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Frederick R. Parker Jr.

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Frederick R. Parker, Jr.*

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1. The author and Charles J. Paine, M.D., developed the clinical cases discussed in this Article for a Special Report. See Frederick R. Parker & Charles J. Paine, *At the Intersection of Tax Policy and Bioethics: Considering Tax-Exempt Status in the Context of Palliative Sedation to Unconsciousness*, in 66 EXEMPT ORG. TAX REV. 121 (2010). That work addressed the issue of whether a health care facility’s tax-exempt status should be conditioned upon its adherence to minimum ethical standards when providing extreme palliative interventions. *Id.* Portions of the clinical basis for the tax policy discussion in that publication are presented here with the permission of Tax Analysts.

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INTRODUCTION

The latter part of the 20th century saw significant developments in the fields of health law and bioethics in the United States when advances in artificial respiration, circulation, nutrition, and hydration made it possible to maintain biological life well beyond the natural ability of the human body.² These life-sustaining clinical interventions gave rise to solemn questions in law and bioethics not only about the scope of a patient's right to refuse such measures, but also about the corresponding extent of a physician's obligation to provide them.³

A fairly consistent body of jurisprudence, statutory schemes, and pronouncements of professional ethics has mostly resolved these questions—all of which acknowledge in general terms the fundamental nature of one's right to accept or refuse life-sustaining medical treatment. Although the jurisprudence reflects a diversity of thought in terms of legal theory, courts have demonstrated a consistent appreciation for the same moral and ethical concerns that have guided the medical profession and the various state legislatures in their efforts to balance appropriately the competing interests of the individual in the exercise of autonomy and the state in the preservation of life.⁴

2. See, e.g., *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 328 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976), cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

3. See generally ALAN MEISEL & KATHY CERMINARA, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 2.01 (3d ed. 2004 & Supp. 2008).

4. Although the early cases arose in the context of religious liberty under the First Amendment, the later cases focused on the common law concept of informed consent to medical treatment and the corollary right not to consent, as well as the rights to privacy and liberty grounded in the Constitution. See, e.g., *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250 (1891); *Superintendent of Belchertown St. Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Storar*, 420 N.E.2d 64 (N.Y. 1981), cert. denied, 454 U.S. 858 (1981); *In re Conroy*, 486 A.2d 1209 (N.J. 1985); *In re Estate of Longeway*, 549 N.E.2d 292 (Ill. 1989); *Jacobson v.*

Questions in early cases concerning patient autonomy in the context of end-of-life decision-making focused only on the scope of one's right to refuse life-sustaining treatment.⁵ In contrast with this traditionally negative focus, the contemporary formulation of the query goes further by asking whether, or under what circumstances, the law would accommodate the positive right of a patient not only to refuse treatment in the form of artificial nutrition and hydration, but also to be rendered unconscious and maintained in that state without sustenance until death ensues. This question can present itself in a variety of clinical situations:

A patient in the advanced stages of lung cancer requests morphine and other sedatives in doses that increase proportionately as the intensity of his distress deepens with the progression of the disease. Expecting to eventually receive sedatives in doses that render him permanently unconscious, the patient asks that nutrition and hydration are withheld when he becomes unable to ingest food and fluids on his own.

A patient who suffers from esophageal cancer declines further treatment in the form of artificial nutrition and hydration when the disease progresses to the point that he can no longer swallow. He also asks to be sedated immediately to unconsciousness to relieve the suffering that eventually will accompany the absence of food and fluids, with death by dehydration to be expected within a few days.

A patient who suffers intractable and interminable pain as a result of rheumatoid arthritis has asked to be sedated immediately to unconsciousness to relieve her suffering. Although the disease process does not impair her natural ability to receive food and fluids, she requests that artificial nutrition and hydration are withheld until she dies.

A patient who survived numerous bouts of cancer while raising her children to adulthood is now in remission. Although she is able to ingest food and fluids naturally on her own, she is fearful that her cancer will return and asks to be sedated to unconsciousness and then be allowed to die by the withholding of artificial nutrition and hydration.

Massachusetts, 197 U.S. 11, 24–30 (1905); *Washington v. Harper*, 494 U.S. 210, 221–22 (1990); *Vitek v. Jones*, 445 U.S. 480, 494 (1980); *In re Yetter*, 62 Pa. D. & C.2d 619 (Pa. Com. Pl. 1973); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

5. See, e.g., cases cited *supra* note 4.

Although the rights of patients and the authority of physicians in such cases have been the subject of meaningful discourse among commentators in the disciplines of health policy and bioethics,⁶ Louisiana law has not addressed these issues. In particular, there is a dearth of commentary with respect to this issue in the context of the Louisiana Natural Death Act (the “Natural Death Act,” or the “Act”) even though the statute would both inform and enrich that discussion.⁷

This silence is not necessarily surprising because many of these procedures occur in the complexities of the clinical setting, in which the untrained observer might not readily identify them. In fact, these procedures may have sometimes been undertaken in silence either to mitigate the emotional consequences borne by the patient’s family or to avoid the perplexing legal issues they inevitably present. Notwithstanding this somewhat silent history, these measures have increasingly become the subject of discussion in recent mainstream media articles.⁸ Moreover, the use of palliative sedation may become more common in the future as our population ages and economic concerns over the cost of health care continue to grow. In light of this possibility, citizens should carefully consider the legal implications of these ethically problematic interventions before encountering them on a larger scale. This Article is intended to initiate that discussion in the specific context of the Natural Death Act.

I. DEFINING PALLIATIVE SEDATION: CLINICAL METHODS AND RELATED LEGAL AND ETHICAL IMPLICATIONS

The term “palliative sedation”⁹ refers to the use of sedatives as a method of relieving intractable pain and other distressing physical

6. See generally MEISEL & CERMINARA, *supra* note 3, §§ 7.01–15.

7. LA. REV. STAT. §§ 40:1151–1151.9 (2016).

8. See, e.g., Michael Ollove, *Assisted Suicide is controversial, but palliative sedation is legal and offers peace*, WASH. POST (July 27, 2018), https://www.washingtonpost.com/national/health-science/assisted-suicide-is-controversial-but-palliative-sedation-is-legal-and-offers-peace/2018/07/27/e9b02cf8-8922-11e8-8ae-a-86e88ae760d8_story.html?noredirect=on&utm_term=.37caf4e54dbc [<https://perma.cc/2EUM-3CYE>].

9. The practice is also referred to as “terminal sedation,” “deep sedation,” “sedation for intractable distress in [the] dying [patient],” “total sedation,” “slow euthanasia,” and “sedation to unconsciousness.” See, e.g., Mark A. Levine, *Sedation to Unconsciousness in End-of-Life Care*, CEJA REPORT 5-A-08 (2008), <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/coet-1-1305.pdf> [<https://perma.cc/H7PB-YFK2>]; Sef Gevers, *Terminal Sedation: A Legal Approach*, 10 EUR. J. HEALTH L. 359, 360 (2003); Robert J. Kingsberry & Howard M. Ducharme, *Two Perspectives on Total/Terminal/Palliative Sedation*,

symptoms that tend to accompany the latter stages of a terminal illness.¹⁰ The process generally involves the administration of a sedative in progressively increasing doses to relieve suffering, even to the point of eventually rendering the patient unconscious with the understanding that he would be maintained in that state until death. It is common to withhold food and fluids in such cases, and death tends to occur within several days.

A. The Relationship Between Palliative Sedation, Assisted Suicide, and Euthanasia

Because palliative sedation involves an affirmative intervention that leads to the same result as assisted suicide and euthanasia, it is sometimes difficult to draw a meaningful distinction between these practices. The distinction is particularly difficult to make when the sedation is accompanied by the withholding of nutrition and hydration. It is thus a challenge to place this palliative intervention on the continuum of end-of-life treatment alternatives other than to say in general terms that it falls somewhere between the widely accepted “passive” withholding or withdrawal of life-sustaining treatment and the more controversial “active” interventions of assisted suicide and euthanasia. Nevertheless, commentators widely perceive palliative sedation as an essential element of the right to refuse treatment at the end of life.¹¹

One factor that may distinguish palliative sedation from assisted suicide and euthanasia is the absence of any direct causal or chronological relationship between the act of sedation and the patient’s death.¹² Palliative

CTR. FOR BIOETHICS & HUMAN DIGNITY (2002), http://www.cbhd.org/resources/endoflife/kingsberry-ducharme_2002-01-24.html [<https://perma.cc/J8KF-BUYS>].

10. These symptoms can include anxiety, agitated depression, insomnia, and vomiting. *See, e.g.*, Dieter Birnbacher, *Terminal Sedation, Euthanasia and Causal Roles*, MEDSCAPE GEN. MED. (May 31, 2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1994875/> [<https://perma.cc/55DU-YZR6>].

11. One author described the relationship between palliative sedation and the right to refuse treatment in this manner: “The right to refuse treatment and the availability of palliative [sedation] are inextricably intertwined. The attempt to think about one without thinking about the other is a formula for making bad law and bad policy, and for increasing human suffering.” Stephen Arons, *Palliative Care in the U.S. Healthcare System: Constitutional Right or Criminal Act*, 29 W. N. ENG. L. REV. 309, 311 (2007).

12. Because palliative sedation leads to the same end as assisted suicide and euthanasia, some commentators have argued that they cannot logically or ethically be distinguished. *See* the discussion at notes 29–33, *infra*, and accompanying text. Despite the blurring of these procedures in the eyes of many observers on both sides of the autonomy spectrum, evidence tends to suggest that physicians prefer

sedation involves only the administration of a sedative as a means to relieve suffering, and it does not itself induce or necessarily accelerate the moment of death.¹³ This is true whether the sedative is administered only proportionately in conformity with the degree of suffering or rapidly to render the patient unresponsive with all possible haste. Perhaps because palliative sedation differs from both assisted suicide and euthanasia in terms of its immediate consequence, commentators perceive it as an appropriate means of last resort to relieve a patient's suffering as death becomes imminent.¹⁴ Assisted suicide and euthanasia both have the immediate and intended effect of causing death. Physician-assisted suicide involves the prescription of a barbiturate in a dosage intended to terminate the patient's life when he ingests it by his own hand.¹⁵ Euthanasia, on the other hand, entails one person's affirmative act to bring about the death of another—such as by administering the same lethal concoction the patient might use in assisted suicide.¹⁶ For practical purposes, therefore, palliative sedation differs from both assisted suicide and euthanasia in terms of immediate effect; assisted suicide and euthanasia produce the same effect but differ in terms of the actor's identity.¹⁷

palliative sedation to assisted suicide. *See, e.g., Studies reveal physicians' attitudes on end-of-life care*, U. IOWA (Dec. 6, 2004), https://www.eurekalert.org/pub_releases/2004-12/uoi-srp120304.php [<https://perma.cc/B7XA-GGZ2>].

13. *See* Gevers, *supra* note 9, at 361. As noted in the discussion at note 27, *infra*, and accompanying text, however, the maintenance of a patient in a deeply sedated state for an extended period of time poses its own complications that may hasten death.

14. These procedures tend to be employed only after less intensive palliative options have been exhausted. The prevalence of palliative sedation as a means of providing relief to terminally ill patients has been estimated to fall within the range of 21% to 54.5%, and it has been suggested that the average time from sedation to death runs between two and four days. *See* Rob McStay, *Terminal Sedation: Palliative Care for Intractable Pain Post Glucksberg and Quill*, 29 AM. J.L. & MED. 45, 46 (2003).

