide might respond that we *should* focus exclusively on the immediate cause of death because that will tell us whether the patient died from *natural causes* or from *human intervention*. And it is clearly preferable that patients die from natural causes than from human intervention.

While this argument is rhetorically seductive, it is substantively bankrupt. It is rhetorically seductive because it relies on very powerful connotations. But it is substantively bankrupt because these connotations are inapplicable in the context of physician-assisted suicide. On the one hand, death by natural causes connotes peacefulness and unavoidability. On the other hand, death by human intervention connotes violence and avoidability. But, again, these connotations are simply inapplicable in this context. While a death by prescribed lethal drugs is a death by human intervention—the doctor and the patient herself—it is certainly not violent. It is therefore not deplorable, even if it is tragic. Moreover, if one argues that death by natural causes is preferable to physician-assisted suicide, then one is in effect making the arguably cruel suggestion that patients should be forced to endure longer, possibly much longer, periods of suffering for no better reason than to avoid the pejorative implications of human intervention, implications that simply do not apply in the context of euthanasia.

Finally, opponents of physician-assisted suicide might argue that the causal distinction between death by physician-assisted suicide and death by removal of life support *is* morally relevant. For a doctor who practices physician-assisted suicide helps to *kill* her patient. But a doctor who removes life support from her patient merely *lets her patient die*. And there is a clear moral difference between killing and letting die. All else being equal, killing is (much) worse than letting die.¹⁰²

There are, however, two problems with this argument against physician-assisted suicide. First, not everybody agrees with it.¹⁰³ On the contrary, whether or not, all else being equal, killing is worse than letting die is a very difficult and hotly contested philosophical question.¹⁰⁴ Because it is so difficult and contested, it (alone) should not be allowed to decide the debate on physician-assisted suicide.

Second, in the context of euthanasia, the distinction between killing and letting die

because it does not inflict any external injury on the patient and may be self-administered by the patient.

102. For example, before *Vacco* went up to the Supreme Court, the Second Circuit Court of Appeals held that there is *no* principled distinction between physician-assisted suicide and withdrawal of lifesaving medical treatment. In particular, it held that New York statutes that allowed the withdrawal of lifesaving medical treatment but prohibited physician-assisted suicide violated the Equal Protection Clause. *Quill v. Vacco*, 80 F.2d 716, 727 (2d Cir. 1996). For terminally ill patients on life-support systems are similarly situated to terminally ill patients who are not. So the only justification for allowing only the former to terminate their lives would be a rationally related legitimate State interest. *Id.* at 729. According to the Second Circuit, such an interest simply does not exist. *Id.* at 729–30.

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104. See, for example, the variety of positions represented in *Killing and Letting Die* (Bonnie Steinbock and Alastair Norcross, eds., Fordham University Press 1994).

is not always clear. There are borderline situations that do not fall easily or obviously on either the “killing side” or the “letting die” side. Indeed, one situation that is not easily classified as either a killing (a positive action bringing about another’s death) or a letting die (a failing to prevent another’s death by refraining from performing a life-saving action) is withdrawal of life support itself. On the one hand, it may seem to be a letting die because, in terminating the life support, the physician is failing to prevent the patient’s impending death. On the other hand, it may seem to be a killing because terminating the life support involves a positive action by the physician.

The underlying problem is that we have no principled basis for determining the proper baseline—namely, whether or not the patient is already moving toward death. On the one hand, if we deem the patient already to be moving toward death, then the life support system constitutes an active interference. It does not continue but interrupts the movement. So if the physician terminates the life support, she merely removes this interruption and thereby lets the movement toward death continue. And to say that she lets the movement toward death continue is just to say that she lets the patient die. On the other hand, if we deem the patient not already to be moving toward death, then the physician’s removing the life support system constitutes an active interference. She actively interrupts the patient’s movement toward more life, in which case she may be said to kill the patient.

