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The Alleged Distinction between Euthanasia and the Withdrawal of Life-Sustaining Treatment: Conceptually Incoherent and Impossible to Maintain

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THE ALLEGED DISTINCTION BETWEEN EUTHANASIA AND THE WITHDRAWAL OF LIFE-SUSTAINING TREATMENT: CONCEPTUALLY INCOHERENT AND IMPOSSIBLE TO MAINTAIN

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Richard Epstein, in his book Mortal Peril, *supports euthanasia and assisted suicide and rejects the distinction between them and withdrawal of treatment. In this essay, Professor Orentlicher argues that Epstein is correct in finding no meaningful moral distinction between euthanasia and treatment withdrawal, examines the reasons why the distinction has persisted in American jurisprudence, and explains why the distinction has eroded.*

Epstein also concludes in his book that there is no constitutional right to euthanasia or assisted suicide. Professor Orentlicher's response is that constitutionality is not the appropriate inquiry; rather, the better question is whether to recognize a right to assisted suicide once a right to euthanasia in the form of terminal sedation already exists. He answers this question in the affirmative, arguing that assisted suicide enhances patient welfare and reduces risks of abuse in a world with euthanasia.

I. INTRODUCTION

Before reading *Mortal Peril: Our Inalienable Right to Health Care?*,[1] I was not sure what position Richard Epstein would take on euthanasia (and physician-assisted suicide).[2] On the one hand, his libertarian philosophy suggested that he would support the legalization

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1. RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? (1997).

2. I mention euthanasia first and assisted suicide second because that is the order in which Epstein takes up the two practices. *See generally id.* chs. 13 & 14.

of euthanasia. On the other hand, his affinity for the common law[3] suggested he might support the common-law tradition of a prohibition on euthanasia.[4]

In fact, both strands of Epsteinian thought shape the argument in this important new book. Invoking principles of individual autonomy, Epstein first explains why states should permit euthanasia (or assisted suicide) just as they have permitted the withdrawal of life-sustaining treatment. His rejection of the distinction between treatment withdrawal and euthanasia is very much on target. As Epstein observes, the usual philosophical and practical arguments for the distinction do not withstand scrutiny—the concerns raised about euthanasia also apply to withdrawal of treatment.[5]

But when it comes to the constitutional issue, the common-law Epstein dominates. Given the risks of abuse, Epstein argues that it would be wrong, at least at this time, for there to be a constitutional right to euthanasia or assisted suicide.[6] Accordingly, he concludes, the Supreme Court should not override state bans on euthanasia or assisted suicide.[7]

Although there is an apparent inconsistency between Epstein's support for euthanasia/assisted suicide and his objection to a constitutional right to either, he provides a reasonable basis for the different outcomes.[8] Hence, it is not worth dwelling on this point. Indeed, there are larger issues on which to focus discussion. First, I will indicate an important way in which Epstein could have pursued the implications of his moral analysis. Second, I will suggest a more appropriate way to frame the constitutional question.

The implications of Epstein's moral analysis are pertinent in terms of his rejection of the distinction between treatment withdrawal and euthanasia/assisted suicide. Epstein is surely correct that there is no meaningful moral distinction here. Yet, if there really is no moral difference at work, we need to explain why many courts, legislatures, and scholars still invest the distinction with great weight. Accordingly,

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3. *See, e.g.*, RICHARD A. EPSTEIN, TAKINGS: PRIVATE PROPERTY AND THE POWER OF EMINENT DOMAIN vii-viii (1985) (stating that "[f]rom the time I first entered teaching in 1968, my main interest has been in the common law" and observing that the common-law rules of property, tort, and contract form "the basis of our legal culture").

4. *Cf.* Washington v. Glucksberg, 117 S. Ct. 2258, 2263 (1997) ("[F]or over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.").

5. *See* EPSTEIN, *supra* note 1, at 289; *see also* David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 NEW ENG. J. MED. 663 (1996) [hereinafter Orentlicher, *Legalization*]; David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443 (1997) [hereinafter Orentlicher, *Modest Revolution*]. In Parts II and III of this article, I draw on these two earlier articles.

6. *See* EPSTEIN, *supra* note 1, at 330-31.

7. *See id.* at 343. The book came out just before the Supreme Court's assisted suicide decisions in *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), and *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

8. *See infra* text accompanying notes 93-95.