15. *See, e.g.,* Parker & Paine, *supra* note 1, at 125.

16. *Id.*

17. Dr. Jack Kevorkian, for example, initially helped terminally ill persons bring about their own deaths and later progressed to administering the fatal injection himself, thus crossing the line from assisted suicide to euthanasia and leading to his conviction of second-degree murder. *See* Dirk Johnson, *Kevorkian Sentenced to 10 to 25 years in Prison*, N.Y. TIMES (Apr. 14, 1999), <https://www.nytimes.com/1999/04/14/us/kevorkian-sentenced-to-10-to-25-years-in-prison.html> [<https://perma.cc/H8Z7-HBPU>].

B. Forms of Palliative Sedation in the Clinical Setting

The practice of palliative sedation in the contemporary clinical setting manifests itself in two primary expressions: “proportionate palliative sedation,” commonly referred to simply as “proportionate sedation,” and “palliative sedation to unconsciousness,” or “sedation to unconsciousness.” Proportionate sedation is the most prevalent form of these two interventions.¹⁸

Proportionate sedation involves the progressive administration of the minimum amount of sedative necessary to relieve the patient’s suffering as it intensifies with the progression of the patient’s disease.¹⁹ For example, physicians commonly administer morphine and other sedatives to lung cancer patients who are in the terminal stages of their disease in doses that proportionally increase with the intensity of the patients’ distress typically in the form of pain, dyspnea, and anxiety.²⁰ Although physicians employ proportionate sedation with the understanding that the progressive increase in sedatives will eventually render the patient unconscious or hasten death by hours or days, the practice does not purpose either of those consequences; rather, these results merely correspond with the relief of suffering at the margin of either unconsciousness or death.²¹ For this reason, proportionate sedation is generally considered to be an acceptable intervention from an ethical perspective.

This ethical view is grounded in a fundamental principle of bioethics known as the rule of double effect, sometimes called the “doctrine of double effect” or the “principle of double effect.”²² According to the principle of double effect, it is morally acceptable to engage in an affirmative act that one might expect to cause harm, but only if that harm is an unavoidable consequence of an attempt to achieve an identifiable good.²³ The doctrine of double effect serves as an exception to the broader

18. For purposes of this Article, both proportionate palliative sedation and palliative sedation to unconsciousness are referred to as “palliative sedation.”

19. Parker & Paine, *supra* note 1, at 123–24.

20. *Id.*

21. *Id.*

22. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 206 (4th ed. 1994).

23. *Id.* The classical formulation of the rule requires that all four of the following elements be satisfied in order for an action to be morally permissible:

(1) The act must be good, or at least morally neutral (independent of its consequences);]

bioethics principle of non-maleficence, which holds that a physician must not intentionally inflict harm.²⁴

The principle of double effect is now widely employed to justify the use of intense doses of narcotics and sedatives as a palliative measure to relieve suffering at the end of life, but it came from the Roman Catholic tradition of defining the circumstances under which therapeutic abortions may be morally appropriate.²⁵ For example, it might sometimes be necessary to treat a pregnant woman's cancer of the cervix by performing a hysterectomy, or to remove the fallopian tube from a woman who has an ectopic pregnancy to prevent a fatal hemorrhage.²⁶ In each of these cases, a physician employs a legitimate medical procedure to save the mother's life even though it will inevitably claim the life of the fetus. Notwithstanding the certainty of that cause and effect, the doctrine of double effect would justify these procedures from a moral perspective so long as the physician's intent was not the fetus's death. Stated another way, the physician whose actions caused the fetus's death would not be considered to have violated the principle of non-maleficence if: (1) his sole purpose was to save the life of the mother; and (2) the death of the fetus

(2) [t]he agent intends only the good effect of the act. The bad effect can be foreseen, tolerated and permitted, but it must not be intended[;]

(3) [t]he bad effect must not be a means to the good effect. If the good effect were the direct causal result of the bad effect, the agent would intend the bad effect in pursuit of the good effect[; and]

(4) [t]he good effect must outweigh the bad effect. The bad effect is permissible only if a proportionate reason is present that compensates for permitting the foreseen bad effect.

Id. at 207 (subheadings omitted).

The mere legality of one's decision under state law is not sufficient to invoke the principle of double effect. Rather, the rule would accommodate the combination of sedation and another lawful act or omission, such as withholding nutrition and hydration, only if the sedation does not achieve its palliative objective by causing death—a fundamental requirement of the double effect doctrine. Thus, the doctrine would apply when sedation to unconsciousness is combined with the withholding of artificial nutrition and hydration only if sedatives are employed to render the patient unconscious, but no further. It is this distinction that denies ethical justification for physician-assisted suicide, even in states in which that intervention is lawful.

24. *Id.*

25. *See, e.g.,* Parker & Paine, *supra* note 1, at 124.

26. *Id.*

was merely the unintended, although foreseen and inevitable, result of the physician's legitimate purpose.²⁷

The same logic justifies the use of powerful sedatives as a palliative measure when death is near, at least when a physician administers sedatives in a manner that proportionally correlates the increase in doses with the patient's level of distress. Although these interventions may eventually render the patient unconscious and even hasten the moment of death—because of the risk of infection that tends to accompany a prolonged period of sedation—the realms of both bioethics and law accept that the physician's singular intent in employing them is to relieve suffering, even though the means of achieving that goal will cause a correlative harm. Grounded in the principle of double effect, proportionate sedation has gained wide acceptance within the medical profession as an appropriate way to address a patient's intractable pain and distress during the dying process, and these interventions are commonly employed for the purpose of pain relief.²⁸

Although a patient may be rendered unconscious at some point during the course of administering proportionate sedation, a physician employs the intervention known as "sedation to unconsciousness" with the specific intent of immediately rendering the patient unresponsive and then maintaining him in an unconscious state until death.²⁹ Because most candidates for sedation to unconsciousness are unlikely to have any desire to eat or drink by the time this intervention is considered, it tends not to be accompanied by the administration of artificial nutrition and hydration.³⁰

27. In its classical expression, the doctrine of double effect would not apply to every abortion that may be necessary to save the mother's life. For example, a woman who has serious heart disease might face a significant risk of death unless her pregnancy is terminated. An abortion in that case, however, would not satisfy all four elements of the doctrine of double effect because the action of killing the fetus—the bad effect—would serve as the means to save the mother's life—the good effect. *See, e.g.*, BEAUCHAMP & CHILDRESS, *supra* note 22, at 207–08.

28. *See, e.g.*, Levine, *supra* note 9; Gevers, *supra* note 9.

29. *See, e.g.*, Mark F. Carr & Gina Jervey Mohr, *Palliative Sedation as Part of a Continuum of Palliative Care*, 11. J. PALLIATIVE MED. 76, 76 (2008); Timothy E. Quill et al., *Last Resort Options for Palliative Sedation*, 151 ANNALS INTERNAL MED. 421 (2009). A third form of sedation, which Quill et al. identified as "ordinary sedation," is employed both within and outside of the palliative care context and provides relief from symptoms without impairing the patient's level of consciousness. *Id.*

30. *See* Quill et al., *supra* note 29, at 422 ("Except under very unusual circumstances, artificial hydration and nutrition are not provided."); Gevers, *supra* note 9, at 361 ("Terminal patients are not eating or drinking substantial amounts; the patients that are considered for deep sedation [sedation to

Sedation to unconsciousness is more controversial and less common than its proportionate counterpart, primarily because of the complex blurring of intent created when a physician purposefully renders the patient unable to receive nutrition and hydration naturally and then orders that food and fluids be withheld.³¹ Focusing on the intentional, pre-planned coupling of sedation with the withholding of nutrition and hydration, some observers have concluded that sedation to unconsciousness is more closely identified with euthanasia than palliative care.³²

The argument that sedation to unconsciousness is akin to euthanasia is most compelling when the patient's ability to receive food and fluids has not been compromised. In one case, for example, a former cancer patient who was fully able to eat and drink expressed a desire to be sedated to unconsciousness and then forego the administration of artificial nutrition and hydration. Although thought to be in remission at the time of

unconsciousness] are not likely to eat and will hardly drink. Although artificial hydration and nutrition would seem indicated when the patient is no longer able to eat and drink himself, in some patients—in particular those already dying—it will be contraindicated because it would only lengthen the dying process. In others—apart from the risk of pulmonary edema and other adverse effects—it may be withheld either on the basis of an explicit refusal of the patient, or because in the final analysis the patient—taking into account his intolerable situation and the inevitability of an imminent death—has nothing to gain from it.”); Carr & Mohr, *supra* note 29, at 79 (suggesting that artificial nutrition and hydration are neither palliatively nor medically indicated for patients at the terminal stages of their disease process because they “often feel no hunger and may be unable to utilize nutrients as a healthy body would”).

31. See, e.g., Parker & Paine, *supra* note 1, at 123–24.

32. See McStay, *supra* note 14. Those who challenge the propriety of palliative sedation to unconsciousness draw from legal notions of causation and intent to deny any meaningful distinction between that intervention and euthanasia, simply because death is equally certain with either measure. As one commentator noted:

While similar to palliative measures as far as the sedation itself is concerned, withholding of hydration and nutrition brings terminal sedation into the realm of non treatment decisions. At the same time, to the extent that the combination of these two measures may shorten the patient's life, the practice may be easily associated with euthanasia. It is no surprise, therefore, that terminal sedation has been called . . . “slow euthanasia” or “backdoor euthanasia,” suggesting that it should be dismissed as a covert form of practice which is by many already considered as unacceptable per se.

Gevers, *supra* note 9, at 360. See also David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, 24 HASTINGS CONST. L.Q. 947 (1997).

her request, she had undergone treatment for several recurring bouts of cancer throughout her life and was fearful that the cancer would return. Having fulfilled the responsibility of raising her children and desiring to avoid the discomfort she had experienced during the prior incidents of illness, she decided that she would rather die than live with the fear of another episode of cancer. She eventually located a facility that accommodated her wishes.³³

Whatever reasoning the facility used to justify its acquiescence to this woman's request, it was not grounded in the principle of double effect. To the contrary, the facts of the case suggest strongly that a physician employed the sedatives in a contrived but thinly veiled effort to provide a comfortable death without appearing to cross the line from the passive refusal of treatment to an active intervention logically indistinguishable from euthanasia.

Not all such cases so closely mirror the practice of euthanasia. Therefore, it would be premature to universally dismiss the rule of double effect as a meaningful tool for evaluating all cases in which sedation to unconsciousness is accompanied by the withholding of artificial nutrition and hydration.

The euthanasia analogy loses its force altogether when a pre-existing medical condition drives the patient's need for artificially delivered nutrition and hydration. Consider, for example, a patient who suffers from esophageal cancer. Such a patient might refuse artificial nutrition and hydration when he becomes unable to swallow and then ask to be sedated to unconsciousness to relieve the suffering that accompanies the absence of food and fluids, with death by dehydration to be expected within a few days. A patient's decision to withhold nutrition and hydration in such a case should be considered independently of the fact that he would require deep sedation to mitigate the suffering that will follow. Under this view, it would be logical to view the act of sedation and the patient's refusal of treatment as separate and unique events, and to attribute death to the underlying medical condition that precipitated the need for artificially delivered sustenance.

The key factor that justifies the conclusion that the underlying medical condition caused death is the absence of any proximate causal relationship between the act of sedation and the patient's death. Since the patient's need for sedation as a palliative measure would arise from his irreversible inability to swallow, and since that inability would exist without regard to his state of consciousness—reflecting merely the natural progression of

33. The author became aware of this case during a personal conversation with the bioethicist whom the facility consulted after the event.

the disease—no relationship exists between the act of sedation and the patient's death. In the absence of that link, there would be no basis on which to conclude that the physician undertook the act of sedation with any intent other than palliation, and the doctrine of double effect would negate the euthanasia analogy.