3. The Third Distinction: The Consequences of Prohibition

Finally, Chief Justice Rehnquist’s third distinction—that prohibiting only withdrawal of lifesaving medical treatment, not physician-assisted suicide, would violate patients’ “well-established, traditional rights to bodily integrity and freedom from unwanted touching”¹⁰⁵—fails because it falsely assumes that the constitutional right to withdraw unwanted lifesaving medical treatment derives from “well-established, traditional rights to bodily integrity and freedom from unwanted touching.” In fact, the majority opinion in *Cruzan*, which was also written by Chief Justice Rehnquist, did not really advance this proposition. Instead, *Cruzan* stated that patients’ right to withdraw lifesaving medical treatment derived from the Fourteenth Amendment’s Due Process Clause, which secured their “liberty interest in refusing unwanted medical treatment.”¹⁰⁶ So the right to withdraw unwanted lifesaving treatment was thought to derive not from a concern to protect bodily integrity *per se* but rather from a concern to protect liberty, which may safely be translated as a right to self-determination.¹⁰⁷ Indeed, the text of Chief Justice Rehnquist’s opinion in *Cruzan* contains only one mention of “bodily integrity,” as contrasted with thirteen mentions of “liberty interest.”

Given this clarification, Rehnquist’s third distinction collapses. Even if prohibiting physician-assisted suicide does not violate terminally ill patients’ bodily integrity, it might still violate their right to self-determination. Because it might violate this right just as much as does prohibiting withdrawal of lifesaving medical treatment, and because

105. *Vacco*, 521 U.S. at 807 (citing *Cruzan*, 497 U.S. at 278–79, 287–88 (O’Connor, J., concurring)).

106. *Cruzan*, 497 U.S. at 278.

107. See also Rawls et al., *supra* n. 8, at 44 (“The liberty interest at stake in *Cruzan* was a more profound one” than “a right to reject an unwanted invasion of one’s body.”).

prohibiting withdrawal of lifesaving medical treatment is unconstitutional precisely because it violates this right, it follows that prohibition of physician-assisted suicide might very well be unconstitutional as well.¹⁰⁸

One might object that this point leads to an absurdity. If terminally ill patients had a constitutional right to physician-assisted suicide, then the State would be equally constitutionally obligated to provide a physician to each patient who sought this treatment and did not already have a doctor of her own. But is difficult to accept the notion that States would be constitutionally obligated to provide this affirmative medical assistance—especially when, for better or worse, they do not otherwise have a constitutional obligation to provide health care to those who cannot afford it.¹⁰⁹

The appropriate response to this objection is that constitutional protection of physician-assisted suicide would not entail the positive right to be provided with a doctor if need be. Rather, it would entail only the negative right of non-interference—i.e., the right that States not interfere with any arrangements for physician-assisted suicide made by patients with their own doctors.¹¹⁰

IV. POLICY ISSUES

Even though the Court ruled in *Vacco* and *Glucksberg* that patients do not have a constitutionally protected right to receive physician-assisted suicide, it does not at all follow that States should prohibit physician-assisted suicide. There are many actions and activities that are not constitutionally protected and yet are—and should be—perfectly legal. For example, individuals do not have a constitutional right to drive (no less have) a car. Yet it would be foolish for any State to interpret this absence of constitutional protection as a good reason to outlaw driving. In this respect, physician-assisted suicide is like driving. While we do not currently have a constitutional right to it, some advocates of physician-assisted suicide argue that we should still be permitted this option if we are ever in the unfortunate position of facing a future of unrelenting pain before a certain death.

Why, then, does every State but Oregon still prohibit physician-assisted suicide? While some opposition to legalizing physician-assisted suicide may be rooted in some of

108. See also *Cruzan*, 497 U.S. at 298–99 (Scalia, J., concurring) (rejecting Chief Justice Rehnquist's third distinction because its assumption that the State may not violate a patient's bodily integrity to save her life is both question-begging and, in many cases, false). Respondents in *Vacco* offered another argument against the third distinction:

[Patients who have previously consented to bodily intrusions such as insertion of an artificial heart valve or a kidney or bone marrow transplant] may wish to die by withdrawing their consent to the bodily intrusion to which they have been subjected. But their cases demonstrate that the State's line is not about permitting patients to undo a battery. Even where withdrawal of consent is theoretically possible, the State would doubtless say that a patient has no right to end his own life by insisting, for example, that surgeons remove a donor kidney or heart that had already been implanted. On the other hand, if the State *did* permit this type of life-ending physician assistance, how could it argue that it is rational not to permit the same patient to obtain a lethal dose of medication from a physician for the same ultimate purpose?