I will explore the reasons why the distinction has played a critical role in American jurisprudence. I will also argue that we can understand the current erosion of the distinction (e.g., in Oregon's enactment of a statute permitting assisted suicide)[9] in terms of the reasons why we have maintained the distinction for so many years.

On the constitutional issue, I will argue that the question is not whether to grant a constitutional right to euthanasia or assisted suicide. As a practical matter, a right to euthanasia was effectively granted when the Supreme Court recognized a right to refuse life-sustaining treatment in *Cruzan v. Director, Missouri Department of Health*.[10] Rather, the question is whether to recognize a right to assisted suicide once a right to euthanasia already exists. And, on that question, I will argue that assisted suicide enhances patient welfare and reduces risks in a world in which euthanasia is permitted.

II. Rejecting the Distinction Between Treatment Withdrawal and Euthanasia/Assisted Suicide

Epstein's rejection of the distinction between treatment withdrawal and euthanasia/assisted suicide follows ineluctably from his "simple rules for a complex world."[11] In Epstein's view, the ideal society is one based on individual autonomy, with the state stepping in only to protect individuals from force and deceit.[12] In an autonomy-driven world, as long as a patient makes a competent, informed, and voluntary choice (i.e., a choice that reflects a genuine expression of autonomy rather than misinformation or coercion), it should be irrelevant whether the person chooses to die by withdrawal of treatment, euthanasia, or assisted suicide.

Although one might challenge Epstein on his choice of foundational principles, his objections to the treatment withdrawal and euthanasia/assisted suicide distinction do not stand or fall on his simple rules. As we will see, the problems with the distinction exist over a wide range of moral systems.[13] Let us now turn to Epstein's arguments against the distinction.

A. The Act-Omission Distinction

As Epstein observes, courts and scholars who reject euthanasia/assisted suicide but support treatment withdrawal commonly cite the

9. Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800-.897 (1996).

10. 497 U.S. 261, 281 (1990).

11. Epstein previously developed these rules in greater depth in his book, Simple Rules for a Complex World (1995).

12. *See* Epstein, *supra* note 1, at 8-13.

13. Epstein's principles are nevertheless important. Deciding that there is no moral distinction between withdrawal of treatment and euthanasia/assisted suicide leaves the question whether we should permit or prohibit both practices together. Epstein's principles tell us that we should permit both treatment withdrawal and euthanasia/assisted suicide.

act-omission distinction.[14] In the view of these commentators, patients who die by withdrawal of a ventilator or a feeding tube die from the underlying disease, while patients who die by euthanasia/assisted suicide die from the actions of their physicians.[15]

Although it is often useful to distinguish between acts and omissions, Epstein rightly points out that the distinction lacks moral force in the context of treatment withdrawal, euthanasia, and assisted suicide.[16] A person who turns off a ventilator is surely "acting," and the law will properly call for the prosecution of someone who turns off a patient's ventilator without authorization.[17] Indeed, in assisted suicide, the physician's action makes less of a causal contribution to the patient's death than it does in either treatment withdrawal or euthanasia.[18] When a physician writes a prescription for a lethal dose of barbiturates, the physician's role in the patient's death is more attenuated than is that of the physician who turns off a ventilator on a patient who cannot breathe without assistance.[19]

As others have argued, and as Epstein acknowledges, withdrawals of treatment kill only when the person has a fatal disease, while euthanasia/assisted suicide can kill a healthy person.[20] However, Epstein notes, this point demonstrates that "dangerous acts" put more people at risk than "dangerous omissions," not that individual omissions are morally justified.[21] Moreover, even if it did matter whether the physician's act would kill only the seriously ill, that argument would not explain the distinction between treatment withdrawal and

14. *See* EPSTEIN, *supra* note 1, at 290.

15. *See, e.g.*, *In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985) ("[D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury."); NATIONAL CTR. FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 145 (2d ed. 1992) ("There are significant moral and legal distinctions between letting die (including the use of medications to relieve suffering during the dying process) and killing (assisted suicide/euthanasia). In letting die, the cause of death is seen as the underlying disease process or trauma. In assisted suicide/euthanasia, the cause of death is seen as the inherently lethal action itself.").

16. *See* EPSTEIN, *supra* note 1, at 291.

