

SEMANTICS AND POLICY IN PHYSICIAN- ASSISTED DEATH: PIERCING THE VERBAL VEIL

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During the last twenty years, courts and legislatures have developed principles that allow individuals and their surrogates to refuse medical care, even when refusal will lead to death. This article traces these developments, from early cases concerning withdrawal of respirators and decisions not to treat fatal illnesses through withdrawal or refusal of artificial nutrition and hydration to the current debate over physician-assisted death. Throughout these developments, those who believed that the law should allow refusal of care have characterized the issue as a matter of personal autonomy, while their opponents have called refusal of care "suicide" and denial of care "homicide." This article traces the rhetorical battle from the early cases through the most recent Supreme Court decisions on physician-assisted death, showing that the rhetoric predicts outcomes but does not explain them. The rhetoric reveals one important set of issues that are at stake in these decisions—who should choose among the varying definitions of respect for human life and the role that law should place in this debate. However, the language obscures other important issues that should be figured heavily in deciding whether to allow refusal of treatment, as well as physician-assisted death. These issues include how power should be distributed between doctors and their patients and how much of society's resources should be allocated to health care.

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In *Vacco v. Quill*¹ and *Washington v. Glucksberg*,² the Supreme Court reversed decisions from the Second³ and Ninth⁴ Circuits which held that the Constitution requires that terminally ill people be allowed to seek the assistance of physicians in ending their lives. In *Vacco* and *Glucksberg*, the Court found that legislation in the area of physician-assisted death does not violate equal protection or due process, leaving the continuing debate over physician-assisted death to the various state legislatures.⁵ Legislation to allow physician-assisted death has been introduced in more than fifteen states,⁶ though only Oregon has enacted this type of legislation.⁷ The Oregon statute survived an effort to repeal it by popular initiative in November 1997.⁸

1. 117 S. Ct. 2293 (1997).

2. 117 S. Ct. 2258 (1997).

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

4. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

5. See *Glucksberg*, 117 S. Ct. at 2267 (Rehnquist, C.J.); *Vacco*, 117 S. Ct. at 2296 (Rehnquist, C.J.).

Litigation based on state constitutions is another potential arena for this struggle. For example, the trial court in *McIver v. Krischer*, No. CL-96-1504-AF, 1997 WL 225878 (Fla. Cir. Ct. Jan. 31, 1997), held that a terminally ill, competent, and not suicidal person has a constitutional right under the Florida Constitution to make the decision to terminate his own suffering, and to seek and obtain his physician's assistance to do so under the circumstances of this case. On July 17, 1997, the Florida Supreme Court reversed. *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997), available at <<http://www.law.stetson.edu/mciver.htm>>. The state supreme court opinion is at <<http://www.law.stetson.edu/elderlaw/krischer.htm>>.

6. For a review of this proposed legislation, see Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICHMOND L. REV. 1, 18-58 (1996). See also William J. Tarnow, *Recognizing a Fundamental Liberty Interest Protecting the Right to Die: An Analysis of Statutes Which Criminalize or Legalize Physician-Assisted Suicide*, 4 ELDER L.J. 407, 433-46 (1996).

7. See Oregon Death with Dignity Act, Oregon Ballot Measure 16, enacted by popular initiative in 1994, reprinted in Tarnow, *supra* note 6, at app.

8. The state legislature referred the Death with Dignity Act back to the voters recommending that they repeal it. H.R. 2954, 69th Leg. (Or. 1997). The electorate rejected this request and upheld the act by a margin of nearly 60%-40%. *Suicide Law Stands*, PORTLAND OREGONIAN, Nov. 4, 1997, § A, at 1.

The Oregon Death with Dignity Act was successfully challenged in the federal district court on the basis that it denied them from protection against incompetent doctors and their own mental incapacity. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995). However, the Ninth Circuit reversed because the challengers lacked standing. *Lee v. Oregon*, 107 F.3d 1382 (9th Cir.), cert. denied, 118 S. Ct. 328 (1997). Although there has been discussion about the opponents of the act refileing with the plaintiff who does have standing, this had not occurred as of early November 1997.

In *Compassion in Dying v. Washington*, the Ninth Circuit, sitting en banc, sharply criticized the district court opinion in *Lee*. 79 F.3d at 838 n.139. On appeal, the Supreme Court commented, "*Lee*, of course, is not before us, any more than it was before the Court of Appeals below, and we offer no opinion as to the validity

This article puts physician-assisted death into historical and rhetorical context as public debate enters this new phase. The first part of this article will survey major legal developments over the last twenty years regarding medical decisions that are intended or likely to shorten life, including withholding and refusing treatment as well as physician-assisted death. Within this very short time, Western societies have had to confront these issues seriously, and the law has developed with amazing speed.

The second part of this article will discuss the rhetoric of the debate. At each major decision point, up to and including the decisions in *Vacco* and *Glucksberg* and the competing legislative proposals in Oregon, essentially the same arguments have been made in favor of and in opposition to changing the law, using very similar rhetoric. Those who favor the legalization of actions that shorten life characterize the issue as one of personal autonomy and speak of individual rights to make personal decisions regarding health care. Opponents speak of social interests in protecting the value of human life and call the proposed actions euthanasia or suicide. At each stage, as the then-current issue is settled, the language changes to reflect the outcome. Legally authorized actions that effectively hasten death are not called "suicide," but rather "refusal of health care." And the pejorative terms "euthanasia" and "suicide" are invoked by opponents at the next stage of legal development.⁹

While this rhetoric emphasizes some of the important moral and ethical issues that are at stake as we decide how to manage health care at the end of life, this language also conceals some other very important issues. The last part of this article will discuss some of these issues—the extent to which disputes over the meaning of a good life

of the *Lee* courts' reasoning. In *Vacco v. Quill*, however, . . . we hold that New York's assisted-suicide ban does not violate the Equal Protection Clause." *Glucksberg*, 117 S. Ct. at 2262 n.7.

The constitutional challenge in *Lee* is quite different from those in *Glucksberg* and *Quill*. The Supreme Court's holding in those cases—that the Constitution does not require states to allow physician-assisted suicide—does not mean that legislation allowing and regulating physician-assisted suicide is unconstitutional.

9. When discussing a death caused intentionally by a doctor, either by lethal injection or by prescribing or providing lethal medication, this article uses the term "physician-assisted death," which is intended to be morally neutral. This term is broad enough to include deaths that occur when a doctor withholds treatment, but for the sake of clarity, I will call such actions withholding life support or treatment. When discussing the views of others—courts, legislatures, and commentators—I will use their own terminology where precision is important.

and a good death should be resolved by law, the status of doctors in society, and how health care resources should be allocated.

I. Historical Perspective

Although serious discussion about legalizing euthanasia occurred over sixty years ago, the major events in the development of the "right to die" have occurred in the last twenty years.¹⁰ This section traces that history and considers what social forces have shaped the "right to die" debate.

A. Early Arguments for Euthanasia

In 1938 the Euthanasia Society of America was formed with the goal of legalizing euthanasia so that dying people would have the choice of avoiding prolonged agony, but this Society made no serious legal headway.¹¹ Philosophical, religious, and medical writers discussed the topic throughout the 1930s, 1940s, and 1950s.¹² Many of these early euthanasia advocates closely linked the practice with then-current eugenic arguments that openly called for policies to eliminate "socially undesirable" people.¹³ After World War II, as word of the Nazi atrocities spread, euthanasia ceased to be widely discussed.¹⁴ In this social context, even the common-law right to refuse medical treatment required justification.¹⁵

Glanville Williams's book *The Sanctity of Life and the Criminal Law*, published in 1957, reopened serious discussion of the topic.¹⁶ The focus of his concern was the cancer victim, in pain and begging for death.¹⁷ He proposed that euthanasia be allowed at the voluntary

10. See Jim Persels, *Forcing the Issue of Physician-Assisted Suicide: Impact of the Kevorkian Case on the Euthanasia Debate*, 14 J. LEGAL MED. 93, 101-04 (1993) (discussing bills legalizing euthanasia in Ohio and Nebraska).

11. See *id.* at 101.

12. See Yale Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 MINN. L. REV. 969, 970-71 (1958).

13. See *id.* at 1017-19.

14. See Persels, *supra* note 10, at 101.

15. See Donald L. Beschle, *The Role of Courts in the Debate on Assisted Suicide: A Communitarian Approach*, 9 NOTRE DAME J.L. ETHICS & PUB. POL'Y 367, 367 (1995) (citing cases from the 1960s).

16. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 311 (Alfred A. Knopf, Inc., 2d ed. 1966) (1957).

17. See *id.*

request of a competent, terminally ill person.¹⁸ Williams argued that his proposal furthered two goals—the merciful prevention of suffering and respecting the choice of the individual about how to live life.¹⁹

However, when courts took the first steps toward recognition of a strong common-law and constitutionally protected individual interest in avoiding unwanted medical treatment, they did not address claims from competent adults. Instead, these first cases involved incompetent persons—those who were in a persistent vegetative state or severely brain injured or retarded. From the perspective of protecting individual autonomy, these cases are far more difficult than Williams's paradigm case, for they involve incompetent people who can make no request and who, in some cases, do not appear, in the usual sense, to be suffering. A significant reason for this apparent anomaly is developments in medical technology that Williams's proposal could not take into account.

As Lewis Thomas reminds us, in the 1940s, not long before Williams wrote, people routinely died of infectious diseases such as pneumonia, meningitis, septicemia, and tuberculosis, as well as cancer and heart disease.²⁰ Antibiotics to fight infection, and technology which allows people to remain alive but in a persistent vegetative state or to have a substantial chance of surviving cancer or kidney failure, developed in the next decades. As these methods for maintaining life became widely available, questions arose about whether they should always be used.

B. Recognizing Brain Death as Death

A 1967 law review article raised the issue of whether a doctor is guilty of "cold-blooded murder" if the doctor turns off the respirator of a comatose patient with no sign of brain activity.²¹ Although the author argued that this action does not amount to murder, his argument assumed that such a person was still alive.²² In 1968 a team of Harvard Medical School doctors addressed this problem by proposing

18. See *id. passim*; see also Glanville Williams, *Euthanasia and Abortion*, 38 U. COLO. L. REV. 178 (1966); Glanville Williams, "Mercy-Killing" Legislation—A Rejoinder, 43 MINN. L. REV. 1 (1958).

19. See WILLIAMS, *supra* note 16, at 1-2.

20. See Lewis Thomas, *Dying as Failure*, 447 AM. ACAD. POL. & SOC. SCI. AN. NALS 1, 2 (1980).

21. See George P. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999 (1967); see also Persels, *supra* note 10, at 111.

22. See, e.g., Fletcher, *supra* note 21, at 1001.

that "death" be redefined to include brain death as well as heart-lung death.²³ By the early 1980s, the proposed redefinition of death was widely accepted in the United States.²⁴ Although some scholars have proposed that the legal definition of "death" be further expanded to apply to anyone who has lost all conscious functions,²⁵ this proposal has not been seriously considered by most involved in this debate.²⁶ Instead, the law has developed to allow substantial diversity of practice in treating terminally ill people, as the next sections will describe.