Vacco, Respt.'s Br., *supra* n. 60, at 47 (emphasis in original).

109. See, e.g. *Harris v. McRae*, 448 U.S. 297, 317–18 (1980) (The Due Process Clause does not impose an obligation on the government to fund abortions or other medical services.).

110. *Orentlicher*, *supra* n. 30, at 664.

the weaker arguments that we have encountered above—e.g., physician-assisted suicide, unlike withdrawal of unwanted life support, involves killing or the intent to kill—the stronger arguments derive less from moral considerations and more from a practical worry. The practical worry is that legalizing physician-assisted suicide will have serious negative effects on patients, physicians, medical practice, and society in general. This part will explicate what these negative effects might be.

A. *The Strongest Policy Arguments for Physician-Assisted Suicide*

It would help first to see the strongest policy arguments for physician-assisted suicide. Suppose an elderly woman—Lisa—is terminally ill with no chance of recovery, suffers excruciating pain, and has decided, after much careful thought and deliberation with her family and friends, that she wishes to die. Suppose also that Lisa does not depend on artificial life support; has no more than six months to live; is not pressured or coerced by anybody else to end her life; and is fully conscious and mentally competent. So far, Lisa's decision to commit suicide—whether physician-assisted or not—seems as rational and voluntary as such a decision can ever be.¹¹¹ Committing suicide would maximize Lisa's autonomy by maximizing her control over how and when her impending death occurs; both Lisa's preference for no suffering to suffering and her belief that death is the only means to this end are reasonable; and Lisa reasonably believes that her family supports her decision for the right reasons—because they too wish her suffering to end and not to spare them the burden of taking care of her or save them the expense of Lisa's continued medical care.

What, then, justifies the inference from the fact that Lisa's decision to commit suicide is rational and voluntary to the conclusion that physician-assisted suicide is warranted? Why should Lisa's method of suicide involve a physician's prescription of a lethal medication? Why can't Lisa terminate her life in some other way? An analogy with abortion might help to answer these questions. Most "pro-choice" advocates—i.e., advocates for keeping the option of abortion legal—argue that if abortion were made illegal, many pregnant women would then seek "back-alley" abortions. And back-alley abortions are undesirable for two primary reasons, one practical, the other moral. The practical reason is that the individuals performing the back-alley abortions are likely to lack the knowledge, skill, and resources necessary to perform safe abortion procedures and would therefore expose these women to serious bodily injuries. The moral reason is

111. It has been suggested to me in personal conversation that a patient's decision to terminate her life while undergoing a sharp surge of pain is *not* rational. My response to this point is that the patient's decision *is* rational if the patient has been informed by her doctor that she is terminally ill and can reasonably expect to suffer this level of pain, either constantly or continuously, until death. Moreover, even if this decision *is* irrational, all fifty States allow such alleged irrationality in the case of withdrawal of lifesaving medical treatment. Scholars who accept the proposition that a patient can rationally request physician-assisted suicide include Robert L. Barry, *Breaking the Thread of Life: On Rational Suicide* (Transaction Publishers 1994) and Jamison, *supra* n. 85, at 42 ("The overwhelming majority of mental health professionals, according to surveys conducted by James Werth and Barbara Liddle, believe that individuals can make rational decisions to control the time and manner of their deaths."); *see also* Justice Stevens' concurrence in *Glucksberg*, 521 U.S. at 747 (patients may make a "rational and voluntary decision to seek assistance in dying."). Scholars who reject this proposition (i.e., those who accept what Jamison, *supra* n. 85, at 41, refers to as the "traditional view") include Callahan, *supra* n. 96, at 66–67; Kathleen Foley (testifying before Congress in 1996), Herbert Hendin (of The American Suicide Foundation), Kass, *supra* n. 36, at 24–25.

that the illegal status of these abortions would imply that society regards abortions in general—and therefore the women undergoing these back-alley abortions—as morally reprehensible. And pro-choice advocates reject both this moral conclusion and the assumption that society endorses this moral conclusion.