One cannot rely on this reasoning in all cases, however, to alleviate concerns about the use of sedation to unconsciousness as a disguised method of euthanasia. Assume, for example, that a patient who suffers intractable pain as a result of rheumatoid arthritis requests that he is sedated immediately to unconsciousness and that food and fluids thereafter are withheld. By simultaneously creating and failing to satisfy the patient's need for the artificial delivery of nutrition and hydration, this application of palliative sedation would on its face appear to reflect a subtle form of euthanasia.³⁴

34. Legal principles of causation would suggest that death was intended in a case such as this, thus exposing the physician to criminal liability for homicide. Although prosecution may be unlikely, as a practical matter this risk would exist even in states in which assisted suicide is lawful. The risk exists because, in assisted suicide, the patient would administer the death-inducing agent. Euthanasia, on the other hand, is directly brought about at the physician's hand. In light of this distinction, the law may consider physician-assisted suicide more as a form of suicide with the indirect assistance of a physician rather than as a homicide directly at his hand.

One might anticipate an argument grounded in the doctrine of double effect that would purport to distinguish this situation from euthanasia if the sedative is administered at the minimum dosage necessary to relieve suffering. In effect, this argument would correlate proportionate sedation with sedation to unconsciousness when the sedative is applied at the margin of unconsciousness. Under this view, the patient's simultaneous loss of both consciousness and the ability to ingest nutrition and hydration would be merely foreseeable but unintended consequences of administering the sedative—the sole intent of which was to relieve suffering. Considered in the double effect context, the bad effects of the sedative, rendering the patient unable to ingest food and fluids, would be not the means of achieving the intended good effect of relief from suffering, but as the inevitable though unintended consequence of it. Those who would deny the identity between sedation to unconsciousness and euthanasia in such a case may also focus on the fact that, unlike cases of assisted suicide and euthanasia, the act of sedating the patient to relieve suffering would not, of itself, result in her immediate death, whether the sedative is administered proportionally, in increments, or immediately, with a single dose. *See* Gevers, *supra* note 9, at 361. The ethical basis for this distinction has been the subject of considerable discussion among moral philosophers, lawyers and practicing physicians. *See, e.g.,* Levine, *supra* note 9. The maintenance of a patient in a deeply sedated state for an extended period of time, however, poses its own complications that might

C. Palliative Sedation and Professional Medical Standards

The medical profession widely views the practice of palliative sedation as an appropriate means of last resort to relieve suffering, at least when the physician administers the sedative in a manner that denies any direct causal relationship or chronological identity with the patient's death.³⁵ Despite the occasional blurring of the procedures involved, evidence suggests that physicians prefer palliative sedation to assisted suicide—and, by implication, to euthanasia.³⁶ Moreover, courts tend to consider decisions concerning the provision of palliative care to be primarily a matter of medical judgment and professional discretion.³⁷

The American Medical Association (“AMA”) responded to this judicial deference in 2008 by adopting general clinical policies and professional guidelines to address the ethical dilemmas extreme palliative interventions such as sedation to unconsciousness pose.³⁸ These professional standards limit the provision of palliative sedation to circumstances of unrelieved, severe physical suffering of patients who are imminently dying and whose clinical symptoms have been unresponsive to other aggressive treatment geared to symptom relief. The AMA guidelines also recognize that extreme palliative interventions should be employed only: (1) as a last resort; (2) with the sole intent to relieve

hasten death. This fact is true whether the sedative is administered proportionately with the degree of suffering, or rapidly in order to render the patient insensate and unresponsive with all possible haste.

35. Gevers, *supra* note 9, at 361.

36. See, e.g., *Studies reveal physicians' attitudes on end-of-life care*, *supra* note 12, and statistical evidence reported therein. According to Lauris Kaldjian, NMD, the lead investigator in the studies cited in this article, physician attitudes appear to be related to their experience in caring for terminally ill patients and the frequency with which they attend religious services: “[T]hose who had cared for a greater number of terminally [ill] patients in the preceding year were more opposed to assisted suicide and also more supportive of terminal sedation . . . , [and among those physicians] [t]here seemed to be both a greater willingness to be rigorous in end-of-life care but also less willingness to cross that line into actually intending death.” *Id.* See also Levine, *supra* note 9, and references cited therein.

37. See, e.g., Gevers, *supra* note 9, at 366 (“What is needed is not so much specific legislation, but authoritative clinical guidelines providing a workable protocol on how physicians should proceed.”).

38. See, e.g., CODE OF MEDICAL ETHICS, Principles of Medical Ethics §§ I, VII (AM. MED. ASS'N 2001); Levine, *supra* note 9.

suffering rather than to cause or hasten death; and (3) in a manner that does not directly cause death.³⁹

For all practical purposes, the AMA standards incorporate the ethics-based rule of double effect. The standards also reflect the manner in which the law has traditionally balanced the patient's interest in self-determination and the state's interest in preserving life. Finally, as borne out in the following discussion, the AMA guidelines weigh these competing interests in much the same way as does the Natural Death Act, creating an effective symmetry between these ethical standards and Louisiana law.⁴⁰ The Natural Death Act also implicitly reflects the manner in which the courts have weighed these interests in the constitutional context.

II. THE STATUS OF SEDATION TO UNCONSCIOUSNESS AS A MATTER OF CONSTITUTIONAL LAW

By definition, sedation to unconsciousness arises in the context of treatment at the end of life. It entails not only the withholding of artificial nutrition and hydration, but also subjecting the patient to deep sedation to relieve the distress expected to follow the absence of food and fluids. This integration of passive and active steps suggests that the same body of law that relates to one's "negative" right to refuse medical treatment and one's "positive" right to a physician's assistance in bringing about his death should inform the legal implications of sedating a patient to unconsciousness.

A. The "Negative" Right of a Terminally Ill Patient to Withhold or Withdraw Life-Sustaining Treatment

The body of constitutional jurisprudence concerning the refusal of medical treatment in the United States originated in 1891, when the Supreme Court first addressed the sanctity of one's right to control his own body in the health care context. Holding that a plaintiff in a personal injury

39. In addition, the AMA guidelines recommend that: (1) the patient or an authorized surrogate provide an explicit informed consent to the use of an extreme palliative intervention; (2) reasonable steps be taken to ensure that physicians are educated about the proper clinical context for their use; (3) physicians consult with an interdisciplinary team that includes an expert in palliative care before recommending their use to ensure that it is the most appropriate course of treatment; and (4) health care facilities establish an internal mechanism to review all cases in which patients request these measures. Levine, *supra* note 9.

40. See the discussion *infra* at notes 111–47 and accompanying text.

case cannot be compelled to undergo a pretrial medical examination without consent, the Court stated:

No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.⁴¹

Implicit in this notion of bodily integrity is the concept that a patient has the right to refuse medical treatment.⁴²

Although courts have cited different premises as the theoretical basis for the right to refuse medical treatment, courts have come to apply this right even when the patient's refusal of treatment is reasonably expected to result in death:

Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.⁴³

Courts throughout the United States thus readily acknowledge that a competent person possesses what one might broadly describe as the right to refuse medical treatment, and courts are willing to recognize this right

41. *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

42. *See* *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914), *overruled in part by* *Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957). Justice Cardozo described the doctrine of informed consent in these terms: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id.* at 93. *See also* MEISEL & CERMINARA, *supra* note 3, § 2.06[A] ("The right to refuse medical treatment is a corollary of the requirement of consent to medical treatment and has always been implicit in it.").

43. *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960). Although many of the early cases arose in the context of competent patients who refused treatment either on religious grounds or simply as a matter of personal preference, the modern so-called "right to die" cases corresponded with the emergence of advanced medical technology that enabled physicians to sustain life by employing a combination of devices for artificial respiration, circulation, feeding, and hydration. *See, e.g.*, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 270 (1990).

unconstrained by the fact that the refusal will result in an otherwise avoidable death.⁴⁴

The Supreme Court first addressed this question in *Cruzan v. Director, Missouri Department of Health*⁴⁵ in the context of withdrawing artificial nutrition and hydration from a patient in a persistent vegetative state. After being ejected from her car in an accident, Nancy Cruzan was discovered lying face down in a ditch, unconscious and without any detectable cardiac or respiratory function. Paramedics were able to restore her heartbeat and breathing prior to transporting her to the hospital, but Nancy remained in a coma for approximately three weeks before progressing to a vegetative state in which she exhibited no evidence of significant cognitive function. Although she was able to receive some amount of nutrition orally, her physicians surgically implanted a gastrostomy tube to better provide nutrition and hydration. Nancy's physicians were of the opinion that this procedure would enable her to live for another 30 years, but only in a persistent vegetative state.

In light of this prognosis, and believing that Nancy would have refused artificial nutrition and hydration if she were capable of speaking for herself, her parents requested that the physicians remove the gastrostomy tube and allow her to die.⁴⁶ Nancy's parents sought judicial authorization to withdraw treatment when the hospital refused to honor their request without court approval.

Although the trial court authorized the hospital to withdraw treatment,⁴⁷ the Missouri Supreme Court reversed by a divided vote. The Court acknowledged that one's right to refuse treatment was implicit in the common law doctrine of informed consent, but it expressed skepticism about the application of that doctrine under the specific facts of Nancy's

44. See, e.g., MEISEL & CERMINARA, *supra* note 3, and cases cited therein. See also *Cruzan*, 497 U.S. at 328.

45. *Cruzan*, 497 U.S. at 261. *In re Quinlan* was the seminal decision in the U.S. concerning the refusal of life-sustaining treatment. *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

46. *Cruzan*, 497 U.S. at 267.

47. The trial court found that a person in Nancy's condition had a fundamental right under the Missouri and U.S. Constitutions to refuse or direct the withdrawal of "death-prolonging procedures." *Id.* at 261. The court also found:

Nancy's "expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration."

Id. at 268 (citation omitted).

case.⁴⁸ The Court also expressed doubt as to whether such a right existed under the U.S. Constitution,⁴⁹ and it was unwilling to construe the Missouri Constitution as embodying a right of privacy that would “support the right of a person to refuse medical treatment in every circumstance.”⁵⁰ Finally, noting that Missouri’s living will statute embodied a policy that strongly favored the preservation of life,⁵¹ the Court held that “no person can assume that choice for an incompetent in the absence of the formalities required under [the living will statute] or the clear and convincing, inherently reliable evidence absent here.”⁵² The Missouri Supreme Court thus reversed the decision of the trial court on the grounds that the record did not reflect sufficient evidence to indicate that Nancy would have wanted treatment to be withdrawn.⁵³

The U.S. Supreme Court thereafter granted certiorari to consider the question of whether the U.S. Constitution would accord Nancy Cruzan a right that “would require the hospital to withdraw life-sustaining treatment from her” under the specific circumstances of her case.⁵⁴ In addressing that question, the Court referred to its own prior jurisprudence concerning the Fourteenth Amendment’s Due Process Clause in light of decisions by various state courts concerning the doctrine of informed consent.⁵⁵

48. *Cruzan v. Harmon*, 760 S.W.2d 408, 416–17 (Mo. 1988) (en banc).

49. *Id.* at 417–18.

50. *Id.*

51. *Id.* at 419–20.

52. *Id.* at 425.