17. *See* Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CTR. REP., Mar.-Apr. 1992, at 10, 13; Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473, 480 (1995).

18. *See* Orentlicher, *Modest Revolution*, *supra* note 5, at 448.

19. *See* Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

20. *See, e.g.*, Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CTR. REP., Mar.-Apr. 1992, at 52, 53 (observing that "the physician's omission can only bring about death on the condition that the patient's disease will kill him in the absence of treatment").

21. *See* EPSTEIN, *supra* note 1, at 292. In theory, because anyone may commit suicide, suicide puts more people at risk for premature death than does the withdrawal of life-sustaining treatment. However, as a practical matter, it is not clear where the greater risk lies. With treatment withdrawal, incompetent patients are at risk for premature death because their family members may underestimate their desire for life-sustaining treatment. With assisted suicide, the patient has to perform the life-ending act, and that provides an important safeguard against abuse. *See* Marcia Angell, *The Supreme Court and Physician-Assisted Suicide—The Ultimate Right*, 336 NEW ENG. J. MED. 50, 51 (1997).

euthanasia or assisted suicide. The law does not limit withdrawals of treatment only to cases in which a patient is irreversibly ill. Patients whose lives could be saved and who could be restored to very good health with the brief use of a ventilator or the transfusion of blood can still refuse the treatment.[22]

B. Autonomy as Limited by Self-Preservation

Epstein addresses a second conceptual attack on euthanasia/assisted suicide when he discusses the argument that a right to autonomy does not imply a right to give up autonomy entirely.[23] This argument may derive from theistic concepts of people as the stewards of a divinely given body and soul, or from the secular belief that ending one's life is autonomy-defeating rather than autonomy-enhancing. Regardless of its foundation, Epstein correctly observes that this argument against euthanasia/assisted suicide also applies to the refusal of life-sustaining treatment, for that decision also utterly precludes future expressions of autonomy.[24]

C. Euthanasia/Assisted Suicide Violates the Physician's Role

Epstein cites Leon Kass for a third common objection to euthanasia/assisted suicide: Although there might be a role for euthanasia and suicide, it would violate the professional role of physicians to participate in either act.[25] According to Kass, physicians are fundamentally preservers of life and therefore must not engage in death-causing activities.[26] Moreover, to do so would undermine patient trust in physicians.[27]

Epstein rejects this objection as well, in large part because he believes that Kass's argument misconceives the nature of the patient-physician relationship. According to Epstein, the relationship should be defined by the voluntary agreement of the patient and the physician.[28] Ethical considerations are relevant to the extent that the patient and physician import them into their relationship. The principle of autonomy requires only that the patient and physician come to an agreement that is not poisoned by incompetence, fraud, or undue in-

22. *See, e.g.*, Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300 (Ct. App. 1986) (a competent adult patient "has the right to refuse *any* medical treatment, even that which may save or prolong her life"); *In re* Conroy, 486 A.2d 1209, 1226 (N.J. 1985) (a competent patient's right to refuse life-sustaining treatment "would not be affected by her medical condition or prognosis"); Fosmire v. Nicoleau, 551 N.E.2d 77, 84 (N.Y. 1990) (recognizing the right of a 36-year-old adult with serious bleeding during a cesarean section to refuse blood transfusions that could restore her to good health).

23. *See* EPSTEIN, *supra* note 1, at 293-97.

24. *See id.* at 294.

25. *See id.* at 306-07.

26. *See id.*

27. *See id.* at 307.

28. *See id.*

fluence. Otherwise, autonomy does not leave room for externally imposed limits on the kinds of agreements that patients and physicians can reach.[29]

This response to Kass is controversial, but it is not critical to countering the argument from the physician's professional role. As Epstein points out, the logic of Kass also applies to withdrawals of life-sustaining treatment.[30] Physicians are free to turn off ventilators not only when the patient will die without the ventilator, but also when the patient might still be restored to very good health.[31]

There are other important responses to Kass as well. Physicians are providers of comfort just as fundamentally as they are preservers of life. When the life-preserving and comforting roles conflict, it is not clear why the life-preserving role should take priority. Indeed, if we view the physician's role as being fundamentally about the relief of discomfort or disease, with preservation of life being a part of that role, then the obligation to relieve suffering would take priority over the obligation to preserve life.[32] Under this view, patients' mistrust of physicians is bred not by the thought that physicians may dispense lethal agents, but by the thought that they will not do so.[33] Patients fear that, when they are suffering intolerably, they will be denied the drugs that are necessary to end their suffering.[34]