Advocates of physician-assisted suicide would likely argue that keeping this practice illegal produces practical dangers and conveys the wrong message. The practical danger is that patients will seek to end their lives in ways that may not be effective, thereby complicating their situation and quite possibly increasing the patients'—and their families'—suffering. And the message conveyed by keeping physician-assisted suicide illegal is that it is *wrong* for doctors to help patients like Lisa end their lives. But advocates of physician-assisted suicide argue that Lisa's doctor is doing the *right* thing by helping Lisa to execute her fully rational and family-supported decision. That is precisely what doctors *should* do. After all, doctors routinely implement, as they should, their patients' decisions to terminate lifesaving medical care and administer palliative but death-hastening treatment. And there is no principled distinction between these two methods and physician-assisted suicide. In all three situations, a patient asks her doctor to help alleviate her suffering, and the doctor respects her patient's request by prescribing, dispensing, and/or administering to her patient a drug that has the reasonably foreseeable effect of causing the patient to die earlier than she would have without the drug.

Moreover, physician-assisted suicide has a distinctive advantage over withdrawal of lifesaving medical treatment and administration of palliative but death-hastening treatment: it liberates the patient from any sense that she is committed to carrying through with her decision to terminate her life. If a patient decides to administer the lethal substance to herself, she may still change her mind before executing her decision without worrying that this change of mind will yield any negative consequences. But if a patient asks her doctor to withdraw treatment or administer palliative but death-hastening treatment, she may feel reluctant to change her mind for fear of disappointing or bothering the doctor and losing eligibility for the same treatment the next time she requests it.¹¹²

B. *The Undue Pressure Argument*

While the policy arguments for physician-assisted suicide in Part IV.A are strong,

112. Brody uses this same psychological point to argue that if physician-assisted suicide is allowed, the lethal substance should be administered by the patient herself rather than by the doctor. See Brody, *supra* n. 97, at 1386. But see Cohn & Lynn, *supra* n. 102, at 249–50 (“Because of either patient condition or incorrect dosing, many patients will be unable to swallow or keep the pills down. This raises the probability that assistance beyond prescribing lethal medications will be essential and may even suggest that active euthanasia, or lethal injection, would be more effective and likely would seem more humane. Furthermore, the question of how to deal with a failed attempt remains, particularly if that act has rendered the patient worse off or unable to request or complete another attempt.”); Edmund D. Pellegrino, *Compassion Is Not Enough*, in Foley & Hendin, *supra* n. 7, at 46 ([I]n fact, self-administered prescriptions may fail in a significant number of cases. As a result, the act of dying may be prolonged and unpleasant. The dose of the lethal medication may well have to be repeated or replaced by direct euthanasia. If this is so, it would require the physician to administer the dose, or to be present and ready to accelerate death more directly if the first effort fails. Assisted suicide quickly becomes direct and active euthanasia with the transfer of power from the patient to the physician – the antithesis of the expression of autonomy so many seek.”).

they are not strong enough. They are counteracted by even stronger policy arguments *against* physician-assisted suicide. Importantly, the latter arguments apply with greater force to physician-assisted suicide than to withdrawal of lifesaving medical treatment or palliative but death-hastening treatment, a point that will be defended in Part IV.F

The Undue Pressure Argument predicts that legalizing physician-assisted suicide will put serious financial pressure on terminally ill patients, especially terminally ill patients who are poor, to choose this option rather than the option of lifesaving medical treatment. Because physician-assisted suicide will be significantly cheaper than life-sustaining treatments, it is highly likely that Medicare and Medicaid officials, health and life insurance companies, viatical settlement companies, and managed care plans—all of which are concerned at least to minimize their costs and possibly to maximize their profits—will much more frequently recommend against lifesaving medical treatment than they would have if the much cheaper option of physician-assisted suicide were not available as a legal alternative.¹¹³

Needless to say, this situation would be highly undesirable. We do not want patients choosing—no less being forced to choose—physician-assisted suicide simply for financial considerations. For, first, financial considerations are simply the wrong kind of basis for decisions that have such significant *non-financial*—i.e., personal, interpersonal, and spiritual/religious—significance and ramifications. Second, the financial pressure may be so overwhelming that it would render many less affluent patients' decisions to elect physician-assisted suicide non-voluntary and non-consensual.¹¹⁴