53. Finding that Nancy’s statements to her roommate regarding her desire to live or die under certain conditions were “unreliable for the purpose of determining her intent,” *id.* at 424, the Missouri Supreme Court concluded that the evidence was “insufficient to support the co-guardians claim to exercise substituted judgment on Nancy’s behalf.” *Id.* at 426. Finally, the court expressed its view that “[b]road policy questions bearing on life and death issues are more properly addressed by representative assemblies” than judicial bodies. *Id.*

54. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990).

55. *See, e.g., Jacobson v. Massachusetts*, 197 U.S. 11, 24–30 (1905) (balancing an individual’s liberty interest in declining an unwanted smallpox vaccination against the state’s interest in preventing disease); *Washington v. Harper*, 494 U.S. 210, 221–22 (1990) (recognizing that prisoners possess “a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment”); *Vitek v. Jones*, 445 U.S. 480, 494 (1980) (finding that liberty interests were implicated when an inmate is transferred to a mental hospital for mandatory behavior modification treatment); *Parham v. J.R.*, 442 U.S. 584, 600 (1979) (holding that an individual has a substantial liberty interest in not being confined unnecessarily for medical treatment). According to the Court in *Cruzan*:

The Supreme Court expressed the issue before it as “whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did.”⁵⁶ In addressing that question, the Court first noted the logical correlation between the common law doctrine of informed consent and the right of a competent individual to refuse medical treatment.⁵⁷ The Court then established the general framework for its analysis by noting that the opinions in the various lower courts regarding the scope of that right “demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones.”⁵⁸ Recognizing the significance of those moral and ethical issues from the perspectives of law and public policy, the Court said that in deciding “a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.”⁵⁹

Having so framed the question, the Court focused its inquiry on the Fourteenth Amendment’s proscription against deprivations of liberty

At common law, even the touching of one person by another without consent and without legal justification was a battery This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until . . . the seminal decision in *In re Quinlan*, the number of right-to-refuse-treatment decisions was relatively few. Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common-law rights of self-determination. More recently, however, with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones.

Cruzan, 497 U.S. at 269–70, 277 (citations omitted).

56. *Cruzan*, 497 U.S. at 277.

57. *Id.*

58. *Id.*

59. *Id.* at 277–78 (quoting *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897)) (alteration in original) (internal quotation marks omitted).

without due process of law, and it inferred from its prior decisions “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment.”⁶⁰ The Court went on to qualify the patient’s right, however, by noting that the finding of a liberty interest under the Due Process Clause was only the beginning of the inquiry. Rather, the Court stated that whether a person’s constitutional rights have been violated “must be determined by balancing his liberty interests against the relevant state interests.”⁶¹

With respect to those state interests, the Court took notice of the fact that Missouri had adopted its high evidentiary standard in reliance “on its interest in the protection and preservation of human life, and there can be no gainsaying this interest.”⁶² The Court further noted that all states

60. *Id.* at 278. In support of this inference, the Court cited *Jacobson v. Massachusetts*, 308 U.S. 184 (1934) (balancing an individual’s liberty interest in declining an unwanted smallpox vaccine against the State’s interest in preventing disease). The Court further noted that its decisions prior to the incorporation of the Fourth Amendment into the Fourteenth Amendment analyzed searches and seizures involving the body under the Due Process Clause and were thought to implicate substantial liberty interests. *Id.* (citing *Breithaupt v. Abram*, 352 U.S. 432, 439 (1957)) (“As against the right of an individual that his person be held inviolable . . . must be set the interests of society . . .”). The Court also cited *Washington v. Harper*, 494 U.S. at 221–22 (in the course of holding that a State’s procedures for administering antipsychotic medication to prisoners were sufficient to satisfy due process concerns, the Court recognized that prisoners possess “a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment”); *see also id.* at 229 (holding that “[t]he forcible injection of medication into a nonconsenting person’s body represents a substantial interference with that person’s liberty”); *Vitek*, 445 U.S. at 490 (holding that the transfer to mental hospital coupled with mandatory behavior modification treatment implicated liberty interests); *Parham*, 442 U.S. at 600 (“[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment . . .”); *Cruzan*, 497 U.S. at 278–79.

61. *Cruzan*, 497 U.S. at 279 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982) (citing *Mills v. Rogers*, 457 U.S. 291, 299 (1982))) (internal quotation marks omitted). These state interests include: (1) the interests in preserving life, *see, e.g., In re Conroy*, 486 A.2d 1209, 1239 (N.J. 1985); (2) preventing suicide, *id.* at 1223; (3) preserving the ethical integrity of the medical profession, *id.*; and (4) protecting members of vulnerable groups, *see, e.g., Cruzan*, 497 U.S. at 281.

62. *Cruzan*, 497 U.S. at 280. Although the Court addressed only the constitutionality of Missouri’s heightened evidentiary standard for confirming that a surrogate’s decision reflects the patient’s preference, the law is clear that the state’s interest applies even when the patient speaks for himself:

demonstrate their commitment to life by treating homicide as a serious crime and that a majority of states impose criminal penalties on persons who assist others in committing suicide.⁶³ Even with respect to a competent patient who expresses an informed refusal of nutrition and hydration, the *Cruzan* Court opined that “[w]e do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.”⁶⁴ Finally, the Court noted that the state has an unqualified interest in the preservation of life: “[W]e think a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.”⁶⁵

The *Cruzan* Court thus effectively dispensed with any notion that a patient might enjoy an unbridled liberty interest in the refusal of life-sustaining treatment, whether the patient refuses directly or indirectly by a surrogate.

B. The “Positive” Right of a Terminally Ill Patient to Receive the Assistance of a Physician in Committing Suicide, and the Problematic Relationship Between Sedation to Unconsciousness, Assisted Suicide, and Euthanasia

In contrast with the mere tranquilizing effect of sedation to unconsciousness, assisted suicide involves the self-administration of a barbiturate in a dosage a physician prescribes for the specific purpose of

The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, “[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.”

Id. at 281 (quoting *In re Jobs*, 529 A.2d 434, 447 (N.J. 1987)). A state is entitled to guard against potential abuses in such situations. Similarly, a state is entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it. *See id.* *See also* *Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502, 515–16 (1990).

63. *Cruzan*, 497 U.S. at 281.

64. *Id.* at 280.

65. *Id.* at 282.

enabling the patient to immediately terminate his own life. Euthanasia, on the other hand, entails one person's affirmative act to bring about the death of another—generally by the administration of a lethal dose of medication such as that employed in assisted suicide. Although the practices of sedation to unconsciousness, assisted suicide, and euthanasia differ in terms of the actor's identity and clinical method, they are similar because each represents an active intervention certain to result in the patient's death, whether immediate—as in the case of assisted suicide and euthanasia—or eventual—as in the case of sedation to unconsciousness. This common result renders all of these measures ethically and morally problematic.⁶⁶

Euthanasia and assisted suicide are especially dubious from an ethical perspective because the procedures purposely result in the patient's immediate death. The ethical challenges sedation to unconsciousness poses, however, vary with the manner and circumstances under which the physician administers the sedative, making questions about the propriety of the practice both subtler and more case-specific than the infamy commonly associated with euthanasia and assisted suicide.

Such weighty ethical concerns invoke equally significant questions of law, and the Supreme Court has twice issued writs of certiorari to address facial challenges asserted on Equal Protection and Due Process grounds concerning the constitutionality of statutory prohibitions against assisted suicide. *Washington v. Glucksberg*⁶⁷ and *Vacco v. Quill*⁶⁸ represent the Court's most recent expressions concerning this issue, and they reflect the full evolution of thought concerning the legal implications of end-of-life decision-making in the contexts of both the right to "passively" refuse life-sustaining treatment and the right to "actively" receive an intervention that will cause death directly and immediately. Although these cases involved only the constitutional implications of physician-assisted suicide, the Court informed its inquiry concerning that issue with reference to the closely related practice of sedation to unconsciousness.

Four physicians, three gravely ill patients, and Compassion in Dying, a nonprofit organization that counsels people who are considering assisted suicide, initiated *Glucksberg*.⁶⁹ These plaintiffs asserted the existence of a substantive due process right to commit suicide with the assistance of a

66. See MEISEL & CERMINARA, *supra* note 3, § 7.01[C].

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

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

69. *Glucksberg*, 521 U.S. at 707–08. *Glucksberg* was initiated in the U.S. District Court for the Western District of Washington. *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *aff'd en banc*, 79 F.3d 790, *rev'd*, *Glucksberg*, 521 U.S. 702.

physician, and the district court agreed that they possessed such a right.⁷⁰ Relying primarily on the Supreme Court's decisions in *Planned Parenthood v. Casey*⁷¹ and *Cruzan v. Director, Missouri Department of Health*,⁷² the court held that Washington's ban on assisted suicide placed "an undue burden on the exercise of [that] constitutionally protected liberty interest."⁷³

Although a panel of the Ninth Circuit initially reversed the district court decision,⁷⁴ the appeals court later affirmed the lower court's holding when rehearing the case *en banc*,⁷⁵ concluding that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death—that there is, in short, a constitutionally recognized 'right to die.'"⁷⁶ More specifically, and in light of that liberty interest, the Ninth Circuit held that Washington's prohibition against assisted suicide was unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians."⁷⁷

70. *Glucksberg*, 521 U.S. at 708. More specifically, the plaintiffs claimed "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide." *Compassion in Dying*, 850 F. Supp. at 1459. They complained that Washington's statutory prohibition against "caus[ing]" or "aid[ing]" a suicide violated, on its face, the Fourteenth Amendment to the Constitution. *Id.* at 1458–59. See WASH. REV. CODE § 9A.36.060(1) (1998). Washington's Natural Death Act specifically excluded from the definition of a suicide "[t]he withholding or withdrawal of life-sustaining treatment" in accordance with the patient's direction. *Id.* § 70.122.070(1) (1998). See also *Glucksberg*, 521 U.S. at 707. The Fourteenth Amendment provides, in pertinent part: "[N]or shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

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

72. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 328 (1990).

73. *Compassion in Dying*, 850 F. Supp. at 1465. The District Court also held that the Washington statute violated the Equal Protection Clause. *Id.* at 1467. The Ninth Circuit, however, did not reach the equal protection issue when the case came before that court on appeal. *Compassion in Dying*, 49 F.3d 586, *aff'd en banc*, 79 F.3d 790, *rev'd*, *Glucksberg*, 521 U.S. 702.

74. *Compassion in Dying*, 49 F.3d at 594.

75. *Compassion in Dying*, 79 F.3d at 798.

76. *Id.* at 816.

77. *Id.* at 837. The Ninth Circuit did not find the Washington statute to be invalid on its face. *Id.*

The Supreme Court reversed.⁷⁸ The Court framed the issue before it as “whether the ‘liberty’ specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.”⁷⁹ In resolving that question, the Court undertook a careful review of “our Nation’s history, legal traditions, and practices” that treated as a crime any act of assisting a person in the commission of suicide.⁸⁰ After noting that most states treated one’s assistance in a suicide as a crime at the time the Fourteenth Amendment was ratified,⁸¹ that nearly every state defined assisted suicide as a crime at the time the Court was deciding the case, and that federal law expressly prohibited the use of federal funds to support the commission of suicide with the assistance of a physician,⁸² the Court found in these facts a longstanding tradition that represented “the States’ commitment to the protection and preservation of all human life.”⁸³

Though recognizing that the Court in *Cruzan* had “assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment,”⁸⁴ the Court refused to extend its assumption to embrace assisted suicide. After emphasizing that the right to refuse treatment was grounded in the common law notion of informed consent rather than “abstract concepts of personal autonomy,” the Court noted:

Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse

78. *Glucksberg*, 521 U.S. at 735–36. The majority opinion in *Glucksberg* was joined by Justices Scalia, O’Connor, Kennedy, and Thomas. Justices O’Connor, Ginsberg, Breyer, Stevens, and Souter each filed concurring opinions. *Id.* at 736–92.