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29. *See id.* at 307-08. Although Epstein and Kass have different views about the nature of the patient-physician relationship, that difference does not necessarily lead to different views about the physician's professional role. From their different theories, Epstein and Kass could come to exactly the same ethical responsibilities of physicians. For example, under Epstein's voluntary-agreement view, one could argue that physicians should adopt a code of ethics that incorporates the constraints to which patients and physicians would normally agree. It does not make sense for patients and physicians to start from scratch in negotiating the terms of their relationship. It is more efficient to start from a baseline of commonly accepted terms of the relationship (e.g., confidentiality and truth telling).

Under Epstein's view, patients and physicians in a particular relationship could decide whether to deviate from the normally assumed conditions of the patient-physician relationship. However, Epstein would not give patients and physicians complete freedom to do so. Because of the risk of fraud or abuse, parties to a contract are limited in their ability to fashion their own agreement. *See id.* at 314-15. Thus, in an Epsteinian world, some background terms of the patient-physician relationship could be relinquished, while other terms would have to remain part of any individual patient-physician relationship. Similarly, Kass would undoubtedly view some ethical responsibilities of physicians as waivable by a patient (e.g., confidentiality) and others as nonwaivable (e.g, the duty not to assist a suicide).

30. *See id.* at 307.

31. *See supra* note 22.

32. *See* Orentlicher, *Legalization*, *supra* note 5, at 664; Orentlicher, *Modest Revolution*, *supra* note 5, at 452.

33. *See* MARGARET PABST BATTIN, ETHICAL ISSUES IN SUICIDE 206 (1995).

34. *See* Christine K. Cassel & Diane E. Meier, *Morals and Moralism in the Debate over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750, 751 (1990). In a survey of adult patients, researchers found that 90.5% of the patients would consider a physician who assisted suicides to be as trustworthy as other physicians in providing care to critically ill patients. *See generally* Mark A. Graber et al., *Patients' Views About Physician Participation in Assisted Suicide and Euthanasia*, 11 J. GEN. INTERNAL MED. 71 (1996) (studying 228 patients at a single university-based family practice program).

Second, even accepting the premise that preserving life is the fundamental physician role, permitting euthanasia and assisted suicide can facilitate that role. As Epstein later notes, although euthanasia and assisted suicide will shorten some patients' lives, they will prolong other patients' lives.[35] What patients often want from the right to euthanasia/assisted suicide is not so much the ability to die but the knowledge that they have control over the timing of their death.[36] Without such control, patients may choose to die too soon rather than too late.[37] In addition, if euthanasia and assisted suicide are available, patients may be more willing to undergo aggressive medical treatments that are painful and risky. If the treatments do not succeed but only worsen the patients' condition, the patients would be assured that they could end their suffering. Without such assurance, they might well forgo the treatments entirely.[38]

D. Abuse and Overreaching

Epstein reserves a separate chapter for a fourth important objection to euthanasia/assisted suicide: Although it may be possible to imagine appropriate cases for patients to take their lives by euthanasia or suicide, serious problems of abuse will follow the legalization of the practices as weak and vulnerable patients are pressured to end their lives by emotionally and/or financially burdened families and physicians.[39] As Epstein points out, the law has long worried about abuse or overreaching in the context of other seemingly voluntary transactions (e.g., ordinary consumer sales).[40] The more likely it is that abuse will occur, the greater the justification for regulation or even prohibition, because it is not always possible to expose cases of incompetence, fraud, or undue influence.