This financial pressure will only be compounded by psychological pressure as well. Too many terminally ill patients wish to die because they feel—or, worse, have been made to feel—like annoying nuisances to their families and doctors.¹¹⁵ Legalizing physician-assisted suicide would simply intensify this guilt and therefore the “subtle coercion” on these patients to take this now legally available route. When physician-assisted suicide is illegal, patients do not have to justify their failure to exercise this option. It is simply not an option in the first place. If anything, they would have to justify why they still wish to die in spite of this legal roadblock. But if physician-assisted suicide were legalized, then the burden *would* suddenly fall on patients to justify why they are continuing to live—and thereby inconveniencing everybody around them for the indefinite future—rather than choosing this now legally available alternative. And they will feel themselves unable to satisfy this burden precisely because they will have internalized the attitude of rejection that they perceive all around them. They will deem themselves unworthy of continued existence precisely because everybody else around them deems them unworthy of continued existence.¹¹⁶

113. See Cohn & Lynn, *supra* n. 102, at 238–39; Stephanie Graboyes-Russo, *Too Costly to Live: The Moral Hazards of a Decision in Washington v. Glucksberg and Vacco v. Quill*, 51 U. Miami L. Rev. 907, 919–924 (1997); Jamison, *supra* n. 85, at 37.

114. See Graboyes-Russo, *supra* n. 126, at 925–27.

115. See Cohn & Lynn, *supra* n. 102, at 257–59; Graboyes-Russo, *supra* n. 126, at 925–28; Jamison, *supra* n. 85, at 37; Kass, *supra* n. 36, at 22–30; Pellegrino, *supra* n. 85, at 48.

116. See Kass, *supra* n. 36, at 24; Martha Minow, *Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases*, 1997 S. Ct. Rev. 1, 21 (One of two “lies” the Court told in *Vacco* and *Glucksberg* was that permitting physician-assisted suicide “would *not* systematically and routinely be used to push dying people into death. . . . [T]he problem arises from the inauguration of a regime in which people

C. *The Too Early Argument*

The patients who would feel themselves unable to satisfy this burden (of justifying their continuing to live) would then be dying too early—too early relative to when they would have died had their preferences been optimized.¹¹⁷ As a society, we simply don't want people choosing to die prematurely for the wrong reasons. And one very wrong reason would include a sense of worthlessness, a sense that one is not worth the inconvenience and financial hardships that one's continuing to live might impose on others.¹¹⁸

Of course, an advocate of physician-assisted suicide might respond that even if the Too Early Argument applies to some patients, it does not apply to Lisa. Therefore if physician-assisted suicide were legalized, it should be restricted to patients in Lisa's situation—again, terminally ill with no chance of recovery, less than six months to live, and suffering excruciating pain.

Even then, however, Lisa may be dying too early. If she is suffering excruciating pain, death is not the only possible means of escape. She still has the option of palliative care. And if she, for some reason, does *not* have this option, then she should be given it. For *this* approach would enable Lisa to overcome her pain and thereby to enjoy another day, another week, another month, or even another six months of life. Physician-assisted suicide wipes out this possibility entirely. It simply destroys the possibility of recovery and, with it, the prospect of continuing a life of value.

There are very few situations in which palliative care, when made available, is insufficient to alleviate a patient's pain and suffering.¹¹⁹ Unfortunately, it is not always

would have to justify continuing to live. Rooting the permission in a right or protected interest . . . would not save individuals from pressures to die imposed directly or indirectly by family members, physicians, managed care providers, or the patients' own sense of guilt and burden." (footnotes omitted) (emphasis in original)). These arguments are especially applicable to terminally ill patients who are disabled. See Diane Coleman, *Not Dead Yet*, in Foley & Hendin, *supra* n. 7; Evan J. Kemp, Jr., *Could You Please Die Now? Disabled People Like Me Have Good Reason to Fear the Push for Assisted Suicide*, Wash. Post C1 (Jan. 5, 1997); Julie G. Madorsky, *Is the Slippery Slope Steeper for People with Disabilities?* 166 W. J. Med. 410 (1997); Anita Silvers, *Protecting the Innocents: People with Disabilities and Physician-Assisted Dying*, 166 W. J. Med. 407 (1997).