79. *Id.* at 723.

80. *Id.* at 710.

81. *Id.* at 715. The Court also noted that the American Law Institute’s Model Penal Code, which prohibited the “aiding” of a suicide, played a significant role in prompting many states in the 20th century to enact or revise their bans against assisted suicide. Moreover, the Court noted that those bans had been reaffirmed in the years prior to *Glucksberg* and *Quill*, and that other changes had been wrought in the law to protect the interests of the terminally ill, such as the enactment of “living will” statutes, other provisions that expressly recognized the role of surrogates in making health care decisions, and provisions dealing with the withholding or withdrawal of life-sustaining treatment. *Id.* at 715–16.

82. *Id.* at 710. The Court noted that, at the time of the Ninth Circuit’s decision, 44 states had statutes prohibiting assisted suicide, and three others had enacted such statutes before the case reached the Supreme Court. *Id.* at 710–11 n.8.

83. *Id.*

84. *Id.* at 720.

unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.⁸⁵

The Court thus based its holding primarily on the distinction between a person's right to refuse an unwanted touching and one's right to demand a desired one, again with reference to the support it found in "this Nation's history and [] traditions."⁸⁶

Quill is like *Glucksberg* in that three physicians and three gravely ill patients asserted interests in assisted suicide.⁸⁷ In contrast with the due process focus of *Glucksberg*, however, *Quill* raised equal protection concerns.⁸⁸ More specifically, the plaintiffs in *Quill* argued that because New York law permitted competent patients to refuse life-sustaining treatment, and because the refusal of such treatment was tantamount to assisted suicide, the state's ban on the latter practice violated the Equal Protection Clause of the Fourteenth Amendment to the Constitution.⁸⁹

The lower court rejected the plaintiffs' equal protection claim. Focusing on the state's "obvious legitimate interests in preserving life, and in protecting vulnerable persons," the court found it "hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device."⁹⁰

85. *Id.* at 725.

86. *Id.*

87. *Id.* at 797. *Quill* and *Glucksberg* were also similar in the sense that the patients in both cases died before the issues reached the Supreme Court. *Id.* at 707; *Vacco v. Quill*, 521 U.S. 793, 797 (1997).

88. *Quill*, 521 U.S. at 797.

89. *Id.* The New York law at issue in *Quill* provided that "[a] person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide. Manslaughter in the second degree is a class C felony." N.Y. PENAL LAW § 125.15 (McKinney 1998). In contrast with this express prohibition against aiding a suicide, New York law quite clearly provided that a competent person had the right to refuse medical treatment, even if his refusal would result in death. N.Y. PUB. HEALTH LAW §§ 2960–79 (McKinney 1993); see *Quill*, 521 U.S. at 797 n.2.

90. *Quill v. Koppell*, 870 F. Supp. 78, 84–85 (S.D.N.Y. 1994), *aff'd in part and rev'd in part*, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, *Quill*, 521 U.S. 793.

On appeal, the Second Circuit reversed, finding that New York law does not treat equally all competent persons who are in the final stages of a terminal illness and who wish to hasten their deaths.⁹¹ The court based this conclusion on the fact that:

“[T]hose in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.” . . . “[T]he ending of life by [the withdrawal of life-support systems] is *nothing more nor less than assisted suicide*.”⁹²

The appeals court then concluded that New York’s statutory distinction between assisted suicide and the withdrawal of life-sustaining treatment was not rationally related to any legitimate state interest and, therefore, that it violated the Equal Protection Clause.⁹³

Consistent with its reversal of the Ninth Circuit in *Glucksberg* under the Due Process Clause, the Supreme Court rejected the Second Circuit’s Equal Protection analysis in *Quill*. Denying that it should treat the refusal of treatment and assisted suicide the same simply because they both hasten death,⁹⁴ the Court focused on the fact that the New York statute drew no unlawful distinction between terminally ill persons because “[e]veryone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide.”⁹⁵ The majority drew support for its holding from the AMA’s amicus brief, which contended that members of the medical profession “widely recognized and endorsed” the substantive distinction between suicide and the refusal of treatment.⁹⁶ The Court stated that this distinction was “important,” “logical,” and “rational,” and that it “comports with fundamental legal principles of causation and intent.”⁹⁷

91. *Quill*, 80 F.3d 716.

92. *Quill*, 521 U.S. at 798 (quoting *Quill*, 80 F.3d at 727, 729) (alteration in original).

93. *Id.* at 799.

94. *Id.* at 809. As in *Glucksberg*, Justice Rehnquist wrote the majority opinion in *Quill* and Justices Scalia, O’Connor, Kennedy, and Thomas joined him; Justices O’Connor, Ginsburg, Breyer, Stevens, and Souter each filed concurring opinions. *Id.* at 809–10.

95. *Id.* at 800.

96. *Id.* at 801.

97. *Id.* at 800–01.

The *Quill* Court found the distinction between assisted suicide and the refusal of life-sustaining treatment relevant from a causation perspective by noting that a patient who refuses treatment will die from the natural progression of the underlying disease, whereas a patient who receives a lethal concoction will die from the body's reaction to the foreign matter.⁹⁸ In terms of intent, the Court found that physicians who comply with a patient's request to withhold or withdraw life-sustaining treatment do not necessarily act with the intent of causing death,⁹⁹ but that those physicians who provide assistance in committing suicide "must, necessarily and indubitably, intend primarily that the patient be made dead."¹⁰⁰

The *Quill* Court, however, refused to infer a physician's intent to cause death when employing aggressive palliative measures to control a patient's pain.¹⁰¹ This distinction between palliative sedation, on the one

98. *Id.*

99. *Id.*

100. *Id.* at 802 (quoting *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 104th Cong., 2d Sess., 367 (1996) (testimony of Dr. Leon R. Kass)) (internal quotation marks omitted). Whether intentionally or not, this conclusion is consistent with the line of reasoning the American Hospital Association presented in its amicus brief concerning the finding of intent. That argument focused on the different responses one might expect to follow when a patient continues to live after the withdrawal of treatment, on the one hand, and after a failed suicide attempt, on the other. The patient who requested only the withdrawal of treatment presumably would be allowed to continue living. In contrast, the only rational course of action for the patient who sought assistance in committing suicide would be to try again. This argument provides a meaningful contextual reference point in the clinical setting for the doctrine of double effect as a supplement to the traditional legal notion of intent, which relates to "the exercise of intelligent will, the mind being fully aware of the nature and consequences of the act which is about [t]o be done, and with such knowledge, and with full liberty of action, willing and electing to do it." BLACK'S LAW DICTIONARY 810 (6th ed. 1990) (citations omitted). This argument not only accommodates the unique nature of the relationship that exists between a physician and a patient; it also implicitly recognizes that the physician-patient relationship is governed by professional norms that justify a presumption that the physician always acts with the intent to preserve life rather than cause death.

101. *Quill*, 521 U.S. at 807–08 n.11 (rejecting the respondents' argument that "the State irrationally distinguishes between physician-assisted suicide and 'terminal sedation,' a process respondents characterize as 'induc[ing] barbiturate coma and then starv[ing] the person to death'"). The Court recognized that the practice of palliative sedation is based on informed consent and the principle of double effect: "Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care

hand, and euthanasia or physician-assisted suicide on the other, acknowledged implicitly the principle of double effect and embraced the reasoning a group of bioethics professors espoused in their amicus brief:

Providing medication to control pain has always been a legitimate and lawful medical act, even if death . . . is risked. Most invasive medical interventions carry the risk of death or disability. But if a patient dies during surgery, the surgeon is not guilty of homicide. This is because there is a real difference between an intended result and an unintended but accepted consequence of medical care where the goal is to benefit the patient.¹⁰²

Although the holdings in *Glucksberg* and *Quill* invoked the doctrine of double effect to distinguish palliative sedation from physician-assisted suicide from a constitutional perspective, Justices O'Connor, Breyer, and Stevens expressly limited their concurring opinions to the specific facts under review in those cases. Justice O'Connor, for example, suggested that the Court might reach a different result if presented with an as-applied challenge that established a legal impediment to effective pain relief. Emphasizing that neither Washington nor New York law raised any barriers to a physician's ability to manage a patient's pain, she explained that it was unnecessary for the Court to reach the question of whether there exists a "constitutionally cognizable interest in controlling the circumstances of [one's] imminent death."¹⁰³ More specifically, Justice O'Connor noted that the plaintiffs in *Glucksberg* and *Quill* had raised only facial challenges to the laws of Washington and New York and noted that "in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."¹⁰⁴ Justice O'Connor thus qualified implicitly her concurrence upon the availability of sedation to unconsciousness.¹⁰⁵ Justice Breyer adopted the same view:

[A]s Justice [O'Connor] points out, the laws before us do not *force* a dying person to undergo [severe physical] pain. Rather, the laws

related to that refusal, which may have the foreseen but unintended 'double effect' of hastening the patient's death." *Id.*

102. Brief for Bioethics Professors Amicus Curiae Supporting Petitioners at 18, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858, 96-110).

103. *Washington v. Glucksberg*, 521 U.S. 702, 736 (1997) (O'Connor, J., concurring).

104. *Id.* at 736–37.

105. *Id.* at 736.

of New York and of Washington do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill . . . [W]ere state law to prevent the provision of palliative care, including the administration of drugs as needed to avoid pain at the end of life—then the law’s impact upon serious and otherwise unavoidable physical pain . . . would be more directly at issue. And as Justice [O’Connor] suggests, the Court might have to revisit its conclusions in these cases.¹⁰⁶

Justice Breyer also indicated that he would go one step further in the face of an impediment to effective pain control by framing the question more specifically: “[A]t its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined.”¹⁰⁷ Justice Breyer thus implied that he would find a due process “right to die with dignity” if state law prevented the provision of sedation to unconsciousness.¹⁰⁸

Justice Stevens similarly qualified his concurrence, stating that the Court’s holding in *Glucksberg*:

[D]oes not foreclose the possibility that some application of [a statute that prohibits assisted suicide] may impose an intolerable intrusion on the patient’s freedom. There remains room for vigorous debate about the outcome of particular cases that are not necessarily resolved by the opinions announced today. How such cases may be decided will depend on their specific facts. In my judgment, however, it is clear that the so-called “unqualified interest in the preservation of human life” . . . is not itself sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying patient’s dignity and alleviating her intolerable suffering.¹⁰⁹

Each of these concurring opinions suggests that it was only the absence of a legal impediment to the availability of sedation to unconsciousness in Washington or New York that enabled Justices O’Connor, Breyer, and Stevens to join the majority of the Court in *Glucksberg* and *Quill*.

At their cores, the holdings in the assisted suicide cases of *Glucksberg* and *Quill* reflect a subtle stand-off between members of the Court who

106. *Id.* at 791–92 (Breyer, J., concurring) (citation omitted).

107. *Id.* at 790.

108. *Id.* at 791.