C. Development of the Right to Refuse Lifesaving Medical Treatment

Through the 1960s and early 1970s, a number of courts required *competent* patients to accept treatment against their wishes, at least where the proffered treatment had a good chance of success.²⁷ The three most important early cases recognizing a constitutional right to refuse medical care, even if the result would be death, did not involve legally competent, terminally ill patients. Instead, each of the three dealt with a major complicating factor—the person was either legally incompetent, not terminally ill, or both legally incompetent and not terminally ill. In all three cases, the courts held that medical care

23. See Ad Hoc Comm. of the Harvard Med. Sch. to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 JAMA 337, 337 (1968). According to George Annas, the reason for the proposed change was that heart transplantation had become feasible and doctors needed to take a beating heart from one body to put it in another. See George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875, 878 (1996). Robert D. Truog offers criticism of the idea of "brain death" and calls for directly addressing the criteria for making organs available for transplantation. See Robert D. Truog, *Is It Time to Abandon Brain Death?*, 27 HASTINGS CENTER REP. 29 (1997).

24. See PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIOR RESEARCH, *DEFINING DEATH* (1981); UNIF. DETERMINATION OF DEATH ACT (1980).

25. See, e.g., Raymond J. Devettere, *Neocortical Death and Human Death*, 18 LAW, MED. & HEALTH CARE 96 (1990).

26. See *id.*

27. See, e.g., *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir. 1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *Commissioner of Correction v. Myers*, 399 N.E.2d 452 (Mass. 1979); *John F. Kennedy Mem'l Hosp. v. Heston*, 279 A.2d 670 (N.J. 1971); *Raleigh Fitkin-Paul Morgan Mem'l Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964). All of these cases except *Myers* concern Jehovah's Witnesses who rejected blood transfusions. *Myers* was a prisoner who required hemodialysis and who refused, according to the trial judge's findings, to protest his placement in a medium security rather than a minimum security prison. The court ordered his treatment, though it would require putting him in restraints, to further the state's interests in protecting life and in orderly prison administration. Compare *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993) (en banc), see *infra* note 45.

could be rejected, establishing methods of analysis and principles for decision making that most courts have followed.

The first and still most famous case, *In re Quinlan*,²⁸ decided in 1976, raised both difficulties. Karen Ann Quinlan was in a persistent vegetative state, and her breathing was supported only by a respirator.²⁹ She was, therefore, incompetent, and she was not, in the ordinary sense of the word, terminally ill, for she could live indefinitely with life support. Nevertheless, the New Jersey court held that her respirator could be terminated.³⁰ The court reasoned that in general individuals have a constitutionally protected right to refuse medical care³¹ and that people do not lose the right because they are incompetent.³² Therefore, the court concluded that means should be created to allow others to decide whether to exercise the right for incompetent people, and it upheld the appointment of Quinlan's father as her guardian, allowing him to exercise her right to terminate life support.³³

A year later in *Superintendent of Belchertown v. Saikewicz*,³⁴ the Massachusetts Supreme Judicial Court decided whether a mentally retarded sixty-seven-year-old man with the mental age of two years and eight months would receive chemotherapy for his leukemia.³⁵ Here, the court had to deal with decision making for a never-competent person. Relying on *Quinlan*, the court concluded that Saikewicz had a right to refuse treatment and that he did not lose it just because he was not and never had been competent.³⁶ This court used a best interests test to reach the conclusion against ordering treatment.³⁷ Even though competent adults would probably have accepted the chemotherapy, the court refused to order it for Saikewicz because the chemotherapy would not cure the disease and would cause significant bad side effects that he could not understand.³⁸ *Saikewicz* is famous for listing the four state interests most commonly posed as limitations on the individual's right to determine medical care: preservation of life,

28. 355 A.2d 647 (N.J. 1976).

29. *See id.* at 654.

30. *See id.* at 671.

31. *See id.* at 663.

32. *See id.* at 664.

33. *See id.*

34. 370 N.E.2d 417 (Mass. 1977).

35. *See id.*

36. *See id.*

37. *See id.* at 427.

38. *See id.* at 430.

protection of the interests of innocent third parties, prevention of suicide, and maintaining the ethical integrity of the medical profession.³⁹ The *Saikewicz* decision, like most cases that followed it, recognized the state's interest in preserving life but held that that interest was not strong enough to prevail over the individual interest at stake, and it concluded that the acts contemplated could not properly be termed "suicide."⁴⁰

In the third early case, *Satz v. Perlmutter*,⁴¹ decided in 1978, a competent man, able to communicate but paralyzed by amyotrophic lateral sclerosis (Lou Gehrig's disease) sought to have his respirator removed.⁴² The state based its objection on its interest in preserving life, for Perlmutter, like Quinlan, could have lived for an indefinite time with the respirator.⁴³ Like the *Quinlan* and *Saikewicz* courts, the Florida court held that the Constitution protects individual choice to refuse treatment and that this right to choose is stronger than the state interest in preserving life.⁴⁴

Most other courts followed these strong early precedents, consistently refusing to order lifesaving medical treatment over the objection of a competent individual or an incompetent person's surrogate decision maker.⁴⁵ However, although the New York Court of Appeals recognized the right of competent people to refuse lifesaving medical

39. See *id.* at 425.

40. See *id.*

41. 362 So. 2d 160 (Fla. Dist. Ct. App.), *aff'd*, 379 So. 2d 359 (Fla. Dist. Ct. App. 1978).

42. See *id.*

43. See *id.* at 162.

44. See *id.*

45. For an extensive listing, see *Cruzan v. Harmon*, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (en banc). Some of the most dramatic cases have arisen in California. In 1983, a California doctor treating a patient in a persistent vegetative state terminated a respirator, artificial nutrition, and hydration at the request of the family and was prosecuted for murder. In the first appellate opinion addressing the criminal liability of a doctor who withdraws life support, the court in *Barber v. Superior Court*, 195 Cal. Rptr. 434, 484 (Cal. Ct. App. 1983), rebuffed the prosecution, finding that people have the right to refuse medical treatment. In 1984, in *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984), the court applied this principle to allow a competent man with cancer to have a ventilator removed, even though he was not terminally ill. The court extended the principle even further in *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986), ruling that a woman with severe cerebral palsy, who was a quadriplegic, completely bedridden, almost entirely immobile, and in continuous pain had the right to refuse artificial nutrition and hydration, even though her life expectancy was 15 to 20 years. Most recently, in *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993) (en banc), the California Supreme Court held that a prisoner who was quadriplegic because of injuries suffered in prison had the right to refuse medication and artificial nutrition.

treatment,⁴⁶ the court did not allow withdrawal of life support for an incompetent person unless it was proven by clear and convincing evidence that the person would not have wished treatment under the circumstances.⁴⁷ Similarly, the Missouri Supreme Court in *Cruzan v. Harmon*⁴⁸ refused to allow third parties to withdraw life support from a person in a persistent vegetative state in the absence of clear and convincing evidence that the patient would have wanted life support to be withdrawn.⁴⁹ The Missouri court's opinion in *Cruzan* is the only reported appellate opinion after *Quinlan* to further imply that the state's interest in preserving life might justify requiring even a competent person to accept unwanted medical treatment.⁵⁰

At the same time that courts were developing common-law and constitutional doctrines that permit patients or their surrogates to refuse lifesaving medical care, state legislatures were enacting statutes to allow "health care advance directives"—living wills and durable powers of attorney for health care. The term "living will" was coined in 1969 to describe a document, executed in much the same form as a will, that expresses the signer's wish not to have life support if he or she is terminally ill and incompetent.⁵¹ California enacted the first statute allowing living wills in 1976, the year in which *Quinlan* was decided.⁵² A health care power of attorney is broader than a living will, designating a trusted person to make health care decisions of all kinds, not just those related to withdrawal of lifesaving care, in the event of the signer's incompetence.⁵³ The federal Patient Self-Determination Act of 1989 gave impetus to this trend by requiring health care facilities and agencies to disseminate information about the availability of advance directives.⁵⁴ Today only one state does not have a

46. See *Westchester County Med. Ctr. ex rel. O'Connor v. Hall*, 531 N.E.2d 607, 611 (N.Y. 1988); *In re Storar*, 420 N.E.2d 64, 71 (N.Y. 1981).

47. See *In re Storar*, 420 N.E.2d at 71.

48. 760 S.W.2d 408 (Mo. 1988) (en banc).

49. See *id.* at 424.

50. However, Justice Stevens, concurring in *Glucksberg* and *Vacco*, suggested that in some situations it might be constitutional to force unwanted medical care on a competent adult. See *Washington v. Glucksberg*, 117 S. Ct. 2302, 2310 (1997); *Vacco v. Quill*, 117 S. Ct. 2293, 2293 (1997).

51. See Luis Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 IND. L.J. 539 (1969). For an overview of types of living will statutes, see Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737.

52. See California Natural Death Act, 1976 Cal. Stat. c.1439, § 1 (codified as amended at CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West 1990 & Supp. 1997)).

53. See CAL. HEALTH & SAFETY CODE § 7193.

54. 42 U.S.C. §§ 1395cc(f), 1395mm(c)(8), 1396a(w) (1994).

statute or case law recognizing the legal efficacy of living wills,⁵⁵ and at least thirty-eight states have statutes that allow durable powers of attorney for health care.⁵⁶

Parallel with the development of law surrounding termination of medical care for adults, questions about the treatment of severely disabled newborn babies were also becoming highly visible.⁵⁷ A famous article published in the *New England Journal of Medicine* in 1973 openly acknowledged that doctors sometimes allowed parents to decide not to authorize treatment for such babies, with the knowledge that the child's death would be highly likely.⁵⁸ The issue was brought dramatically to public attention in the early 1980s when lawsuits were filed challenging decisions to deny critical surgery to Siamese twins born in Illinois and to a child with Down's syndrome in Bloomington, Indiana.⁵⁹ In both cases the courts ultimately ruled in favor of the doctors and parents, but the public furor continued.⁶⁰ In 1983, in what was known as the Baby Jane Doe case, an activist lawyer sued parents in New York, seeking to override the parents' refusal to consent to surgery for a child born with spina bifida.⁶¹ The trial judge appointed a guardian for the child to consent to the surgery, but on the parents' appeal, the decision was reversed because the plaintiff lacked stand-

55. See JUDITH AREEN ET AL., *LAW SCIENCE AND MEDICINE* 1181 n.1 (2d ed. 1996) (45 states and the District of Columbia have enacted statutes which allow living wills. Michigan is the only state that has not recognized living wills by statute or case law.).

56. See *id.* (33 states and the District of Columbia have durable power of attorney for health care statutes. All the states without such statutes have general durable power of attorney statutes that could be interpreted to authorize powers of attorney dealing with health care. Some of these statutes—Arizona, Colorado, Indiana, Maryland, and Virginia—have judicial decisions or attorney general opinions supporting this interpretation.).