117. See Cohn & Lynn, *supra* n. 102, at 241.

118. For different versions of the Too Early Argument, see Harvey M. Chochinov and Leonard Schwartz, *Depression and the Will to Live in the Psychological Landscape of Terminally Ill Patients*, in Foley & Hendin, *supra* n. 7; Cohn & Lynn, *supra* n. 102, at 243, 247, 257-59; Coleman, *supra* n. 129, at 224; Council on Ethical & Jud. Affairs, *supra* n. 1, at 2231; Kass, *supra* n. 36, at 36; Cicely Saunders, *A Hospice Perspective*, in Foley & Hendin, *supra* n. 7, at 289.

119. See Callahan, *supra* n. 96, at 65; Cohn & Lynn, *supra* n. 102, at 258; Kass, *supra* n. 36, at 23. Still, it must be acknowledged that in at least some situations, even the most advanced palliative care fails to reduce patients' suffering to a tolerable level. See Justice Breyer's concurrence in *Glucksberg*, 521 U.S. at 791-92; Brief of the Coalition of Hospice Professionals in *Vacco and Glucksberg*, 1996 WL 709342 at **6-7 (Dec. 10, 1996); Brody, *supra* n. 97, at 1385; Michael H. Levy, *Medical Management of Cancer Pain*, in *Principles and Practice of Pain Management* 235 (Carol A. Warfield ed., McGraw Hill 1993); New York State Task Force on Life and Law, *supra* n. 42, at 40; Rawls et al., *supra* n. 8, at 44; Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 32 N. Eng. J. Med. 691, 694 (Mar. 1991); Timothy E. Quill, Christine K. Cassel, & Diane E. Meier, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 N. Eng. J. Med. 1380, 1383 (Nov. 1992); Student Author, *supra* n. 36, at 247 n. 98; *Vacco*, Respt.'s Br., *supra* n. 60, at 8-9.

made available.¹²⁰ But this is not an argument for physician-assisted suicide. This is an argument for improving the current situation and extending adequate palliative care to every patient who needs it.¹²¹

Too many patients like Lisa wish to die because they suffer less from physical pain and more from “psychic” pain—i.e., because they are depressed, hopeless, or terrified. Once again, death is not the only means of escape from these feelings. Not only palliative care but also adequate psychiatric care, in conjunction with love and support from family and friends, provides a more desirable means. This is a more desirable means because, unlike an early death, it serves intrinsically desirable ends. Psychiatric care can help patients like Lisa to enjoy life again, recognize how valued and valuable they are, conquer their despair, fulfill more goals, indulge in pleasant memories, come to terms with their past failures, make amends for previous misdeeds, reconcile with people they may have neglected or cut off, share more quality time with their family and friends, and generally find greater meaning in their lives and experiences.¹²² Unfortunately, like palliative care, adequate psychiatric care is not always made available either. But once again, this is not an argument for physician-assisted suicide. It is an argument for extending adequate psychiatric care to every patient who needs it.

D. *The Trust Argument*

The Trust Argument proceeds in two parts.¹²³ The first part suggests that a patient is entitled to believe that her physician has her best interests in mind. Without this entitlement, she will be less likely to confide in her physician. And the less likely she is to confide in her physician, the less likely she will be to give her physician all of the information that the physician needs in order to give her optimal treatment. All else being equal, then, there is a direct correlation between the level of a patient’s trust in her physician and the level of medical care that she receives. Whatever works to diminish the former will also work to diminish the latter.

The second part of the Trust Argument suggests that if physician-assisted suicide were legalized, then diminished trust and inferior medical care would likely result. If physician-assisted suicide were legalized, then a patient who is, or even just appears to be, terminally ill might very well worry that her physician secretly intends to kill her either because the physician thinks that killing the patient is in the patient’s best interest or because the physician regards the patient’s continued existence as an unnecessary burden on the doctor herself, on the patient’s family, or on society. As a result, the patient may not tell her physician everything she needs to know. Indeed, she may even

120. See Cohn & Lynn, *supra* n. 102, at 241, 243–44; Foley & Hendin, *supra* n. 7, at 2, 3–4, 14.

121. See Chochinov and Schwartz, *supra* n. 131, at 269–70; Cohn & Lynn, *supra* n. 102, at 243–44, 260; Kathleen Foley, *Compassionate Care, Not Assisted Suicide*, in Foley & Hendin, *supra* n. 7; Graboyes-Russo, *supra* n. 126, at 934; Kass, *supra* n. 36, at 36; Pellegrino, *supra* n. 85, at 50; Saunders, *supra* n. 131, at 285–86, 289.