109. *Id.* at 751–52 (Souter, J., concurring) (citations omitted).

held different visions about the appropriate balance between the patient's right to self-determination and the state's interest in preserving life.¹¹⁰ The only collective certainty, or least common denominator, to be gleaned from these cases is that a terminally ill patient does not possess a constitutional right to assisted suicide on either due process or equal protection grounds in a state that imposes no legal impediment to effective pain relief. Although the concurring opinions suggest that such relief would include sedation to unconsciousness, the majority opinion did not address specifically the scope of a patient's right to palliative care.

III. THE STATUS OF SEDATION TO UNCONSCIOUSNESS UNDER THE LOUISIANA NATURAL DEATH ACT

The unresolved question about the legal status of sedation to unconsciousness can leave physicians just as unsettled about the consequences of employing aggressive palliative measures as they were about complying with their patients' requests to withhold or withdraw life-sustaining treatment prior to the enactment of advance directive statutes. The uncertainty in both situations stems from the inherent conflict between the patient's interest in autonomy and the state's interest in preserving life.

The Natural Death Act¹¹¹ provides a meaningful reference point for addressing this question in Louisiana. Although the range of contemporary palliative care options now available might have been unknown to the legislature at the time it adopted the Act, the statute is broad enough in purpose, policy, and expression of legislative intent to inform our understanding about the scope of a patient's right under Louisiana law to receive palliative care when exercising his right to withhold or withdraw life-sustaining treatment.

110. Apparently relying on the doctrine of double effect, the majority of justices refused to recognize one's right to assisted suicide, but they found that sedation to unconsciousness posed no meaningful challenge to the state's interest in preserving life. Although Justices O'Connor, Breyer, and Stevens agreed with the majority under the specific facts of *Glucksberg* and *Quill*, they suggested that they might reach a different result in an "as applied" challenge to an assisted suicide ban, particularly where there exists a legal impediment to the availability of palliative sedation. *See id.* at 736 (O'Connor, J., concurring), 741–42 (Stevens, J., concurring), and 790 (Breyer, J., concurring). These concurring justices found it unnecessary to address that question in *Glucksberg* and *Quill* simply because the plaintiffs there had asserted only a facial challenge and had not presented evidence of such an impediment.

111. LA. REV. STAT. § 40:1151 (2019).

A. *The Purpose and Scope of the Natural Death Act*

Like its counterparts in other jurisdictions, the Act reflects the negative implication of the doctrine of informed consent: if a physician is obligated to obtain a patient's consent prior to providing treatment, the clear inference is that the patient has a corresponding right to deny that consent even in the face of death.¹¹² As a legislative response to the body of jurisprudence that followed in the wake of *Quinlan*,¹¹³ the statute seeks not only to balance the competing interests of the individual in self-determination¹¹⁴ and the state in the preservation of life,¹¹⁵ but also to alleviate physicians' concerns about potentially adverse legal and professional consequences of complying with a patient's request that life-

112. See, e.g., *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960) ("Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception."). See also *In re Conroy*, 486 A.2d 1209, 1222 (N.J. 1985).

113. See generally MEISEL & CERMINARA, *supra* note 3, § 7.01[C]. Although several of the early cases arose in the context of competent patients who objected to treatment either on religious grounds or simply as a matter of personal preference, the rapid emergence of advanced medical technology since the 1970s provided the main impetus for the modern so-called "right-to-die" cases. Such technology has enabled biological life to be sustained almost indefinitely by a combination of devices for artificial respiration, circulation, feeding, and hydration. See, e.g., *Cruzan v. Dir., Mo. Dep't Health*, 497 U.S. 261 (1990).

114. See, e.g., LA. REV. STAT. § 40:1151(A)(1) ("[A]ll persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances where such persons are diagnosed as having a terminal and irreversible condition.").

115. See, e.g., *id.* § 40:1151.9(E) ("It is the policy of the state of Louisiana that human life is of the highest and inestimable value through natural death. When interpreting this Subpart, any ambiguity shall be interpreted to preserve human life . . ."); *id.* § 40:1151(B)(1) ("The legislature intends that the provisions of this Subpart are permissive and voluntary."); *id.* § 40:1151(B)(2) ("It is the intent of the legislature that nothing in this Subpart shall be construed to require the making of a declaration pursuant to this Subpart."); *id.* § 40:1151.9(A) ("Nothing in this Subpart shall be construed to condone, authorize, or approve assistance to suicide, mercy killing, or euthanasia; or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."); MEISEL & CERMINARA, *supra* note 3, § 7.07[D].

sustaining treatment be withheld or withdrawn.¹¹⁶ For all practical purposes, the Act strikes that balance by codifying the principles reflected in the body of jurisprudence and the pronouncements of professional medical ethics concerning these significant questions that arose out of *Quinlan* and its progeny.

Although the Act acknowledges in broad, general terms that patients possess a fundamental right to control decisions related to the provision of life-sustaining treatment, it does not attempt to define the precise boundaries of that right.¹¹⁷ Those elusive limits remain the subject of

116. See, e.g., LA. REV. STAT. § 40:1151.7(A)(1) (“Any health care facility [or] physician . . . shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the withholding or the withdrawal of life-sustaining procedures . . . in accordance with the provisions of this Subpart.”). According to Meisel and Cerninara, “[Advance directive] statutes are intended to provide assurance to individuals that their wishes will be respected and to provide assurance to health care providers that they will be immune from legal liability if they rely on these instructions.” MEISEL & CERMINARA, *supra* note 3, § 7.01[A].

117. See generally MEISEL & CERMINARA, *supra* note 3, § 2.01. These issues originated when surrogates for permanently unconscious patients began to refuse treatment that offered no hope of either restoring the patient’s capacity or reversing the dying process. The most prominent of these cases in the United States is *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 328 (1990). See also BEAUCHAMP & CHILDRESS, *supra* note 22, at 170–81. Although one’s exercise of this right is generally not controversial, it becomes problematic when the refusal relates to treatment that would either prevent death or extend the life of a patient who has been diagnosed with a terminal condition. This would occur because a patient’s refusal of treatment in either of those cases would bring his interest in self-determination into conflict with the state’s interest in preserving life. See, e.g., *In re Conroy*, 486 A.2d at 1239. Some commentators have observed, however, that the courts predominately consider the state as having no greater interest in preserving a particular life than does the individual whose life is at issue. See, e.g., MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW & ETHICS* 531 (7th ed. 2007). The U.S. Supreme Court noted in *Washington v. Glucksberg*, however, that the states “‘may properly decline to make judgments about the “quality” of life that a particular individual may enjoy,’” and that “[t]his remains true, as *Cruzan* makes clear, even for those who are near death.” 521 U.S. 702, 729–30 (1997) (quoting *Cruzan*, 497 U.S. at 282). Without regard to the perceived momentum of the states toward qualifying their interests in preserving life, that fact would not bear upon the issue when the patient has affirmatively requested treatment.

Meisel has summarized the general judicial consensus concerning this right as follows: (1) patients, whether competent or incompetent, have both a common law and a constitutional right to refuse treatment; (2) the state’s interest in

discussion among scholars and practitioners in the disciplines of law, medicine, and bioethics.¹¹⁸ Whether intentionally or not, this ambiguity reflects the inherent tension between the competing interests of the individual in the exercise of autonomy and the state in the preservation of life, leaving these issues open to the sort of reflection necessary to fully consider the broad societal implications technological developments in the field of medicine pose as they come about. At the same time, the ambiguity gives health care providers sufficient leeway to measure the bounds of their obligations carefully from an ethical perspective and exercise professional discretion in individual cases within the limits of those ethical norms.¹¹⁹

The Act establishes a baseline for defining the point at which one's right to refuse treatment is absolute. The express terms of the statute affirmatively recognize only the right of a terminally ill patient to refuse

opposing a competent patient's right to forego life-sustaining treatment is "virtually nonexistent," and the state's interest is "very weak" with respect to incompetent patients who have a dim prognosis for recovery—although the state would not likely disavow that interest if the patient has chosen not to exercise his right to refuse treatment (as Professor Meisel notes, "The right of self-determination has . . . traditionally been thought to require that treatment *not* be foregone without the informed consent of one legally authorized to provide it." MEISEL & CERMINARA, *supra* note 3, § 2.06[A]); (3) decisions about life-sustaining treatment generally should take place in the clinical setting, although courts are able to resolve disputes about those decisions; (4) surrogate decision makers for incompetent patients should express the patient's own preferences to the extent made known prior to the loss of capacity, and to the extent the patient's preference is unknown, decisions should be made on the basis of the patient's best interests; (5) physicians and surrogates may rely on an incompetent patient's advance directive in ascertaining the patient's preferences concerning life-sustaining procedures; (6) artificial nutrition and hydration is a form of medical treatment that may be withheld or withdrawn under the same conditions as other forms of medical treatment; and (7) the withholding or withdrawal of medical treatment is both morally and ethically distinct from euthanasia and assisted suicide, *id.* § 2.02; preventing suicide, *see, e.g., In re Conroy*, 486 A.2d at 1223; preserving the ethical integrity of the medical profession, *id.*; and protecting members of vulnerable groups, *see, e.g., Cruzan*, 497 U.S. at 281.

118. *See, e.g., Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 830 (N.J. Super. Ct. App. Div. 2010) ("[T]he public has at least an equal, if not greater, interest in a patient's right to live than in a patient's right to die."). The courts also have recognized countervailing state interests in preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. *See, e.g., In re Conroy*, 486 A.2d at 1223; MEISEL & CERMINARA, *supra* note 3, § 13.06.

119. *See generally* MEISEL & CERMINARA, *supra* note 3, §§ 7.01–7.15.

treatment that would merely prolong the dying process.¹²⁰ The Act is silent with respect to one's right to withhold treatment that offers a reasonable prospect of preserving life, leaving those questions to be resolved on a case-by-case basis with reference to the analyses of the courts in prior jurisprudence.¹²¹ Consistently with this silence, the statute provides that it is not to be construed in a manner that would condone euthanasia or assisted suicide.¹²² One might reasonably infer from the Act's limitations

120. The Act provides that a competent patient has the right to personally direct the withholding or withdrawal of treatment in advance, and that a surrogate has the authority to do so on behalf of a "qualified patient" who has not made a previous declaration. *See* LA. REV. STAT. § 40:1151.4. Notwithstanding the general right, the Act expressly provides that a patient who has been diagnosed as having a "terminal and irreversible condition" has the right to withhold or withdraw "life-sustaining procedures," which by definition serve only to prolong the dying process. *Id.* § 40:1151.2A(1). The statute defines a "life-sustaining procedure" as:

[A]ny medical procedure or intervention which . . . would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition, including such procedures as the invasive administration of nutrition and hydration and the administration of cardiopulmonary resuscitation. A "life-sustaining procedure" shall not include any measure deemed necessary to provide comfort care.

Id. § 40:1151.1(8). The statute goes on to define a "terminal and irreversible condition" as "a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death." *Id.* § 40:1151.1(14). The definitions of "life-sustaining procedure" and "terminal and irreversible condition" are tautological.

121. Notwithstanding the narrow scope of these definitions, the Act provides that "[t]he provisions of this Subpart are cumulative with existing law pertaining to an individual's right to consent or refuse to consent to medical or surgical treatment." *Id.* § 40:1151.9(C). According to Meisel and Cerminara, advance directive statutes "are intended to preserve and supplement existing common law and constitutional rights and not to supersede or limit them." *See* MEISEL & CERMINARA, *supra* note 3, § 7.03[B][2].