57. See Raymond Duff & A.G.M. Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 *NEW ENG. J. MED.* 890 (1973).

58. See *id.*

59. See ANGELA R. HOLDER, *LEGAL ISSUES IN PEDIATRICS AND ADOLESCENT MEDICINE* 88-89 (1985) and sources cited within.

60. See *id.*

61. Spina bifida is the common name for a medical condition, meningocele, in which the spinal column fails to close properly during fetal development, often accompanied by hydrocephaly, the accumulation of cerebro-spinal fluid in the cranium. Mild cases of spina bifida can be surgically corrected so that the child has only relatively minor permanent disabilities. In more severe cases, even with surgery, the child may have major disabilities. If the spinal lesion is not closed soon after birth, though, the child is seriously at risk for meningitis, which can cause death. See Anthony Gallo, *Spina Bifida: The State of the Art of Medical Management*, 14 *HASTINGS CENTER REP.* 10, 10-11 (1984).

ing to bring the suit and had failed to comply with procedures for intervention in child neglect cases.⁶²

Beginning in 1982, the federal Department of Health and Human Services began to intervene and, by various routes, attempted to limit the practice of denying medical care to disabled newborns. The Department issued a notice declaring that denying medical care to severely disabled newborns constituted forbidden discrimination against the disabled under section 504 of the Rehabilitation Act.⁶³ It also promulgated a regulation requiring hospitals to display posters declaring that discriminatory failure to feed and care for handicapped infants was against the law and listing a hot line where people could anonymously report suspected cases.⁶⁴ Ultimately, the courts held that Congress did not intend section 504 to apply to decisions about medical care for disabled newborns.⁶⁵

In the interim, in 1984 Congress amended the Child Abuse Prevention and Treatment Act to require states to establish programs and procedures to prevent "medical neglect" of handicapped infants as a condition to receiving federal child welfare funds.⁶⁶ "Medical neglect" is defined so that parents could decide to withhold treatment only: (1) if the "infant is chronically and irreversibly comatose"; (2) if treating "would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant"; or (3) if the treatment would be "virtually futile in terms of the survival of the infant and the treatment itself would be inhumane."⁶⁷

62. See *Weber v. Stony Brook Hosp.*, 456 N.E.2d 1186 (N.Y.), *cert. denied*, 464 U.S. 1026 (1983).

63. See *Discriminating Against the Handicapped by Withholding Treatment or Nourishment: Notice of Health Care Providers*, 47 Fed. Reg. 26,027 (1982).

64. See *Nondiscrimination on the Basis of Handicap*, 48 Fed. Reg. 9630 (1983).

65. See *United States v. University Hosp.*, 729 F.2d 144 (2d Cir. 1984). *University Hospital* arose out of the Department of Health and Human Services' efforts to investigate the Baby Jane Doe case. The agency sought to obtain the baby's hospital records under section 504 of the Rehabilitation Act after the hospital and parents refused to release them. See also *Bowen v. American Hosp. Ass'n*, 476 U.S. 610 (1986).

66. Amendments to Child Abuse Prevention and Treatment Act, Pub. L. No. 98-457, tit. 1, § 106, 98 Stat. 1749, 1751 (1984) (codified as amended at 42 U.S.C. § 5106 (1994)).

67. 45 C.F.R. § 1340.15(b)(2) (1997). For a detailed interpretation of the terms in this section, see U.S. COMM'N ON CIVIL RIGHTS, *MEDICAL DISCRIMINATION AGAINST CHILDREN WITH DISABILITIES* 82-90 (1989). The U.S. Commission on Civil Rights reported in 1989 that these requirements are not vigorously enforced by state child welfare agencies, which are the principal agencies responsible for enforcement. These agencies, according to the Commission, largely defer to the

By the early 1980s, the law in most states allowed termination of respirators, antibiotics, dialysis, chemotherapy, and other medical care used to treat life-endangering conditions, at least under some circumstances. The next major issue was whether providing artificial nutrition and hydration was also medical treatment that could be withdrawn under similar circumstances, or whether this kind of care was qualitatively different, the equivalent of providing food, drink, and warmth, which must be given to all people as a matter of fundamental decency.

D. Withdrawal of Nutrition and Hydration

Cases involving the termination of tube-feeding were highly controversial because of the uncertainty about whether this treatment is "medical" or "comfort" care and because patients typically were not terminally ill.⁶⁸ Patients often could be expected to live, sometimes for many years, if provided with nutrition and hydration. Further, although many of the cases involved people in a persistent vegetative state who had irreversibly lost all higher brain function,⁶⁹ some involved people who were conscious and, sometimes, competent.⁷⁰ In theory, the claim of a competent patient to refuse tube-feeding is easier to handle than that of someone in a persistent vegetative state because the former makes the decision for him or herself whereas someone else must make the decision for the latter. In reality, though, the cases involving competent people were more wrenching because of social ambivalence about whether withdrawal of artificial nutrition and hydration constituted withdrawal of treatment or simply leaving someone to starve.

judgment of hospitals, rather than investigating them. See *id.* at 18-25. In the end the Commission, which took the position that denial of medical care to newborns with disabilities is unlawful discrimination, concluded "that the situation has not dramatically changed since the implementation of the Child Abuse Amendments of 1984." *Id.* at 149.

68. For an early article raising the question of whether it would be medically ethical to withhold or withdraw artificial nutrition and hydration, see Carson Strong, *Can Fluids or Electrolytes Be 'Extraordinary' Treatment?*, 7 J. MED. ETHICS 83 (1981).

69. See, e.g., *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc); *In re Jobes*, 529 A.2d 434 (N.J. 1987).

70. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (involving a competent, largely immobile woman with cerebral palsy); *In re Conroy*, 486 A.2d 1209 (N.J. 1985) (concerning a woman terminally ill and marginally cognitive).

Numerous articles debated whether artificial nutrition and hydration should be regarded as substantially different from other kinds of care. Leading ethicists such as Daniel Callahan argued passionately that it should. He wrote:

An important function of moral culture is to instill in its members deep feelings about the morality of various actions; and one of the most important in all cultures, save the most debased, is that the needy and the helpless must be fed If the practice of ceasing to feed some dying patients would remain . . . rare . . . , the matter need be of little public interest. But the enthusiasm that has greeted the opening up of the subject, the widespread frustration felt by many of those in charge of long-term or chronic care facilities in the face of the biological tenacity of their more vegetative charges, and the pressures to reduce or contain costs, are all reasons to guess that the practice may not remain rare and contained.⁷¹

For constitutional purposes, the Supreme Court's 1990 decision in *Cruzan v. Director, Missouri Department of Health*⁷² resolved the matter contrary to Callahan's view. *Cruzan* concerned whether artificial nutrition and hydration could be withdrawn from Nancy Cruzan, who, like Karen Ann Quinlan, was in a persistent vegetative state following an accident.⁷³ The Court treated nutrition and hydration as medical care, and it assumed without deciding that a competent adult has a right to refuse lifesaving treatment.⁷⁴ The specific issue before the Court was the constitutionality of a state rule allowing denial of life support to an incompetent person only upon proof by clear and convincing evidence that this would be the person's own wish.⁷⁵ The Court held that such a rule was not unconstitutional, concluding that the Constitution supported both the state's interest in preserving life and the state's interest in insuring that the choice of the patient is honored.⁷⁶

Even though the Supreme Court in *Cruzan* did not require states to develop legal mechanisms for allowing decisions to withdraw life

71. Daniel Callahan, *Public Policy and the Cessation of Nutrition*, in *BY NO EXTRAORDINARY MEANS* 61 (Joanne Lynn ed., 1986); see also Daniel Callahan, *On Feeding the Dying*, 13 *HASTINGS CENTER REP.* 22 (1983); Ronald A. Carson, *The Symbolic Significance of Giving to Eat and Drink*, in *BY NO EXTRAORDINARY MEANS*, *supra*, at 84; Alan J. Weisbard & Mark Siegler, *On Killing Patients with Kindness: An Appeal for Caution*, in *BY NO EXTRAORDINARY MEANS*, *supra*, at 108.

72. 497 U.S. 261 (1990).

73. See *id.* at 266.

74. See *id.*

75. See *id.* at 269.

76. See *id.* at 286-87.

support from incompetent people, state courts and legislatures, as well as Congress, have gone far toward developing such means. As described above, all but one of the states by statute or case law clearly allow living wills today, and most also allow durable powers of attorney for health care.⁷⁷

As this discussion shows, in most states, patients are allowed to reject life-preserving medical care whether or not they are terminally ill or suffering, and surrogates can make such a decision for incompetent patients. Within the medical profession, the mainstream view is that little difference exists between tube-feeding and other life-sustaining measures; therefore, doctors may ethically withdraw nutrition and hydration from certain dying, hopelessly ill, or permanently unconscious patients.⁷⁸ The next two important "right to die" issues that have come to the fore in the 1990s are whether doctors can withhold "futile" treatments regardless of patient wishes and whether doctors can assist patients in dying.

E. Withholding "Futile" Treatments

In 1991 doctors in Minnesota caring for Helga Wanglie, a patient in a persistent vegetative state, recommended that her life support be terminated.⁷⁹ Her husband, who had been appointed guardian, refused and insisted that everything possible be done for her.⁸⁰ The doctors went to court, seeking to terminate the husband's appointment as guardian on the grounds that he was not acting in her best interest.⁸¹ They argued that it was wrong to provide "futile" treatment to someone in a persistent vegetative state, the first time that such a legal claim had been advanced.⁸² The doctors lost.⁸³ Since then, several other conflicts between doctors and families have been

77. An issue, not developed in this article, is how important *constitutional* developments, as compared to common law and statutory, have been in the law regarding care at the end of life. Yet the first decisions recognizing an individual's right to refuse treatment, such as *Quinlan*, were, as noted above, constitutionally founded. We cannot know whether legislatures and courts would have moved as rapidly as they did without this constitutional foundation.

78. See Sidney H. Wanzel et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844 (1989).

79. See *Helga Wanglie, Woman in Right-to-Life Battle*, CHI. TRIB., July 6, 1991, at 13.

80. See *id.*

81. See *id.*

82. See *Helga Wanglie's Life*, STAR-TRIB., May 26, 1991, at 18A.

83. See *In re Wanglie*, No. PX91-288 (Prob. Ct., Hennepin County, Minn., June 28, 1991); *Judge Denies Request to Cut Life Support*, CHI. TRIB., July 2, 1991, at 3. Some people have even proposed that "death" be legally defined as termination of

reported in the newspapers, and one, involving the treatment of an anencephalic baby, went to the U.S. Court of Appeals for the Fourth Circuit.⁸⁴ Courts have consistently upheld families' decisions to continue treatment despite doctors' claims that the treatments are futile.

Medical futility clearly raises the conflict between the autonomy of the physician and of the patient. From a medical perspective, the positions of families and doctors in the medical futility cases are completely reversed from *Quinlan*, but from a legal perspective, the doctors' position in the medical futility cases is consistent with their position in *Quinlan*. The essential point established in *Quinlan* was patient control over treatment, even in the face of medical resistance. Proponents of the futility doctrine assert that in some cases doctors should be able to determine treatment without consulting with the patient or patient's surrogate at all.⁸⁵ This posture alone explains why the doctors have not yet prevailed in litigation.⁸⁶

F. Physician-Assisted Dying

Physician-assisted death is, of course, nothing new. For years some doctors have given patients doses of painkillers that they know will shorten the patient's life.⁸⁷ The express motive in such cases, though, is to alleviate suffering, not to help a patient die.⁸⁸ In contrast,

[s]ome physicians, believing it to be the last act in a continuum of care provided for the hopelessly ill patient, do assist patients who request it, either by prescribing sleeping pills with knowledge of their intended use or by discussing the required doses and methods of administration with the patient. The frequency with which

conscious functions. See, e.g., Devettere, *supra* note 25. This radical proposal eliminates the option of providing treatment to anyone without conscious functions.

84. See *In re Baby K*, 832 F. Supp. 1022, 1025 (E.D. Va.), *aff'd*, 16 F.3d 590 (4th Cir. 1994). Some of the cases are discussed in Bethany Spielman, *Collective Decisions About Medical Futility*, 22 J.L., MED. & ETHICS 152 (1994).

85. See, e.g., J. Randall Curtis et al., *Use of the Medical Futility Rationale in Do-Not-Attempt-Resuscitation Orders*, 273 JAMA 124 (1995).