122. See Chochinov & Schwartz, *supra* n. 131, at 270–77; Kass, *supra* n. 36, at 38–39; Pellegrino, *supra* n. 85, at 50; Saunders, *supra* n. 131, at 287–88, 290–91.

123. For similar versions of the Trust Argument, see Cohen-Almagor, *supra* n. 94, at 200; Council on Ethical & Jud. Affairs, *supra* n. 1, at 2232; Jamison, *supra* n. 85, at 34–35; Loewy & Loewy, *supra* n. 92, at 116; Gaylin et al., *supra* n. 85; New York State Task Force on Life and the Law, *supra* n. 42, at 105–06; Kass, *supra* n. 36, at 27–29; Orentlicher, *supra* n. 30, at 664.

refrain from seeing a physician altogether.

E. The Slippery Slope Argument

Finally, the Slippery Slope Argument makes an even more ominous prediction than do the Undue Pressure Argument and the Trust Argument. The Slippery Slope Argument predicts that if physician-assisted suicide is legalized, then both the message of this legal measure itself as well as the fact that some or many physicians will end up killing their patients will ultimately change society's view of physicians and generate devastating psychological and sociological problems.¹²⁴ Once physician-assisted suicide has the stamp of lawfulness, both the physicians who implement it as well as their colleagues will increasingly tend to regard killing as "not so bad," a "necessary evil." And as the practice becomes more and more commonplace, some of them might even come to regard such killings as useful. Some more opportunistic (and malevolent) physicians might come to regard physician-assisted suicide as an all-too-convenient means of "weeding out" the "weakest" or "least desirable" members of society. Inspired by their ideas of what society should look like and their notions about who belongs and who does not, they may actually use their positions of authority to pressure vulnerable patients who were otherwise opposed to dying to change their minds. Even worse, they may attempt to manipulate patients who were not even terminally ill in the first place to consider the option.¹²⁵

This is called the Slippery Slope Argument because it predicts that the legalization of physician-assisted suicide will generate a slippery slope toward a much greater number of premature deaths.¹²⁶ Indeed, as proponents of the Slippery Slope Argument contend, precisely this situation occurred in Nazi Germany.¹²⁷ What started out as a "small" euthanasia program designed to kill "only" the most feeble-minded members of society eventually grew into the Final Solution. It has been well-documented that underlying this dramatic expansion in social engineering was an equally dramatic transformation in physicians' attitudes toward life, death, and killing.¹²⁸ The more commonplace and socially accepted killing by physicians became, the more inured they became to the act of killing itself. And the more inured they became to the act of killing, the more inclined they were to broaden their conceptions of "weak," "undesirable," and "unworthy of life" to include members of society other than the mentally incompetent.

This "brutalization" or "desensitization" to the value of human life eventually spread in part from physicians to society in general. Because physicians tended

124. See Loewy & Loewy, *supra* n. 92, at 115–16; New York State Task Force on Life and the Law, *supra* n. 42, at 107, 109, 112–13.

125. See Cohen-Almagor, *supra* n. 94, at 188–89; Davies, *supra* n. 93, at 90; Jamison, *supra* n. 85, at 43; Kass, *supra* n. 36, at 23–28; Loewy & Loewy, *supra* n. 92, at 121–24; *The Euthanasia Report* 4 (1988).

126. See Callahan, *supra* n. 96, at 61; Cohen-Almagor, *supra* n. 94, at 188–89; Jamison, *supra* n. 85, at 36–39; Loewy & Loewy, *supra* n. 92, at 108–09, 124–26; George J. Annas, *The Promised End—Constitutional Aspects of Physician-Assisted Suicide*, 335 *New Eng. J. Med.* 683 (1996); Herbert Hendin, Chris Rutenfrans & Zbigniew Zylicz, *Physician-Assisted Suicide and Euthanasia in the Netherlands: Lessons from the Dutch*, 277 *J. Am. Med. Assn.* 1720 (1997); Madorsky, *supra* n. 129; Orentlicher, *supra* n. 30, at 664.