122. Louisiana Revised Statutes § 40:1151.9(A) provides: "Nothing in this Subpart shall be construed to condone, authorize, or approve assistance to suicide, mercy killing, or euthanasia; or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." Louisiana Revised Statutes § 14:32.12 defines "[c]riminal assistance to suicide" as "(1) The intentional advising or encouraging of another person to commit suicide or the providing of the physical means or the knowledge of such means to another person for the purpose of enabling the other person to commit or attempt to commit suicide[;]" or "(2) [t]he intentional advising, encouraging, or assisting of another person to commit suicide, or the participation in any physical act which causes,

a legislative intent to affirm the state's traditional interest in preserving life, both when a patient has chosen not to exercise his right to refuse treatment as the Act recognizes and when he refuses treatment under circumstances that lie beyond its scope.¹²³

To give practical effect to the individual's right of self-determination and the state's interest in preserving life, the statute incorporates a narrowly tailored immunity scheme that insulates physicians from liability when they follow their patients' instructions concerning the provision of life-sustaining treatment.¹²⁴ In this manner, the statute reflects the legislature's intent to alleviate physicians' concerns about the legal and professional consequences of failing to provide treatment that would prolong a patient's life.¹²⁵ This immunity, however, arises only when the physician's instructions fall within the express terms of the Act.

aids, abets, or assists another person in committing or attempting to commit suicide." Louisiana Revised Statutes § 40:1151.9(B) defines "suicide" as "the intentional and deliberate act of taking one's own life through the performance of an act intended to result in death." Louisiana Revised Statutes § 40:1151.9(C) exempts from the prohibition against assisted suicide:

any licensed physician or other authorized licensed health care professional who either: (1) [w]ithholds or withdraws medical treatment in accordance with the provisions of LA. REV. STAT. § 40:1151.7[; or] (2) prescribes, dispenses, or administers any medication, treatment, or procedure if the intent is to relieve the patient's pain or suffering and not to cause death.

See also MEISEL & CERMINARA, *supra* note 3, § 7.07[D].

123. The Act expressly states that one's right to refuse treatment is a voluntary matter that rests solely within the patient's discretion. LA. REV. STAT. § 40:1151(B)(1)–(2).

124. Louisiana Revised Statutes § 40:1151.7(A)(1) provides:

Any health care facility, physician, or other person acting under the direction of a physician shall not be subject to criminal prosecution or civil liability or be deemed to have engaged in unprofessional conduct as a result of the withholding or the withdrawal of life-sustaining procedures from a qualified patient.

This immunity applies without regard to whether the patient expressed his decision directly or indirectly through a surrogate. See also MEISEL & CERMINARA, *supra* note 3, § 7.01[C].

125. According to Professor Meisel, "statutes do not confer wholesale immunity; rather, most confer qualified immunity conditioned on the physician's acting in good faith and pursuant to reasonable medical standards." MEISEL & CERMINARA, *supra* note 3, § 7.10[E]; see also *id.* § 7.01[A] ("[Advance directive] statutes are intended to provide assurance to individuals that their wishes will be respected and to provide assurance to health care providers that they will be immune from legal liability if they rely on these instructions.").

B. Application of the Natural Death Act to Palliative Sedation

Although aggressive palliative regimens are often necessary to alleviate the pain and suffering patients experience during the latter stages of a terminal illness, the Natural Death Act does not directly address the provision of palliative care. The Act's silence, however, neither negates the Act's relevance to this intervention nor renders it legally problematic. Rather, the literal terms of the statute suggest that one's right to receive palliative care in Louisiana is incidental to and co-extensive with the statutory scope of the right to refuse treatment.

This conclusion is grounded in two fundamental associations. First, because pain management protocols are a fundamental part of the professional standard of care, the physician's obligation to mediate pain associated with a patient's underlying medical condition will continue so long as the physician-patient relationship exists, and without regard to whether the patient exercises his right to withhold or withdraw life-sustaining treatment. Moreover, because the mere withholding of food and fluids is accompanied by its own physical discomfort, a patient who refuses treatment would be accorded the right to receive such palliative measures as may be necessary to relieve any consequential physical distress. To construe the Act otherwise would so militate against the exercise of one's right to refuse treatment as to practically deny its very existence.

In addition to this logical inference derived from the professional standard of care, a careful construction of the statute itself implies the legislature's intent that the Act embrace palliative interventions such as sedation to unconsciousness so long as the physician employs it in a manner distinguished from assisted suicide and euthanasia. This conclusion rests upon the manner in which the statute expresses the scope of one's right to refuse treatment, and which the Supreme Court's opinions in the assisted suicide cases of *Washington v. Glucksberg*¹²⁶ and *Vacco v. Quill* inform.¹²⁷

The Act provides that a patient who has been diagnosed as having a "terminal and irreversible condition" possesses the right to direct the withholding or withdrawal of "life-sustaining procedures."¹²⁸ The statute

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

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

128. LA. REV. STAT. § 40:1151(A)(1) (entitled "purpose and findings"); *id.* § 1151.2(A)(1) (entitled "patient for himself"); *id.* § 40:1151.4(A) (entitled "declaration for qualified patient"). Beyond this express recognition, the Act states that "[t]he provisions of this Subpart are cumulative with existing law pertaining to an individual's right to consent or refuse to consent to medical or surgical treatment." *Id.* § 40:1151.9(C).

defines a “terminal and irreversible condition” as: “[A] continual [and] profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness which, within reasonable medical judgment, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death.”¹²⁹ It defines the related term, “life-sustaining procedure,” as:

[A]ny medical procedure or intervention which . . . would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition, including such procedures as the invasive administration of nutrition and hydration and the administration of cardiopulmonary resuscitation. A “*life-sustaining procedure*” shall not include any measure deemed necessary to provide comfort care.¹³⁰

The fact that the statute excludes comfort care from the treatment to be withheld when a terminally ill patient refuses artificial nutrition and hydration suggests that one’s right to receive palliative care for the discomfort associated with the absence of food and fluids is ancillary to his refusal of treatment. To construe the text in this manner would give practical effect to the Act’s underlying purpose of ensuring one’s right to a natural death in an age of technology that enables biological life to be extended almost indefinitely.¹³¹ On the other hand, to deny the right to palliative care when a patient refuses treatment would effectively negate the Natural Death Act itself.

At the same time, the Act’s general focus on a “natural” death would preclude a patient from coupling a refusal of treatment with a contrived

129. *Id.* § 40:1151.1(14).

130. *Id.* § 40:1151.1(8) (emphasis added).

131. This general intent is most apparently reflected in the common name by which the statute has come to be known: the Louisiana Natural Death Act. This focus on natural death is also reflected in specific provisions of the statute. For example, the Act provides that “[i]t is the policy of the state of Louisiana that human life is of the highest and inestimable value through natural death.” *Id.* § 40:1151.9(E). This essence also is reflected in provisions of the Act that identify the cause of one’s death as natural when it follows a refusal of life-sustaining treatment. For example, the statute provides that “[t]he removal of life-support systems or the failure to administer cardio-pulmonary resuscitation under this Subpart shall not be deemed to be the cause of death for purposes of insurance coverage.” *Id.* § 40:1151.9(B)(5). The Act also states that “[t]he withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this Subpart shall not, for any purpose, constitute a suicide.” *Id.* § 40:1151.9(B)(1).

claim for comfort care to disguise an act of euthanasia. Although the statute acknowledges reasonable and practical distinctions between decisions to withhold or withdraw treatment and acts that intentionally cause death, it also anticipates the possibility that physicians might engage in euthanasia or assisted suicide under the guise of mere palliation by expressly rejecting such measures. For example, the Act expressly provides that “[n]othing in this Subpart shall be construed to condone, authorize or approve assistance to suicide, mercy killing, or euthanasia; or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.”¹³² Taken together, these express provisions of the statute suggest the legislature’s intention to recognize a patient’s right to comfort care in the form of sedation to unconsciousness, but only when the physician administers the sedative in accordance with the Act’s primary focus on a natural death.

Consider, for example, the case of the esophageal cancer patient previously mentioned who declines medical intervention in the form of artificial nutrition and hydration when the disease progresses to the point that he can no longer receive sufficient nutrition and hydration by mouth.¹³³ In addition to refusing treatment, he asks to be immediately sedated to unconsciousness to relieve the suffering expected to accompany the absence of food and fluids, with death by dehydration to be expected within a few days.

The Act would accommodate the patient’s refusal of nutrition and hydration under these circumstances. A careful parsing of the text would reveal his inability to swallow as the requisite “terminal and irreversible

132. *Id.* § 40:1151.9(A)(1).

133. *See supra* Part I.B.

condition,”¹³⁴ and it would identify the artificial provision of nutrition and hydration as the correlated “life-sustaining procedure” to be withheld.¹³⁵

Just as the Act would accommodate this patient’s refusal of food and fluids, it would likely embrace his request for sedation. This conclusion is grounded in logic, and the statute implies it. Given the law’s express recognition of the patient’s right to refuse artificial nutrition and hydration under these facts, as the requisite “life-sustaining procedure,” denying his right to relieve the distress accompanying the exercise of that right would be incongruous. Logic would compel the conclusion, not that the physician sedated the patient and withheld treatment so he would die, but that the physician sedated him to mitigate the suffering that otherwise would attend his exercise of a right the Act expressly recognizes. Under the facts of this example, the act of sedation is a form of comfort care that merely facilitates one’s exercise of the right to refuse treatment. As previously noted, the statute accommodates this view implicitly by excluding from the definition of a “life-sustaining procedure” “any measure deemed necessary to provide comfort care.”¹³⁶

134. The Act defines a “[t]erminal and irreversible condition” as “a condition *caused by* . . . disease . . . which . . . would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death.” LA. REV. STAT. § 40:1151.1(14) (emphasis added). It is significant to note that the literal terms of the statute do not identify the underlying disease of esophageal cancer as the qualifying “terminal and irreversible condition,” even though it is the disease that will eventually give rise to the conditions that precipitate death. Rather, the statute defines a “terminal and irreversible condition” as a “*condition caused by*” a disease; i.e., the statute arguably applies only to a “condition” that is a *consequence* of the disease rather than to the disease itself. *Id.* (emphasis added). Although this definition is complex, it reflects the state’s continuing interest in the preservation of life. The literal terms of the statute would not recognize the right of a patient diagnosed with esophageal cancer to refuse nutrition and hydration merely because she had been diagnosed with an illness that her physician has determined to be terminal. The statute comes into play only when the disease manifests itself in the form of a condition that requires the artificial provision of food and fluids.

135. Just as the Act defines a “terminal and irreversible condition” only with reference to a “life-sustaining procedure,” it defines a “life-sustaining procedure” only with reference to a “terminal and irreversible condition.” *Id.* § 40:1151.1(8), (14). According to Louisiana Revised Statutes § 40:1151.1(8), a “terminal and irreversible condition” includes “any medical procedure or intervention which . . . would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition, including such procedures as the invasive administration of nutrition and hydration” These tautological and narrow definitions suggest the caution with which the legislature approached the Act.

136. *Id.* § 40:1151.1(8).