86. The term "medical futility" is controversial for other reasons as well. Several authors have noted a lack of consensus on the definition of medical futility and on its use in clinical practice. See *id.*; see also Jeffrey W. Swanson & S. Van McCrary, *Doing All They Can: Physicians Who Deny Medical Futility*, 22 J.L. MED. & ETHICS 318 (1994). Also, some suspect that changes in how insurers reimburse doctors and hospitals may motivate doctors to restrict access to expensive life-support systems, especially when its utility is dubious. When insurers pay doctors for their actual costs, doctors are motivated to provide more care. Current prospective-payment and managed-care systems give doctors an incentive to limit care costs. Robert M. Taylor & John D. Lantos, *The Politics of Medical Futility*, 11 ISSUES L. & MED. 3 (1995).

87. See Wanzer et al., *supra* note 78, at 847.

88. See *id.*

such actions are undertaken is unknown, but they are certainly not rare.⁸⁹

In 1991 Dr. Timothy Quill wrote about knowingly providing such help to his long-term patient Diane, who had leukemia. His article in the *New England Journal of Medicine* described Diane's request and his decision to prescribe barbiturates for her and to make sure that she knew how to use them.⁹⁰

The conduct of Dr. Jack Kevorkian, the most notorious example of a doctor-assisted death, contrasts dramatically with that of Quill.⁹¹ Indeed, legal commentators have debated whether Kevorkian is acting as a physician and whether the people he has helped are his patients.⁹² Yet, despite the differences between Kevorkian and Quill, neither doctor has been criminally convicted for his actions, though prosecutors have brought charges against each of them.⁹³

Both Kevorkian and Quill challenged the constitutionality of statutes that, as applied, made it a crime for doctors to comply with the request of a competent, terminally ill patient for help in dying.⁹⁴ While the Michigan Supreme Court rejected Kevorkian's due process challenge,⁹⁵ Quill's equal protection attack on the New York statute was successful in *Quill v. Vacco*⁹⁶ in the Second Circuit, although the Supreme Court reversed that holding.⁹⁷

Proponents of a constitutional right to physician assistance in dying rely heavily on the refusal of treatment cases, arguing that this kind of assistance should be legally considered a form of health care and that individuals should be able to request this assistance just as they request or reject other kinds of treatments. For example, in *Quill v. Vacco*, the Second Circuit accepted the following argument:

New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support

89. *Id.* at 878.

90. See Timothy E. Quill, *A Case of Individualized Decision Making*, 324 *NEW ENG. J. MED.* 691, 693 (1991).

91. For a detailed description of Kevorkian's career through 1993, see Persels, *supra* note 10, at 95-100.

92. See Annas, *supra* note 23, at 891-92.

93. The grand jury in Rochester refused to indict Quill. See B.D. Cohen, *On Death and Dying—MD Who Aided in Suicide Aims to Humanize Debate*, *NEWSDAY*, Aug. 11, 1991, at 3. Michigan courts dismissed indictments against Kevorkian, and juries refused to convict Kevorkian. See *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994).

94. See *Kevorkian*, 527 N.W.2d at 714; Cohen, *supra* note 93.

95. See *Kevorkian*, 527 N.W.2d at 714.

96. 80 F.3d 716 (2d Cir. 1996).

97. *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

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.⁹⁸

Similarly, the statutes permitting and regulating physician-assisted suicide that were enacted in Oregon are structurally similar to statutes dealing with the withdrawal of medical treatment that authorize living wills and durable powers of attorney for health care.⁹⁹

In contrast, those judges who find criminalization of physician-assisted dying constitutionally permissible sharply differentiate the practice from refusal of medical care.¹⁰⁰ The central point of the Supreme Court's majority opinions in *Washington v. Glucksberg*¹⁰¹ and *Vacco v. Quill*¹⁰² is acceptance of this distinction.¹⁰³

As the next section will discuss, a central part of the development of the law concerning the "right to die" over the last twenty years has been this value-laden battle over analogy and naming.

II. Language and the Law and Ethics of Dying

Common language, as well as the language of ethics and the law, uses terms that express moral and political judgments about the acceptability of refusing lifesaving medical care. The most fundamental distinction is expressed by use of the term "suicide," which connotes the needless, irrational, perhaps insane, taking of one's life, outside the bounds of accepted, much less protected, behavior.¹⁰⁴ Those who

98. 80 F.3d at 729; see also *Compassion in Dying v. Washington*, 79 F.3d 790, 815 (9th Cir. 1996) (en banc) (recognizing that a liberty in the refusal of life-sustaining food and water necessarily implicates a liberty interest in hastening one's own death).

99. Compare the Oregon statutes on advance directives, OR. REV. STAT. §§ 127.505-.658, to the Oregon Death with Dignity Act, Oregon Ballot Measure 16, enacted by popular initiative in 1994, reprinted in Tarnow, *supra* note 6, at app.

100. See *Compassion in Dying*, 79 F.3d at 839 (Beezer, J., dissenting); *id.* at 857 (Kleinfeld, J., dissenting); *Kevorkian*, 527 N.W.2d at 727-33.

101. 117 S. Ct. 2258 (1997). Not all of the Justices hold this view absolutely, though. See *infra* notes 139-60 and accompanying text.

102. 117 S. Ct. 2293 (1997).

103. See *Vacco*, 117 S. Ct. at 2296; *Glucksberg*, 117 S. Ct. at 2267.

104. If a person is called suicidal, the ordinary response is taking him or her into protective custody, to be observed and perhaps medicated. Although we believe in principle that a competent person can commit suicide, people who want to commit suicide are, for practical purposes, often presumed incompetent, which means that we are under no obligation to respect their wishes to die. In litigation over Oregon legislation allowing physician-assisted suicide, the challengers successfully argued at the trial level that the statute's provisions were inadequate to

believe that taking one's life in certain circumstances can be morally valid and should be legally protected reject the "suicide" label, giving the act some other name that evokes notions of personal autonomy.

For example, in *Cruzan*, Justice Scalia, who sided with the majority which held that the Constitution permits states to allow termination of life support only upon clear and convincing evidence of the person's wishes, said that there is no historically recognized right to "suicide."¹⁰⁵ Justice Brennan, who dissented, spoke of the long-recognized right to "avoid unwanted medical treatment."¹⁰⁶

Similarly, those who oppose physician-assisted dying call taking medication to end one's life or submitting to a lethal injection "suicide" and call writing the prescription or giving the injection "criminal homicide." On the other hand, proponents of legalization have coined new terms that connote individual choice, such as "right to die with assistance"¹⁰⁷ and "death with dignity."¹⁰⁸

This section describes the rhetoric used in the bioethical and legal debates surrounding "right to die" issues throughout the second half of this century, showing that at each stage advocates on each side used the same language.¹⁰⁹ The shifts in the meaning of terms, as law and social practice changed, indicate that the terms themselves are conclusory and not analytical.¹¹⁰ Nevertheless, the rhetoric is very influential, for it suggests what some of the issues are and evokes highly

ensure that those who sought such assistance were competent. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *rev'd*, 107 F.3d 1382 (9th Cir.), *cert. denied*, 118 S. Ct. 328 (1997).

105. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

106. *Id.* at 301 (Brennan, J., dissenting).

107. Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2023 (1992).

108. This is the term used in the Oregon measure legalizing physician-assisted dying, Oregon Death with Dignity Act, Oregon Ballot Measure 16, enacted by popular initiative in 1994, reprinted in Tarnow, *supra* note 6, at app.; see also Eugenie A. Gifford, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 U.C.L.A. L. REV. 1545, 1546 (1993).

109. The distinction is not at stake in the debate around the futility of medical treatment. For further discussion of this issue, see *supra* text accompanying notes 79-86.

110. This discussion gives examples of language used in the debates over the last 20 years, but does not exhaustively survey case law and commentary. For other discussions of how terminology shapes ethical and legal concepts, see Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 TENN. L. REV. 519, 527-34 (1992) (naming alternatives and their implications), and Callahan & White, *supra* note 6, at 20 (criticizing the variety of language used and calling language used by proponents of physician-assisted suicide "Orwellian doublespeak").

emotional responses to those issues, while obscuring other important issues. This section discusses three sets of distinguishing terms: (1) "ordinary" and "extraordinary" care; (2) various words that connote the distinction between "killing" and "letting die"; and (3) terms that focus on the intended outcome of the actions. Following this discussion, the last section examines the Supreme Court's opinions in *Vacco v. Quill*¹¹¹ and *Washington v. Glucksberg*¹¹² through the lens of this rhetoric.

A. Ordinary Versus Extraordinary Care

For a time, particularly in the late seventies and early eighties, some medical and ethical discussions attempted to distinguish medical care which could properly be withheld or rejected from that which should be offered and accepted. For purposes of medical practice, "extraordinary" care could permissibly be withheld, whereas refusal of "ordinary" care was considered suicide.¹¹³ The distinction originated in the Catholic tradition.¹¹⁴ However, legal and ethical discussions have largely abandoned this terminology.

B. "Killing" Versus "Letting Die"—Passive and Active Euthanasia, Acts, Omissions, and Causation

A variety of terms in ethical and legal discussions have been used to draw a line between "killing" and "letting die" and between "committing suicide" and "escaping from suffering."

1. ACTIVE VERSUS PASSIVE EUTHANASIA

The ethical terms with the oldest and most elaborate lineage are "passive" and "active" euthanasia. The distinction is typically made in this way: "[P]assive euthanasia involves allowing a patient to die by removing her from artificial life support systems such as respirators and feeding tubes or simply discontinuing medical treatments neces-

111. 117 S. Ct. 2293 (1997).

112. 117 S. Ct. 2258 (1997).

113. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 126-27 (2d ed. 1983). For another statement of the difference, distinguishing the medical definition and the Catholic ethical definition, see Rev. Edward J. Bayer, *Perspectives from Catholic Theology*, in *BY NO EXTRAORDINARY MEANS*, *supra* note 71, at 89, 90-91.

114. See Joanne Lynn & James F. Childress, *Must Patients Always Be Given Food and Water?*, in *BY NO EXTRAORDINARY MEANS*, *supra* note 71, at 47, 53-54.

sary to sustain life. Active euthanasia, by contrast, involves positive steps to end the life of a patient, typically by lethal injection."¹¹⁵

When Glanville Williams proposed in the late 1950s to allow doctors to end the lives of terminally ill, competent, suffering patients at their request, he used these terms.¹¹⁶ In 1975, near the time of the *Quinlan* decision, when the moral and legal acceptability of withdrawing respirators and other sorts of life support was still disputed, a famous ethical debate over the topic was carried out in terms of "active" versus "passive" euthanasia. James Rachels argued that the distinction is not morally sustainable, asking "what is the point of drawing out the suffering" of a person who will die anyway?¹¹⁷ In reply, Tom Beauchamp argued that the distinction is morally significant and should be maintained because of the slippery slope problem, that "active" killing may lead to programs to exterminate people regarded as socially undesirable.¹¹⁸ Because the term "euthanasia" has become associated with this slippery slope,¹¹⁹ those who support actions that allow patients to die have largely quit using the term, while opponents continue to use the term for exactly the same reason.¹²⁰

2. ACTS VERSUS OMISSIONS AND LEGAL CAUSATION

On the legal side, early proponents of allowing withdrawal of life support confronted the legal distinction between acts and omissions. In most American jurisdictions, criminal liability for "omissions" is more limited than for acts, because a person is not legally liable for failure to act unless that person has a legal duty to act, and the sources of legal duty are limited.¹²¹ Writing in 1967, George Fletcher argued that a doctor who turned off the ventilator of a person

115. Gifford, *supra* note 108, at 1546 n.3, 1550-51; see also, e.g., Tom L. Beauchamp, *The Justification of Physician-Assisted Deaths*, 29 IND. L. REV. 1173 (1996) (discussing the differences between suicide and intention to relieve suffering, between various types of euthanasia, between euthanasia and physician-assisted suicide, and between killing and letting die).