127. See e.g. Loewy & Loewy, *supra* n. 92, at 124–26; Sprung, *supra* n. 85, at 2214–15.

128. See generally Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (Basic Books 1986).

increasingly to regard certain human beings as “life unworthy of life,” and because physicians commanded such high respect, their attitudes and actions inevitably helped to soften the rest of society’s opposition to killing. Of course, physicians in Nazi Germany were aided by other societal forces such as propaganda, ethnic prejudice, and terror. But the point remains that physicians played an instrumental role in helping to bring about the changes in attitude that would eventually make the Holocaust possible.¹²⁹

F. Why These Arguments Apply with Greater Force to Physician-Assisted Suicide than to Withdrawal of Lifesaving Medical Treatment

The main reason that physician-assisted suicide constitutes more of a threat than withdrawal of lifesaving medical treatment is because, all else being equal, it is psychologically less difficult—*easier*—for a doctor to carry out. Physician-assisted suicide is easier because it helps to increase the “distance” between the doctor’s actions and the patient’s death. While withdrawal of lifesaving medical treatment requires the doctor to perform acts that lead directly to the patient’s demise, physician-assisted suicide permits the doctor merely to write a prescription and let the patient “do the rest”—i.e., administer the lethal substance to herself. As a result, legalization of physician-assisted suicide is likely to lead to the result that some, and therefore too many, patients are permitted to die *not* for the right reason—i.e., because they fall into the very small category of terminally ill patients for whom adequate palliative care is medically unavailable—but rather for the wrong reason that their doctors simply have less psychological resistance to this option.

V. CONCLUSION

While the United States Supreme Court declined in *Vacco* and *Glucksberg* to extend constitutional protection to physician-assisted suicide, it recently held in *Gonzales* that States may still legalize physician-assisted suicide. So as things stand now, whether or not a given patient has the legal right to elect physician-assisted suicide depends on what her state legislature has said on the matter. So far, only Oregon has legalized this practice. The other forty-nine States have not. If the position taken by this article is correct, the other forty-nine States should not follow Oregon’s example primarily for policy reasons.

Still, this is hardly a categorical stance. Unlike strictly ethical reasons, policy reasons can be undermined by empirical data. So where we go from here largely depends on what has happened, and is happening, in Oregon, the United States’ very own physician-assisted-suicide “laboratory.”¹³⁰ If an objective assessment of the data—

129. See Cohen-Almagor, *supra* n. 94, at 190. Brian Kalt discusses the implications of physician-assisted suicide for the “ethical integrity of the medical profession,” which he abbreviates as “EIMP.” See generally Brian C. Kalt, *Death, Ethics, and the State*, 23 Harv. J.L. & Pub. Policy 487 (2000).

130. Much work has already been done in this area. For essays that offer a negative assessment of the Oregon experience, see Kathleen Foley and Herbert Hendin, *The Oregon Experiment*, in Foley & Hendin, *supra* n. 7; N. Gregory Hamilton, *Oregon’s Culture of Silence*, in Foley & Hendin, *supra* n. 7; David W. Kissane, *Deadly Days in Darwin*, in Foley & Hendin, *supra* n. 7. For a more sanguine assessment primarily of physician-assisted suicide in the Netherlands, secondarily of physician-assisted suicide in Oregon, see Amanda

including physician surveys, psychiatric reports, and family and patient interviews—indicates that too many patients have exercised physician-assisted suicide for the wrong reasons (e.g., treatable pain or depression or worries about being a nuisance or economic burden to one's family), then this practice should not only not be adopted elsewhere but should be abandoned in Oregon as well. Otherwise, if an objective assessment of the data indicates that the "Oregon experiment" has succeeded and physician-assisted suicide has been chosen only by the small minority of patients for whom palliative and psychiatric care was provided but still failed sufficiently to alleviate their suffering, then it should arguably remain legal in Oregon and be adopted by other States, as long as the same restrictions and safeguards are carefully codified and strictly enforced.