This analysis is consistent with the Supreme Court's opinion in *Vacco v. Quill*,¹³⁷ which recognized a distinction between assisted suicide and the refusal of life-sustaining treatment on the basis of causation. Noting that a patient who refuses treatment will die from the natural progression of the underlying disease, the Court found that a physician who complies with a patient's request to withhold or withdraw life-sustaining treatment does not necessarily act with the intent to cause death. In contrast, because a patient who receives a lethal concoction will die from the body's reaction to the foreign substance, the Court found that a physician who provides assistance in committing suicide "must, necessarily and indubitably, intend that the patient be made dead."¹³⁸ In the specific context of sedation to unconsciousness, however, the *Quill* Court refused to infer a physician's intent to cause death when he employs aggressive palliative measures merely to control a patient's pain, implicitly acknowledging the doctrine of double effect.¹³⁹

Although this analysis may obviate most concerns about the sort of potentially self-serving expressions of "intent" that legitimately disturb those who reject sedation to unconsciousness on the grounds that it is analogous to euthanasia, it cannot alleviate those concerns in all cases. Consider, for example, the case of the rheumatoid arthritis patient previously discussed who seeks to be sedated immediately and perpetually to unconsciousness as the only possible means of providing relief from his intractable pain.¹⁴⁰ Recognizing that it would be futile to receive food and fluids when he is to be rendered permanently unconscious, the patient also asks that nutrition and hydration be withheld and that he be allowed to die.

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

138. *Id.* at 802 (quoting *Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary*, 104th Cong., 2d Sess., 367 (1996) (testimony of Dr. Leon R. Kass)) (internal quotation marks omitted). See *supra* note 100 and accompanying text.

139. *Quill*, 521 U.S. at 802. This reasoning found considerable support among *amici* bioethics professors who argued that the principle of double effect encompassed aggressive palliative measures. According to these professors:

Providing medication to control pain has always been a legitimate and lawful medical act, even if death . . . is risked. Most invasive medical interventions carry the risk of death or disability. But if a patient dies during surgery, the surgeon is not guilty of homicide. This is because there is a real difference between an intended result and an unintended but accepted consequence of medical care where the goal is to benefit the patient.

Brief for Bioethics Professors Amicus Curiae Supporting Petitioners at 18, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858, 96-110).

140. See *supra* note 39 and accompanying text.

The facts of this case present a complexity not found in the esophageal cancer case discussed above. In that case, the progression of the disease directly caused the patient's inability to receive sufficient nutrition by mouth, thereby rendering him dependent upon artificial sustenance. It was this direct linkage between the patient's disease process and his inability to receive food and fluids on his own that satisfied the Act's requisite "terminal and irreversible condition" and justified the withholding of artificial nutrition and hydration as a "life-sustaining procedure."¹⁴¹

This necessary linkage is tenuous, if not broken, in the case of the rheumatoid arthritis patient because his dependence on artificial nutrition and hydration would result from the administration of the sedative rather than the natural progression of the disease. This focus on the cause of the patient's need for the treatment he seeks to decline is grounded in a careful reading of the statute.

As previously noted, the Act provides that a patient who has been diagnosed as having a terminal and irreversible condition may direct the withholding or withdrawal of a life-sustaining procedure.¹⁴² The statute employs the words "terminal and irreversible condition" as a specific term of art that means "a condition *caused by* . . . disease . . . which . . . would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death."¹⁴³ Although rheumatoid arthritis may be terminal and irreversible in a colloquial sense, the disease itself would not constitute a "terminal and irreversible condition" within the meaning of the Act; only a condition "caused by" the disease would fall within that definition. The patient's right under the Act to refuse nutrition and hydration therefore would turn on the cause of his inability to naturally receive sustenance.

Application of the Act would be clearest if the patient's dependence on artificial nutrition and hydration could be directly tied to the progression of the disease process rather than the sedative. If, however, the patient's inability to receive sustenance arose only when he was sedated to unconsciousness, it would be two steps removed from the underlying illness—the pain caused by the disease and the sedation administered to relieve his discomfort. Application of the Act would be questionable if this linkage were so tenuous as to define the sedative rather than the disease as the cause of his need for the artificial nutrition and hydration he seeks to refuse.¹⁴⁴

141. See *supra* notes 128–30 and accompanying text.

142. LA. REV. STAT. § 40:1151.2 (2019).

143. *Id.* § 40:1151.1(14) (emphasis added).

144. Although the issue is raised here in the context of a patient who is immediately sedated to unconsciousness, the same definitional problem would

An alternative view might avoid this uncertainty by applying a practical “but-for” causation analysis. By focusing on the fact that the act of sedation presented the only possible remedy to the intractable pain associated with the patient’s disease, this view would inextricably link the act of sedation with the patient’s pain in a way that identifies the *disease* as the ultimate cause of his need for artificial sustenance; after being sedated to unconsciousness to remedy his suffering caused by the disease, he would become dependent on artificial nutrition and hydration. By identifying the act of sedation with the patient’s pain and, in turn, identifying solely his disease as inducing his pain, this argument would suggest that the Act may accommodate both the sedation and the consequential withholding of nutrition and hydration.

Without regard to the reasonable arguments for or against application of the Act in this case, however, those very arguments reveal an ambiguity in the statute that may deny one’s right to refuse life-sustaining treatment after having intentionally created the need for it. This situation may occur because the Act itself emphasizes as a matter of public policy that “human life is of the highest and inestimable value through natural death. When interpreting this Subpart, any ambiguity shall be interpreted to preserve human life”¹⁴⁵

These uncertainties flow from the Act’s structural focus on the causal relationship between the patient’s medical condition and the need for artificial nutrition and hydration. The Act’s focus is admittedly problematic when the suffering related to the underlying disease or injury can be relieved by sedation alone—i.e., when it would be unnecessary to withhold nutrition and hydration to relieve suffering, but futile to artificially provide it when the patient is to be maintained in an unconscious state until death.

Although the Act’s structural focus on causation may be problematic when applied in such cases, it nevertheless provides an objective reference point for ensuring the state’s ability to invoke its interest in preserving life. Without the requisite causal relationship between a patient’s illness or injury and the need for artificial nutrition and hydration—and however distant the horizon of a “natural” death—virtually any terminal medical

arise under the Act in terms of causation when the sedation is administered proportionately with the patient’s level of pain. Consider, for example, the case of a patient who, in the advanced stages of lung cancer, requests morphine and other sedatives in doses that increase proportionately as the intensity of his distress deepens with the progression of the disease. Expecting to eventually receive sedatives in doses that render him permanently unconscious, the patient asks that his physician withhold nutrition and hydration when he becomes unable to ingest them on his own. *See, e.g.,* MEISEL & CERMINARA, *supra* note 3, § 7.06.

145. LA. REV. STAT. § 40:1151.9(E).

condition would suffice to recognize a patient's right to dramatically accelerate the moment of death by coupling sedation to unconsciousness and the withholding of sustenance. To so disregard causation would be effectively to endorse euthanasia and convert the Act from its intended purpose into a safe harbor for its antithesis.

At the core of this unresolved question is the fundamental difficulty of finding an appropriate way to balance the competing interests of the patient in self-determination and the state in preserving life. The fact that the legislature defined that balance in the Act with reference to causation, however, does not suggest that one's right to palliative care is necessarily limited to cases that neatly fit into the statutory text; it simply reflects the fact that the legislature chose not to address the appropriate balance between the competing interests of the individual and the state in all circumstances. Cases that fall outside the purview of the Act therefore remain subject to resolution on an individual basis with reference to the ethical norms of the medical profession and the principles reflected in the jurisprudence.¹⁴⁶

In the rheumatoid arthritis case, for example, one might deny an intent to cause death by grounding an argument in the doctrine of double effect if the physician employed the sedative at the minimum dosage necessary to relieve the patient's pain and suffering. This perspective suggests that the patient's simultaneous loss of consciousness and the natural ability to receive nutrition and hydration—the latter of which would cause his death—were merely foreseeable but unintended consequences of a sedative employed at the minimum dosage necessary to relieve the suffering caused by his disease. Under this reasoning, the act of sedating the patient to unconsciousness would be treated as if it had been proportionally employed, because even proportionate sedation would eventually render the patient unconscious and naturally unable to receive food and fluids. Viewing sedation as proportionately employed would seek to circumvent the problematic causation element in the Act's definition of a "terminal and irreversible condition" simply by looking beyond the limited scope of the Act to find an independent basis on which to justify the patient's refusal of treatment.¹⁴⁷

146. The Act expressly invokes the jurisprudence in cases that do not fall within its limited scope. According to Louisiana Revised Statutes § 40:1151.9(C): "The provisions of this Subpart are cumulative with existing law pertaining to an individual's right to consent or refuse to consent to medical or surgical treatment."

147. Commentators have expressed a wide range of views about how to resolve the tension in cases that implicate both the patient's need for pain relief and societal concerns about euthanasia and the ethical integrity of the medical profession. *See, e.g.,* Roger S. Magnusson, *The Devil's Choice: Re-Thinking Law,*

Not everyone, however, would subscribe to this application of the double effect doctrine, even if the circumstances suggest that it would be futile to provide food and fluids when the patient is to be maintained in a perpetually unconscious state to relieve his intractable suffering. A cautious observer might view this analysis as distorting the doctrine beyond its intended bounds by disguising the withholding of nutrition and hydration as a passive measure when, in fact, it constitutes an affirmative act wholly unrelated to the patient's legitimate need for pain relief. This argument is most compelling when the act of sedation would satisfy that need on its own, revealing the withholding of treatment as the proximate cause of the patient's death.

CONCLUSION

It is not uncommon for patients in the latter stages of a terminal illness to request that life-sustaining treatment be withheld or withdrawn when they believe that the burden of additional treatment will outweigh the benefit of an extended life. Patients at the end of life may also simultaneously ask to be sedated to unconsciousness as a palliative measure to relieve the suffering that is likely to attend the termination of their treatments. Although the Natural Death Act addresses the rights of patients who seek to withhold or withdraw treatment and the corresponding obligations of their physicians to comply with patients' directives, it does not directly speak to those rights and obligations with respect to active palliative interventions such as sedation to unconsciousness. Yet, the natural interrelationship that exists between the provision of palliative care and the withholding or withdrawal of life-sustaining treatment suggests that the Act offers a meaningful reference point for informing that inquiry.

The Act is relevant because sedation to unconsciousness is a logical and sometimes necessary extension of one's right to refuse the sort of life-sustaining treatment with which the statute is primarily concerned. The Act also incorporates the legal and ethical distinction between affirmative interventions intended to accelerate the moment of death—such as physician-assisted suicide and euthanasia—and merely passive decisions to withhold or withdraw methods of treatment that would only prolong the dying process.

The Act strikes a delicate but uncertain balance when seeking to define an individual's rights with respect to these passive and active interventions. The statute clearly reflects the concept that one's right to refuse life-

sustaining treatment does not rest on an abstract notion of individual autonomy that is so broad as to encompass an active intervention designed to bring about his death. By its own terms, the law expressly disavows affirmative interventions such as euthanasia and assisted suicide. At the same time, however, the Act acknowledges implicitly the practical difficulty of characterizing as a crime any circumstance in which death results from the passive refusal of treatment, simply because the facts of each case tend to be both unique and complex. Rather, these cases are marked by subtle differences and subjective questions of causation and intent that effectively preclude the law from universally condemning the practice of sedation to unconsciousness, even when the sedative is combined with a patient's decision to withhold treatment in the form of artificial nutrition and hydration.

Although the Act is sometimes ambiguous when applied in the context of these interventions, that ambiguity is not surprising, particularly in light of the challenging practical and ethical issues that accompany the provision of palliative care at the end of life. Nor is the present ambivalence necessarily troubling, because it allows the sort of reflection necessary to fully consider the implications life-terminating interventions pose before they are implemented. At the same time, it gives health care providers sufficient leeway to carefully measure the bounds of their obligations from an ethical perspective and exercise professional discretion in individual cases within those limits.