116. See *supra* notes 16-19 and accompanying text.

117. James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78, 78-79 (1975).

118. See Tom L. Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia*, in ETHICAL ISSUES IN DEATH AND DYING 246, 249-53 (Tom L. Beauchamp & Seymour Perlin eds., 1978).

119. See *infra* text accompanying notes 157-60 for a discussion of the slippery slope argument.

120. See, e.g., Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?*, 25 GEO. L. REV. 1203 (1991).

121. See WAYNE R. LAFAYE & AUSTIN W. SCOTT, JR., CRIMINAL LAW § 3.3 (2d ed. 1986).

with no brain activity¹²² should be treated as having "omitted" to care for the patient rather than having affirmatively "acted" to kill the patient and that the doctor "permitted death to occur" rather than "caused death."¹²³ In *Barber v. Superior Court*, a 1983 criminal prosecution of a doctor for turning off the respirator of a patient in a persistent vegetative state, the court reversed the conviction, accepting the argument that the doctor had omitted to act when he had no duty to do so.¹²⁴

In other cases courts relied on principles of legal causation to preclude criminal liability for withdrawing life support. For example, in 1985, in *In re Conroy*,¹²⁵ one of the most important and famous cases concerning withdrawal of feeding tubes, the New Jersey court relied in part on a causation argument, saying that refusal of treatment is not suicide because the person's underlying medical condition was not self-inflicted and the person dies from nature "taking its course."¹²⁶

3. CRITICISMS OF THE DISTINCTIONS AS ARTIFICIAL

Although the distinction between "killing" and "letting die" seems clear with regard to the newest issue, physician-aided death, both supporters and opponents of the practice have denied that the distinction is morally significant. For example, Yale Kamisar, who opposed withdrawal of treatment as well as physician-assisted death,¹²⁷ wrote:

[M]any who support the "right to die" say they are strongly opposed to active euthanasia. I must say I do not find the arguments made by proponents of this distinction convincing. Least persuasive of all, I think, are the arguments that lifting the ban against active euthanasia would be "to embrace the assumption

122. At this time, "brain death" was not well established legally. See *supra* text accompanying notes 21-23.

123. See Fletcher, *supra* note 21, at 1007.

124. 195 Cal. Rptr. 484 (1983). *Barber* is discussed in *supra* note 45. See also Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App.), *aff'd*, 379 So. 2d 359 (Fla. Dist. Ct. App. 1978) (finding competent man wanting to withdraw respirator is not committing suicide, for he wants to live, but not with assistance, and if he dies, it will be from natural causes and not from his act).

125. 486 A.2d 1209 (1985).

126. *Id.*

127. When Kamisar was a young associate professor, he wrote a response to Glanville Williams's proposal to allow active euthanasia at the request of competent, terminally ill, patients, laying out arguments that he and others have continued to make for the last 40 years. Kamisar, *supra* note 12, at 969. He denied that the distinction between active and passive euthanasia was morally significant and argued that neither practice was ethically acceptable, a position he has maintained to this day.

that one human being has the power of life over another" (the withholding or withdrawal of life-sustaining treatment embraces the same assumption) and that maintaining the prohibition against active euthanasia "prevents the grave potential for abuse inherent in any law that sanctions the taking of human life" (passive euthanasia, at the very least, presents the same potential for abuse).

Indeed I venture to say that a law that sanctions the "taking of human life" indirectly or negatively rather than directly or positively contains much more potential for abuse. Because of the repugnance surrounding active euthanasia—because it is what might be called "straightforward" or "out in the open" euthanasia—I think it may be forcefully argued that it is *less likely* to be abused than other less readily identifiable forms of euthanasia.¹²⁸

Similarly, Tom Beauchamp, who originally championed the distinction between "killing" and "letting die," has more recently argued that the distinction is difficult to make and creates moral and conceptual confusion.¹²⁹ He argues that the right to autonomy which justifies allowing patients to refuse treatment seems in principle to extend to a patient's request for physician-assisted death.¹³⁰

C. Intent to Die Versus Intent to Relieve or Escape Suffering

Although some definitions of "suicide" include all voluntary acts that result in the ending of one's life,¹³¹ the actor's intent has commonly been used to limit the scope of the term. In *Satz v. Perlmutter*,¹³² a 1978 Florida case involving the request of a competent man with amyotrophic lateral sclerosis (Lou Gehrig's disease) to turn off his respirator, the court denied that Abe Perlmutter wanted to commit suicide.¹³³ The court said that Perlmutter wanted to live, but not with

128. Kamisar, *supra* note 120, at 1216-17.

129. See Beauchamp, *supra* note 115, at 1178.

130. Beauchamp now concludes that nothing about "killing" or "letting die" entails judgment about the wrongness or rightness of either type of action or about the acceptability of the intentions of an actor who performs the actions. Instead, rightness and wrongness depend on the justification of the action. See *id.* at 1181-92; see also Gifford, *supra* note 108, at 1555-58.

131. See, e.g., George P. Smith, *All's Well that Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. DAVIS L. REV. 275, 279 (1989) (quoting Richard B. Brandt, *The Rationality of Suicide*, in *SUICIDE: THE PHILOSOPHICAL ISSUES* 117, 118 (M. Battin & D. Mayo eds., 1980) ("Suicide may be defined 'as doing something which results in one's death, either from the intention of ending one's life or the intention to bring about some other state of affairs (such as relief from pain) which one thinks it certain or highly probable can be achieved only by means of death or will produce death.'").

132. 362 So. 2d 160 (Fla. Dist. Ct. App.), *aff'd*, 379 So. 2d 359 (Fla. Dist. Ct. App. 1978).

133. *Id.* at 163.

assistance.¹³⁴ A Florida trial court recently made a similar distinction in *McIver v. Krischer*,¹³⁵ stating that a man who made a request for physician-assisted death "is not suicidal, but merely wishes to end what is to be a painful and protracted dying period."¹³⁶

The cases involving withdrawal of tube-feeding evoked some of the most spirited discussion about what kind of intention counted as "suicidal" and, by implication, homicidal, because the patients involved were not at immediate risk of dying from their underlying disease or condition, but rather perished most directly from lack of nutrition and hydration.¹³⁷ Yet most courts, like the court in *In re Conroy*, which involved termination of tube-feeding, said that patients who decline treatment are not suicidal, in part because they do not have the specific intent to die.¹³⁸

As this discussion shows, at each of the major steps in the development of the legal "right to die"—withdrawing or withholding life-saving treatments such as respirators, and withdrawing artificial nutrition and hydration—the ethical and legal debate has used remarkably similar terminology. Opponents of legalization call actions "euthanasia," "killing," and "suicide." Proponents accept that such categories exist but deny that the action currently under scrutiny fits

134. *Id.* at 162-63.

135. No. CL-96-1504-AF, 1997 WL 225878 (Fla. Cir. Ct. Jan. 31, 1997).

136. *Id.* at *9. The court said:

Mr. Hall testified that he wishes to live, but has decided to end his suffering at the point where he will no longer feel the comfort and assurance of knowing that his agony will be followed by a period of acceptably renewed health. Contemplating his future suffering, he wants to die at the time and place of his choosing by administering a substance which will induce immediate loss of consciousness and certain death shortly thereafter. Yet, he is afraid that any attempt to take his own life at that time will be unsuccessful, and will worsen his condition. Therefore, Mr. Hall has sought consultation and assistance of a physician to provide him with a prescription for a drug that Mr. Hall would self-administer to precipitate his instant death when he reaches the point where he is convinced that his only alternative is to experience a prolonged period of useless suffering.

Id. at *2. This decision was reversed by the Florida Supreme Court on July 17, 1997. *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997).

137. For a detailed and complex survey of the arguments, see Philip G. Peters, *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 892 (1989).

138. See *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985); see also *Vacco v. Quill*, 117 S. Ct. 2293 (1997) ("[A] patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses to discontinue treatment might not.").

into the category, relying on the distinction between acts and omission and the principles of causation and intention.

Those who seek to extend the legal right to die avoid these terms because they connote illicit choices. This pattern of debate continues, as illustrated in the Supreme Court's recent decisions about physician-assisted death.

D. The Rhetorical Battle in *Vacco* and *Glucksberg*

All nine Justices in *Vacco* and *Glucksberg* agreed that the New York and Washington statutes criminalizing assisted suicide did not violate the Fourteenth Amendment, at least as challenged in the two cases.¹³⁹ However, these decisions produced six opinions, in which the Justices expressed differing views about the proper method for analyzing the due process challenge to the statutes, an issue not at stake in this article.¹⁴⁰ The Justices also examined whether the statutes might be unconstitutional in other circumstances not before the Court. The Justices expressed their differences over the latter issue in the rhetoric described above.

Justice Rehnquist's lead opinions, in which Justices Scalia, Thomas, and Kennedy joined, signaled strong rejection of the challenges to the statutes by the immediate and consistent characterization of physician-assisted death as "suicide."¹⁴¹ This usage is particularly significant in *Washington v. Glucksberg*, where the majority opinion begins with a lengthy discussion of the pedigree of legal disapproval of suicide.¹⁴² Following this discussion, the opinion moves to a shorter review of the history of criminalizing assisted suicide.¹⁴³ Even as the opinion discusses the current debate over physician-assisted death, it always speaks in terms of "assisted suicide," refusing to use alternative terminology.¹⁴⁴ Indeed, the opinion raises rhetoric to a constitutional level, saying that one of the two essential features of substantive due process analysis is "a 'careful description' of the asserted fundamental liberty interests"¹⁴⁵ and implicitly criticizing the challengers of

139. See *Vacco v. Quill*, 117 S. Ct. 2293 (1997); *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

140. On this issue compare particularly Justice Rehnquist's opinion in *Glucksberg*, 117 S. Ct. at 2261, to that of Justice Souter, 117 S. Ct. at 2275 (Souter, J., concurring in the judgment).

141. See *Vacco*, 117 S. Ct. at 2296; *Glucksberg*, 117 S. Ct. at 2251.

142. See *Glucksberg*, 117 S. Ct. at 2263-64.

143. See *id.* at 2264-67.

144. See *id. passim*.

145. *Id.* at 2268.

the statute for not using one term consistently to describe the right they assert.¹⁴⁶

Having laid this rhetorical background, the opinion comes easily to the conclusion that the statute is constitutional:

We now inquire whether this asserted right has any place in our Nation's traditions. Here, as discussed above . . . we are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults. To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State. . . .¹⁴⁷

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.¹⁴⁸

The opinion then concludes that the state has legitimate interests that are rationally related to banning physician-assisted death.¹⁴⁹

In *Vacco v. Quill*,¹⁵⁰ the Court considered whether criminalizing physician-assisted death but allowing withdrawal of life support violates equal protection.¹⁵¹ The majority opinion invoked several of these rhetorical devices in support of the distinction between physician-assisted death and a patient's withdrawal of life support. The opinion said:

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's

146. "Turning to the claim at issue here, the Court of Appeals stated that '[p]roperly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one's death,' or, in other words, '[i]s there a right to die?' Similarly, respondents assert a 'liberty to choose how to die' and a right to 'control of one's final days,' and 'the liberty to shape death.' As noted above, we have a tradition of carefully formulating the interest at stake in substantive-due-process cases." *Id.* at 2268-69.

147. *Id.* at 2269.

148. *Id.* at 2271.

149. *See id.* at 2275.

150. 117 S. Ct. 2293 (1997).

151. *See id.* at 2298-2302.

wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them. . . . A doctor who assists a suicide, however 'must, necessarily and indubitably, intend primarily that the patient be made dead.' Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not."¹⁵²

In contrast, all of the opinions of the Justices who concurred in *Vacco* and *Glucksberg* do not necessarily label physician-assisted death as "suicide," nor do they necessarily accept these rhetorical distinctions. Justice O'Connor stated:

I join the Court's opinions because I agree that there is no generalized right to "commit suicide." But respondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death. I see no need to reach that question in the context of the facial challenges to the New York and Washington laws at issue here.¹⁵³

Justice Breyer wrote:

I also agree with the Court that the critical question in both of the cases before us is whether "the 'liberty' specially protected by the Due Process Clause includes a right" of the sort that the respondents assert. I do not agree, however, with the Court's formulation of that claimed "liberty" interest. The Court describes it as a "right to commit suicide with another's assistance." But I would not reject the respondents' claim without considering a different formulation, for which our legal tradition may provide greater support. That formulation would use words roughly like a "right to die with dignity." But irrespective of the exact words used, at its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined.¹⁵⁴

Justice Stevens described the right in this way:

[Nancy Cruzan's right to refuse treatment] embraces, not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death. . . . The *Cruzan* case demonstrated that some state intrusions on the right to decide how death will be encountered are also intolerable. The now deceased plaintiffs in this action may in fact have had a liberty interest even stronger than Nancy Cruzan's because, not only were they terminally ill, they were suffering constant and

152. *Id.* at 2298-99 (citations omitted).

153. *Glucksberg*, 117 S. Ct. at 2311 (O'Connor, J., concurring in both *Washington v. Glucksberg* and *Vacco v. Quill* combined).

154. *Id.* (Breyer, J., concurring in the judgments).

severe pain. Avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly "[a]t the heart of [the] liberty . . . to define one's own concept of existence, of meaning, or the universe, and of the mystery of human life."¹⁵⁵

While I agree with the Court that *Cruzan* does not decide the issue presented by these cases, *Cruzan* did give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death. Although there is no absolute right to physician-assisted suicide, *Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.¹⁵⁶

The Justices who concurred in the judgments in these cases did so because they found that, at least as presented, the state's interests in protecting individuals who are incompetent, far from death, or acting involuntarily justified legislation prohibiting physician-assisted death.¹⁵⁷ However, as the quotation above suggests, Justice Stevens indicated that he might find specific individuals to have constitutionally protected interests that would outweigh the state interests. Justices O'Connor, Ginsburg, and Breyer indicated that they would probably find the states' interests strong enough to justify a generally applicable ban on physician-assisted death, provided that the state does not prohibit palliative care for the dying.¹⁵⁸ In the most complex opinion, Justice Souter, concurring in the judgment in *Glucksberg*, did not so easily accept that an absolute ban on physician-assisted death was needed to protect individuals who are not terminally ill or who have not given consent for such a procedure.¹⁵⁹ He wrote:

The case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of

155. *Id.* at 2307 (Stevens, J., concurring) (quoting *Planned Parenthood of South-eastern Pa. v. Casey*, 505 U.S. 833, 851 (1992)).

156. *Id.* (Stevens, J., concurring).

157. *See, e.g., id.* at 2302.

158. *See id.* at 2303 (O'Connor, J.); *id.* at 2310 (Ginsburg, J., concurring in the judgments "substantially for the reasons stated by Justice O'Connor"); *id.* at 2310 (Breyer, J., concurring in the judgment).

159. *See id.* at 2275.

difficult judgment, or by gatekeepers who are subject to temptation, noble or not.

Respondents propose an answer to all this, the answer of state regulation with teeth. . . . But at least at this moment there are reasons for caution in predicting the effectiveness of the teeth proposed.¹⁶⁰

The “slippery slope” or “wedge” concern has been raised throughout the development of the legal “right to die.” The concern is that even if a particular action can be justified as a legitimate choice, acceptance of that action will inevitably lead to policies allowing disabled, old, or ill people to be killed without their consent. To a degree the slippery slope argument has proven to be true; over the last twenty or so years, law and policy have redefined death to include brain death and now allow the withdrawal of lifesaving care, including artificial nutrition and hydration. As society decides whether to allow some form of doctor-assisted death, a major issue is whether this practice creates a substantial risk that the law will further evolve to allow “active involuntary euthanasia” of socially disadvantaged people. The next section considers this issue and other conflicts that are at stake in legal struggles over the “right to die.”

III. The Values at Stake

The language used in the “right to die” debate over the last twenty years reveals one major issue: what it means to value and respect human life, and whether a single understanding of this value will be socially imposed or whether a range of views will be tolerated. The first part of this section discusses this issue. The second part discusses two other issues which are also at stake, though these issues are not so apparent from the rhetoric: the position and authority of doctors in society and the allocation of health care resources.

A. The Disputed Meaning of “Respect for Human Life” and the Role of Law in Resolving the Dispute

The most basic issue suggested by the competing labels of “suicide” or “refusal of health care” is what is meant by the obligation to respect human life. On one side are those who believe that this obligation requires preservation of a person’s biological life at all costs. In contrast, support for withdrawal of medical care and for physician-

160. *Id.* at 2291.

assisted death is often based on a judgment that in some circumstances, maintaining biological life is not meaningful and can even be harmful.¹⁶¹

Ordinary people often express the latter view,¹⁶² and the cases about withdrawal of various forms of life support discussed above are full of statements from people indicating that they do not want to live on machines.¹⁶³ Physician-assisted death is also supported by claims for release from the pain and indignity often associated with intensive medical care,¹⁶⁴ and commentators have identified this as a central value advanced by allowing physician-assisted death.¹⁶⁵ Sometimes these arguments are met with the assertion that the proper response is better management of physical pain.¹⁶⁶ However, this argument is not truly responsive, though, for it assumes that the only pain which counts is physical and ignores divergent views about how to live and die peacefully and with dignity.¹⁶⁷

161. See, e.g., Larry Gostin, *Life and Death Choices After Cruzan*, 19 LAW MED. & HEALTH CARE 9, 10 (1991) ("The state interest in preserving the life of a person in [a persistent vegetative state] is purely theoretical. The state's authority to preserve 'life' has become a magical concept, often driven by blind ideology rather than by any thoughtful appreciation of the unique characteristics of human life. When an individual has no meaningful interaction with her environment, no recognition of familiar persons or objects, nor any human feelings or experience of any kind, the state's interest in life is a mere abstraction.").

162. See, e.g., Beauchamp, *supra* note 115, at 1193-94; Board of Trustees of the Am. Med. Ass'n, *Euthanasia Physician-Assisted Suicide: Lessons in the Dutch Experience*, 10 ISSUES L. & MED. 81, 82 (1994) [hereinafter *Lessons in the Dutch Experience*] (acknowledging widespread fear that high technology may maintain life long after life is meaningful).

163. See, e.g., *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 300 (Cal. Ct. App. 1986); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 221-22 (Cal. Ct. App. 1984); *Satz v. Perlmutter*, 362 So. 2d 160, 161 (Fla. Dist. Ct. App.), *aff'd*, 379 So. 2d 359 (Fla. Dist. Ct. App. 1978); *In re Farrell*, 529 A.2d 404, 408-09 (N.J. 1987); *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 608-09 (N.Y. 1988); *In re Eichner*, 420 N.E.2d 64, 68 (N.Y. 1981). Commentators commonly make this argument as well. See, e.g., Gostin, *supra* note 161, at 10.

164. The 1994 Oregon Voter's Pamphlet in support of the ballot measure allowing physician-assisted suicide contains several personal stories of persons in pain who sought help in dying from family members. See OFFICIAL 1994 GENERAL ELECTION VOTERS' PAMPHLET—STATEWIDE MEASURES 125-27.

165. See, e.g., Beauchamp, *supra* note 115, at 1193-94; Bender, *supra* note 110, at 532.

166. See, e.g., OFFICIAL 1994 GENERAL ELECTION VOTERS' PAMPHLET—STATEWIDE MEASURES 127 (providing arguments in opposition from C. Everett Koop, former U.S. Surgeon General); NEW YORK STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994).

167. One of the most articulate proponents of the "right to die" is Dax Cowart, a man who was severely burned in an accident, kept alive, and treated over his objections over a 15-month period. He survived, though he is blind and disfigured

Those who believe that respect for life allows rejection of life support under some circumstances have generally not advocated that law forbid the provision of life support to terminally ill people or those on respirators.¹⁶⁸ Instead, they have argued that the law should be neutral, allowing individuals to choose whether to accept life support.

Where persons being treated are competent, the argument that their choices should be respected makes sense. However, if the person is incompetent, it is really quite difficult to speak meaningfully of the person's choices.¹⁶⁹ When courts allow termination of medical treatment in such cases, they allow some other person, ordinarily a family member, to make the decision; advance directives, particularly durable powers of attorney for health care, do the same, although the evidence of the patient's prior intent is more direct. The effect of these legal devices is to allow diverse interpretations about the meaning of

and has no fingers, and he eventually married and became an attorney. Despite this and in the face of arguments that at the time of his injuries he could not foresee what his life would be like, he has always maintained that his requests to die should have been honored. See Interview with Dax Cowart Ten Months After the Accident, reprinted in JUDITH AREEN ET AL., *LAW SCIENCE AND MEDICINE* 1112-17 (1st ed. 1984); Letter from Dax Cowart (Sept. 19, 1983), reprinted in *id.* at 1117 n.1; *Burn Victim Backs Right to Die*, REGISTER-GUARD (Eugene, Or.), Nov. 24, 1996, at 11D.

Compare the view of Justice Breyer, that only avoidance of severe physical pain would give rise to a constitutionally protected interest in physician-assisted death:

I do not believe, however, that this Court need or now should decide whether or not such a right is "fundamental." That is because, in my view, avoidance of severe physical pain (connected with death) would have to comprise an essential part of any successful claim [to a constitutionally-protected right to physician-assisted death]. . . [T]he laws 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. And under these circumstances the laws of New York and Washington would overcome any remaining significant interests and would be justified, regardless.

Washington v. Glucksberg, 117 S. Ct. 2302, 2311 (1997) (Breyer, J., concurring) (citations omitted). Contrast *id.* at 2304-10 (Stevens, J., concurring in the judgment) (recognizing other forms of pain and indignity as giving rise to constitutionally protected interest).

168. See Devettere, *supra* note 25 (proposing that neocortical death is consistent with our concepts of death but it should not become public policy because of a lack of understanding by the public and society).

169. Others note this anomaly. See, e.g., Louis M. Seidman, *Confusion at the Border: Cruzan, "The Right to Die," and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, 55-59.

"respecting human life," an outcome that is quite consistent with broader themes of pluralism in American law.¹⁷⁰

The contrary view, that "respecting human life" requires preservation of biological life under most or all circumstances, is often religiously based, though it need not be.¹⁷¹ Those who hold this view have opposed all of the steps toward legalizing the "right to die" discussed in this article—termination of respirators and other life support, termination of artificial nutrition and hydration, and physician-assisted death.¹⁷² Sometimes the opponents accept in theory the autonomy-based claim for rejecting treatment, but they argue that the theory is too dangerous to implement because the risk of error in diagnosing a person's condition or in ascertaining that person's competence is too great.¹⁷³ The opponents' principal argument is the slippery slope argument, which supports absolute rejection of a "right to die." The New York State Task Force on Life and the Law used this rationale to argue against legalization of assisted suicide and euthanasia, saying:

Limiting suicide to the terminally ill would be inconsistent with the notion that suicide is a compassionate choice for patients who are in pain or suffering. As long as the policies hinge on notions of pain or suffering, they are uncontainable; neither pain nor suffering can be gauged objectively, nor are they subject to the kind of judgments needed to fashion coherent public policy. Euthanasia to cover those who are incapable of consenting would also be a

170. Examples are innumerable. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973) (abortion), *Wisconsin v. Yoder*, 406 U.S. 205 (1972) (child rearing). Speaking about the *Cruzan* case, Seidman argues that holdings allowing the withdrawal of life support of incompetent people on autonomy grounds really mean "that the state is entitled to use Ms. Cruzan and her predicament as a means of advancing overall social welfare by alleviating the fear of others that they might someday lose their autonomy." Seidman, *supra* note 169, at 61.

171. See, e.g., Kamisar, *supra* note 12, at 969. A variation of this position holds that people with life-endangering conditions may not have a moral obligation to accept treatment, but they are obliged to accept their fate and remain alive until death comes "naturally." See Peters, *supra* note 137, at 957-67.

172. Much of the major litigation over right to die issues has been conducted by the National Legal Center for the Medically Dependent and Disabled, which always opposes measures to end life. For a review of the Center's activities, see Daniel Avila, *Saying No to Life: Reflections on Death and Justice*, 9 ISSUES L. & MED. 227 (1993). This journal, published by the Center, has printed many articles on right to die issues, especially ones advocating against extension of legal authorization to end life.

173. See, e.g., *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *rev'd*, 107 F.3d 1382 (9th Cir.), *cert. denied*, 118 S. Ct. 328 (1997) (challenging the Oregon statute allowing physician-assisted suicide).

likely, if not inevitable, extension of any policy permitting the practice for those who can consent.¹⁷⁴

Other warnings are even more grim, predicting that to allow withdrawal of life support or physician-assisted suicide will gradually lead to Nazi-like atrocities.¹⁷⁵ The idea that some treatments are "futile" and therefore should not even be offered, regardless of patient or family wishes, has been criticized on the same ground.¹⁷⁶

If the slippery slope argument is understood to mean that, with experience, we will come increasingly to accept as legitimate the wishes of very ill individuals to cease living, regardless of how their lives are ended, then the prediction has proven to be accurate. But this is *not* what people always mean by "slippery slope." Sometimes the argument is that law which protects a diversity of perspectives and individual choice against governmental control will evolve into a governmental policy to eliminate the poor, disabled, and sick without their consent and without considering their probable wishes or best interests. However, it is important to remember that Nazi practices originated through racist and eugenicist government policies, not policies to protect individual autonomy. Although such a development is not impossible, current law is very far removed in principle from policies that allow the systematic killing of socially disadvantaged people, and little evidence indicates that such consequences are likely.¹⁷⁷

To date, arguments which favor allowing individuals and their surrogates to refuse life support have prevailed over the concerns about errors and slippery slopes in part because autonomy claims are generally so highly regarded in our society and because so many people believe that a life supported only by means of sophisticated medical technology can be worse than death. We do not know whether this course will continue so that physician-assisted death eventually

174. NEW YORK STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT at xv (1994); see also *Washington v. Glucksberg*, 117 S. Ct. 2258, 2273 (1997).

Many others make the same argument. Examples include Kamisar, *supra* note 12, at 1014-41 (responding to Glanville Williams's proposal to allow euthanasia when voluntarily requested by a competent terminally ill person, making explicit comparisons to Nazi atrocities); Beauchamp, *supra* note 115 (noting that the distinction between letting die and killing is morally significant and should be maintained because of the slippery slope problem); and Weisbard & Siegler, *supra* note 71, at 111.

175. See, e.g., sources cited *supra* note 174.

176. See, e.g., Swanson & McCrary, *supra* note 86, at 318.

177. Beauchamp, *supra* note 115, at 1198.

becomes accepted as well. To the extent that the legal debate over physician-assisted death is about whether an existing practice should be legitimated,¹⁷⁸ we might predict that the law will develop to allow the practice, for legal prohibition of all assisted death can be understood as enshrining the vitalist perspective and not allowing for diversity of views. But more than ideological difference is at stake in the debate over physician-assisted death, as the next section discusses.

B. The Role of Law in Determining the Status of Doctors and the Allocation of Health Care Resources

The debate over legalizing physician-assisted death is significantly influenced by the experience in the Netherlands, where the practice has been legal in some circumstances for more than twenty years.¹⁷⁹ Opponents of legalization regularly point to the Dutch experience to support the slippery slope argument.¹⁸⁰ However, other even more revealing lessons about the role of doctors in society can be drawn from the comparison.

178. See *supra* text accompanying notes 161-77. In addition to the arguments discussed in the text, one argument for legalization of physician-assisted suicide is the generic one that if law and practice part radically, the legal system loses its legitimacy. Bender, *supra* note 110, at 533.

179. In footnote 16 of *Glucksberg*, the Supreme Court discusses efforts in other countries to legalize physician-assisted death, citing a Canadian Supreme Court decision finding no constitutionally protected right, a failed legislative effort in New Zealand, and a negative report from the British House of Lords. See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2266 n.16 (1997). The footnote acknowledges that the Colombian Constitutional Court has ruled that people have a right to "voluntary euthanasia" and discusses the experience in Australia. Under the Northern Territory of Australia Rights of the Terminally Ill Act of 1995, physician-assisted death is also lawful under some circumstances. However, the national Commonwealth Parliament enacted a law to overturn the Northern Territory Act. The Commonwealth Parliament has authority to override the laws of Australian territories, but not states. According to a retired law professor at the Australian National University, two people complied with the requirements of the act and were allowed to die with physician assistance under its terms, and two more complied with the requirements but were not assisted to die before the national repeal became effective. Letter from Professor Charles Rowland, Australian National University to the author (Apr. 18, 1997) (on file with the author). The *Glucksberg* footnote cites a *New York Times* article which says that three people were assisted to die under the provisions of the Northern Territory Act.

Professor Rowland reported that the Australian Parliament's close vote to repeal the Northern Territory law was affected by a "very effective and efficient low profile lobbying effort by people centred on the Roman Catholic Church." *Id.* He adds that a large majority of the public favors physician-assisted death and predicts that legislation to authorize physician-assisted death will be proposed in one or more Australian states. See *id.*

180. See, e.g., *Lessons in the Dutch Experience*, *supra* note 162.

1. THE DISPUTED INTERPRETATIONS OF DUTCH PRACTICE

Beginning in the 1970s, Dutch courts developed the criminal law affirmative defense of "necessity" or "choice of evils" to allow physicians to assist in the death of patients under certain circumstances.¹⁸¹ The necessity defense generally provides that a person who breaks a criminal law as a necessary means of preventing a greater evil is not guilty.¹⁸² This principle has been specifically applied in the Netherlands to physician-assisted death, and doctors who follow established guidelines will not be criminally prosecuted for performing "euthanasia." The Dutch use the term "euthanasia" as providing means to a patient to end life and performing the final act itself.¹⁸³ These guidelines require that:

1. The request for euthanasia must come only from the patient and must be entirely free and voluntary.
2. The patient's request must be well considered, durable and persistent.
3. The patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement.
4. Euthanasia must be a last resort. Other alternatives to alleviate the patient's situation must have been considered and found wanting.
5. Euthanasia must be performed by a physician.
6. The physician must consult with an independent physician colleague who has experience in this field.¹⁸⁴

In 1990 an official Dutch nationwide study, known as the Remmelink study, examined "medical decisions concerning the end of

181. For more details, see John Keown, *The Law and Practice of Euthanasia in the Netherlands*, 108 L.Q. REV. 51 (1992). Some authorities speak of the Dutch doctrine being based on *force majeure*. See, e.g., Johannes J.M. van Delden et al., *The Remmelink Study Two Years Later*, 23 HASTINGS CENTER REP. 24, 25 (1993). The applicable principle is recognized in American and English law as "necessity" or "choice of evils." See LAFAYE & SCOTT, *supra* note 121, § 5.4; see also Barney Sneiderman & Marja Verhoef, *Patient Autonomy and the Defence of Medical Necessity: Five Dutch Euthanasia Cases*, 34 ALB. L. REV. 374 (1996). Thanks to Mary Clayton, Associate Law Librarian at the University of Oregon, for these references.

Some writing in the United States about the Dutch law is unnecessarily mystifying. Anglo-American criminal law also develops specific criteria for affirmative defenses that exonerate people from what would otherwise be criminal homicide, based on the general principles of necessity and duress. One of the best known is self-defense. See LAFAYE & SCOTT, *supra* note 121, § 5.7.

182. See LAFAYE & SCOTT, *supra* note 121, § 5.4.

183. In 1990, the Dutch Minister of Justice agreed to a uniform procedure for handling cases. The doctor does not issue a declaration of natural death but informs local medical examiner, who reports to the prosecutor, who decides whether to prosecute. See Delden et al., *supra* note 181, at 30.

184. Keown, *supra* note 181, at 56 (quoting Mrs. Borst-Eilers, Vice-President of the Health Council, which provides scientific advice to the Dutch government on health issues).

life.”¹⁸⁵ These decisions included: decisions simply not to treat patients; decisions to give very high dosages of opiates to patients to alleviate pain with the knowledge that these dosages may hasten death; and, decisions to end a patient’s life intentionally at the patient’s request by lethal injection or by prescribing medication.¹⁸⁶ The report of the study published in the British medical journal, *The Lancet*, says that of all deaths that occurred in 1990 in the Netherlands, 17.5% resulted from doctors administering opiates to alleviate pain in such high dosages that the patient’s life might be shortened, and in another 17.5%, the doctor did not provide treatment that might have saved the patient’s life.¹⁸⁷ Doctors caused patients’ deaths, at the patient’s request, by intentionally administering lethal drugs in 1.8% of all deaths and by prescribing lethal drugs for patients in 0.3% of the deaths.¹⁸⁸ The report also found that physicians administered drugs with the intention of ending the patient’s life without an explicit and persistent request from the patient in 0.8% of the cases.¹⁸⁹ The *Lancet* report discusses the last category of cases, saying:

In more than half of these cases the decision has been discussed with the patient or the patient had in a previous phase of his or her illness expressed a wish for euthanasia should suffering become unbearable. In other cases, possibly with a few exceptions, the patients were near to death and clearly suffering grievously, yet verbal contact had become impossible. The decision to hasten death was then nearly always taken after consultation with the family, nurses, or one or more colleagues. In most cases the amount of time by which, according to the physician, life had been shortened was a few hours or days only.¹⁹⁰

The majority in *Glucksberg*, citing a secondary report based on the *Lancet* report, describes the results in more alarming terms:

The Dutch government’s own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as “the deliberate termination of another’s life at his request”), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients’ explicit consent.¹⁹¹

185. Delden et al., *supra* note 181, at 30.

186. See Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669 (1991).

187. See *id.* at 670, tbl.I.

188. See *id.*

189. See *id.*

190. *Id.* at 672.

191. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2274 (1997).

The American opponents of physician-assisted death, including the *Glucksberg* majority, conclude that the Rummelink study supports the slippery slope argument.¹⁹² They say that the study shows that the Dutch guidelines to protect patients have not been consistently respected and that physician-assisted death cannot be controlled if legalized.¹⁹³ On the other hand, the researchers who conducted the Dutch study point out:

Requests for euthanasia and, to a lesser extent, for assistance in suicide by patients with a fatal disease are not rare in the Netherlands. Many patients want an assurance that their doctor will assist them to die should suffering become unbearable. We found that about two-thirds of these requests never end up as a serious and persistent request at a later stage of the disease, and of the serious and persistent requests about two-thirds do not result in euthanasia or assisted suicide since physicians can often offer alternatives. Many physicians who had practised euthanasia mentioned that they would be most reluctant to do so again, thus refuting the "slippery slope" argument. Only in the face of unbearable suffering and with no alternatives would they be prepared to take such action.¹⁹⁴

Interpretation of the Rummelink study is likely to have a substantial impact on the acceptance or rejection of physician-assisted death in the United States. Uncertainty about this interpretation ultimately led Justice Souter to conclude that the Constitution does not require states to allow this practice, for, he said, legislatures are far better suited than courts to resolve the uncertainty.¹⁹⁵

The Rummelink study does indicate that doctors in the Netherlands have not strictly adhered to the official guidelines governing physician-assisted death, for the study shows that in some cases physicians intentionally end patients' lives without explicit and persistent requests.¹⁹⁶ Yet, despite the knowledge that sometimes doctors do not adhere strictly to the guidelines, public support for physician-assisted death remains very high in the Netherlands.¹⁹⁷ Thus, for Americans to

192. See, e.g., *id.*

193. See, e.g., Callahan & White, *supra* note 6, at 1; John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, 9 NOTRE DAME J.L., ETHICS & PUB. POL'Y 407 (1995); *Lessons in the Dutch Experience*, *supra* note 162, at 89.

194. van der Maas et al., *supra* note 186, at 673.

195. See *Glucksberg*, 117 S. Ct. at 2292-93.

196. See Delden et al., *supra* note 181, at 24.

197. See Joseph P. Shapiro, *Euthanasia's Home*, U.S. NEWS & WORLD REP., Jan. 13, 1997, at 26. American opponents of physician-assisted suicide argue that the Dutch practice cannot be transferred to the United States, in part because substantial social consensus exists on many ethical issues in the Netherlands. Also, legal problems are resolved by consensus rather than by litigation to a much greater

understand the significance of the Rummelink study, we will need to know more than how many people died and in what ways; we will also need to learn more about the cultural and legal context of the Dutch rules and how these compare to American culture and law.

2. THE RELATIVE AUTONOMY OF DOCTORS AND PATIENTS

The Rummelink study raises more questions besides the extent to which Dutch doctors strictly adhere to guidelines for physician-assisted suicide. One question, which actually may be more important, is the extent to which doctors exercise professional discretion about ending patients' lives.

The study shows that doctors continue to exercise substantial judgment to grant or deny euthanasia and physician-assisted suicide.¹⁹⁸ Indeed, the researchers who conducted the Rummelink study concluded that "doctors themselves are responsible moral agents, not simply instruments of the patient's will."¹⁹⁹ Some opponents of legalizing physician-assisted suicide cite the Dutch experience to show that legalization would enhance doctors' power vis-à-vis patients.²⁰⁰ For example, Daniel Callahan and Margot White have argued:

The fact that the vast majority of physicians are ethical and well-intentioned is beside the point. The adherence to any publicly approved guidelines or safeguards for containing the practice of [physician-assisted suicide] and euthanasia within certain limits, however flawed such guidelines may be, depends almost exclusively on the good will and professional judgment of the individual physician who acts in private. Thus, it is not the patient's request for euthanasia that determines the outcome, but rather the physician's judgment that such a request is appropriate and that the patient is not suffering from impaired thinking in wanting to die. In other words, that the patient's request is warranted because, in the physician's judgment, the patient's life is not worth living.²⁰¹

On the other hand, the American Medical Association's (AMA) opposition to legalized physician-assisted death is based substantially on the fear that legalization would *deprive* doctors of authority and

degree than in the United States. See *id.* These cultural differences could just mean, though, that Americans will follow other paths, such as litigation, to resolutions of these issues.

198. See Delden et al., *supra* note 181, at 26.

199. *Id.*

200. See Callahan & White, *supra* note 6, at 28.

201. *Id.* at 64-65.

discretion.²⁰² The AMA's Council on Ethical and Judicial Affairs, after affirming that patients should have a right to refuse life-sustaining treatment, rejects physician-assisted death. The Council's report says:

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. *The right of self-determination is a right to accept or refuse offered interventions, but not to decide what should be offered.* The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.

. . . Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible. The physician's role is to affirm life, not to hasten its demise.²⁰³

These statements show that the power and professional autonomy of doctors is clearly at stake, but whether legalization would enhance or diminish doctors' authority is unclear. Other arguments for legitimating the practice of physician-assisted death cast light on the question.

Proponents of legalization repeatedly point out that some doctors may be deterred by fear of prosecution from granting requests for such assistance.²⁰⁴ They also argue that to the extent that physician-assisted suicide occurs, the practice is unregulated by law or by conventional medical norms.²⁰⁵ The premise of both of these arguments is that if physician-assisted death is not lawful but is actually practiced, as is the case today, its availability in general and in particular

202. See Council on Ethical & Judicial Affairs of the Am. Med. Ass'n, *Physician-Assisted Suicide*, 10 ISSUES L. & MED. 91, 93 (1994).

203. *Id.* (emphasis added); see also *Lessons in the Dutch Experience*, *supra* note 162, at 82.

204. See, e.g., Beauchamp, *supra* note 135, at 1199; Bender, *supra* note 110, at 532; see also OFFICIAL 1994 OREGON GENERAL ELECTION VOTERS' PAMPHLET—STATE-WIDE MEASURES 125-27 (containing arguments for and against Measure 16 which outline current law that requires people to act secretly to help loved ones or leaves dying people to die violently and alone).

205. See OFFICIAL 1994 OREGON GENERAL ELECTION VOTERS' PAMPHLET—STATE-WIDE MEASURES 125-27 (containing arguments for and against Measure 16 that outline procedural and substantive safeguards that will protect against abuse and stating that current law requires people to act secretly to help loved ones, without guidelines, safeguards, or reporting requirements); see also Wanzer et al., *supra* note 78, at 848 ("Physicians who act in secret become isolated and cannot consult colleagues or ethics committees for confirmation that the patient has made a rational decision. . . . The impulse to maintain secrecy gives the lie to the moral intuition that assistance with suicide is ethical.").

cases is entirely within the control of individual doctors. Whether any particular patient or family can obtain such help depends on their ability to find a willing doctor. This suggests that legalization would, at least in some senses, limit the control of individual doctors by bringing the practice into the open.²⁰⁶ On the other hand, Callahan and White are probably right that there would be little effective public scrutiny of how doctors, patients, and families actually made decisions with regard to physician-assisted suicide, just as there is little scrutiny today of how decisions to withdraw life support are made.²⁰⁷

The real issue is the extent to which we as a society trust doctors with this power over life and death, but this issue is certainly not unique to this aspect of medical practice.²⁰⁸

3. HEALTH INSURANCE, HEALTH CARE COSTS, AND CARE AT THE END OF LIFE

The cost of medical care and how medical care is allocated are also factors in the physician-assisted suicide debate. Opponents of legalization point again to the experience in the Netherlands, which has universal health insurance.²⁰⁹ Opponents maintain that universal health insurance protects against people ending their lives because they lack access to medical care.²¹⁰ They compare this situation to that in the United States, where many people do not have adequate health insurance, arguing that people in the United States may request physician-assisted death to avoid burdening their families with substantial

206. Citizen votes on proposals to allow physician-assisted suicide in Washington, California, and Oregon also suggest a public demand for control over the practice. All three measures were decided by a close margin, with those in Washington and California being defeated, and the one in Oregon passing. Polls conducted in Washington and California after defeat of the measures found public support for the concept but concern that the legislation actually proposed in those states contained too few safeguards and gave doctors too much authority. See Alexander M. Capron, *Sledding in Oregon*, 25 HASTINGS CENTER REP. 34 (1995); Peter Steinfels, *Help for the Helping Hands in Death*, N.Y. TIMES, Feb. 14, 1993, § 4, at 1.

207. See generally Callahan & White, *supra* note 6 (analyzing proposed legislation to legalize physician-assisted death).

208. See Bender, *supra* note 110, at 533 ("As a society we readily give physicians a great deal of responsibility to exercise their best judgments and skills in caring for patients. If we are willing to presume they are responsible enough under most situations to deal with matters of life and death, why would they suddenly be less responsible in helping to implement patients' decisions at life's end?").

209. See Shapiro, *supra* note 197, at 24; see also *Lessons in the Dutch Experience*, *supra* note 162, at 87.

210. See Shapiro, *supra* note 197.

medical bills.²¹¹ This, they suggest, would mean that death was not voluntarily chosen.

The assumption implicit in this argument is that having to choose between extending one's life with expensive medical care or avoiding a burden to one's family is unacceptable. Yet avoiding costs that will burden surviving family members has surely been a motivation for choosing death throughout history and is today a reason for some decisions to refuse treatment at the end of life.

A subsidiary issue is whether family members, for the sake of avoiding expense, may pressure a relative near death to end his or her life, a problem which can also arise with decisions to refuse treatment. This problem is very complex, for implicit in it are questions about the extent to which family members legitimately try to affect each others' choices and for what reasons—questions beyond the scope of this article.²¹²

From a broader perspective, the relationship between legal and social attitudes toward physician-assisted death and access to health care is less clear. The U.S. medical system emphasizes high-tech, expensive care, often used for very ill people as they near the end of life. This emphasis on expensive medical technology has disadvantages, though. The high cost of expensive, high-tech care contributes to the American insurance problem, because bringing more people into the insured pool would create still more claims for access to expensive care.

Perhaps society as a whole would be better off if we all had access to basic health care but not necessarily to the expensive care needed to extend temporarily the lives of very ill or injured people. If as a society we more readily accepted death—by withdrawal of life support or with physician assistance—for the sake of avoiding high-cost end-of-life treatment, as well as avoiding the pain and indignity of living with such treatment, perhaps emphasis in the health care system would shift some toward ensuring broader access to basic care, such as prenatal care and substance abuse treatments. Empirically, these arguments are speculative, but it is still critical that we consider

211. *See id.*

212. Another place in which such issues arise is determining when influence over a testator becomes "undue." *See* EUGENE F. SCOLES & EDWARD C. HALBACH, JR., PROBLEMS AND MATERIALS ON DECEDENTS' ESTATES AND TRUSTS 652-64 (5th ed. 1993).

how our attitudes about death and care at the end of life affect the structure of our health care system.

IV. Conclusion

In declining to find that due process or equal protection requires states to allow physician-assisted dying, the Supreme Court in *Vacco* and *Glucksberg* clearly indicated that states should be allowed to continue debating this issue and that change should come, if it comes, through the legislative process. The Ninth Circuit's reversal of the holding in *Lee v. Oregon*,²¹³ a decision which the Supreme Court declined to review, leaves the Oregon statute allowing physician-assisted suicide standing. Oregon is left free to experiment with physician-assisted suicide, as are other states.

As we as a society deal with this issue, we will debate the issues raised by the rhetoric of "suicide" and "right to choose health care." But we must also consider how legalizing physician-assisted death would affect the balance of authority between doctors and patients and the allocation of health care resources, as among people and among kinds of care. These issues probably have a greater effect on the welfare of all of us, including socially disadvantaged people, than philosophical understandings about whether respect for human life allows physician-assisted death.

213. 891 F. Supp. 1429 (D. Or. 1995), *rev'd*, 107 F.3d 1382 (9th Cir.), *cert. denied*, 118 S. Ct. 328 (1997).