Conceptual arguments about the risk of abuse deserve consideration, Epstein notes, but they do not tell us how to balance the harms from underregulation (killing people who want to live) with the harms from overregulation (keeping people alive who want to die).[41] For help on this question, Epstein turns to the Dutch experience, because the Netherlands is the one country with substantial and documented experience with institutionalized physician-assisted suicide and euthanasia.[42]

Epstein finds that the Dutch experience does not demonstrate serious problems of abuse. In the Netherlands, euthanasia and assisted

35. *See* EPSTEIN, *supra* note 1, at 308-11.
36. *See* Brock, *supra* note 17, at 11.
37. *See* EPSTEIN, *supra* note 1, at 309-10.
38. *See* Orentlicher, *Modest Revolution*, *supra* note 5, at 452-53.
39. *See* EPSTEIN, *supra* note 1, at 313.
40. *See id.* at 314-15.
41. *See id.* at 315-16.
42. *See id.* at 317.

suicide are technically illegal, but physicians can avoid prosecution by adhering to strict guidelines.[43] As Epstein recognizes, leading studies have found that, in about twenty-five percent of cases involving euthanasia or physician-assisted suicide, the strict procedural safeguards are not satisfied.[44] However, Epstein points out, the rule violations do not generally reflect the administration of euthanasia or assisted suicide against the patient's wishes or in response to coercion by family members or physicians. Rather, the violations tend to reflect failures to adhere to reporting requirements or to obtain outside review.[45] In other words, the abuses in the Netherlands do not seem to involve the kinds of problems that the rules are designed to avoid. Epstein also points to private safeguards that have developed in the Netherlands to reinforce the legal safeguards. For example, if patients fear that their lives will be ended against their wishes when they are unable to object because of mental incompetence, they can choose hospitals and nursing homes that, as a matter of institutional policy, have rejected assisted suicide and euthanasia.[46]

Moreover, as Epstein notes, the Netherlands experience may show that legalizing euthanasia or assisted suicide leads to abuse, but the same concerns of abuse arise with the withdrawal of life-sustaining treatment.[47] Indeed, studies have consistently shown that physicians do not follow ethical and legal guidelines when implementing withdrawals of life-sustaining treatment.[48] In a study of living wills, physicians overrode a patient's treatment preference twenty-five percent of the time, and, in three-quarters of those overrides, the physician with-

43. *See id.* at 317-20. For example, the patient must be competent, and the wish to die must be voluntary, persistent, and thoughtfully reached. The patient must also be experiencing unbearable suffering that cannot be relieved by other means, and the physician must consult with an experienced colleague for confirmation that the guidelines have been satisfied. *See* Maurice A.M. de Wachter, *Euthanasia in the Netherlands*, HASTINGS CTR. REP., Mar.-Apr. 1992, at 23, 23; Barney Sneiderman, *Euthanasia in the Netherlands: A Model for Canada?*, 8 HUMANE MED. 104, 105-06 (1992).

44. *See* Paul J. Van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1699, 1701 (1996).

45. *See* EPSTEIN, *supra* note 1, at 321-22. The Dutch studies also indicate that cases in violation of the safeguards often involve a patient who "had in a previous phase of his or her illness expressed a wish for euthanasia should suffering become unbearable," who was "near to death and clearly suffering grievously, yet verbal contact had become impossible," or cases in which the decision had been discussed with the patient but the patient's wishes had not been expressed explicitly and persistently. *Id.*; *see also* Paul J. Van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 672 (1991); Van der Maas et al., *supra* note 44, at 1701-02.

46. *See* EPSTEIN, *supra* note 1, at 324-25.

47. *See id.* at 328.

48. *See* David Orentlicher, *The Limits of Legislation*, 53 MD. L. REV. 1255, 1280-1301 (1994). *See generally* The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995).

held treatment desired by the patient.[49] Similarly, another study has shown that physicians often write do-not-resuscitate orders without discussing the matter with patients who still possess decision-making capacity.[50] Abuses of policy are a serious concern, but they do not explain why the United States has distinguished between treatment withdrawal and euthanasia/assisted suicide. If the risks of such abuse are reason enough to condemn decisions to shorten a patient's life, they should lead a person to oppose treatment withdrawal as well as euthanasia and assisted suicide.[51]

There are two other important arguments for the distinction between treatment withdrawal and euthanasia/assisted suicide that Epstein does not discuss but that are also refutable. First, there are considerations of intent; second there are considerations of negative rights and bodily integrity.

E. Euthanasia and Assisted Suicide Involve an Intent *to Kill*[52]

Treatment withdrawal differs from euthanasia/assisted suicide, it is argued, because the intent is to discontinue an unwanted treatment, not to kill the patient. In contrast, with euthanasia or assisted suicide, the physician must necessarily intend death because the physician relieves the patient's suffering precisely by bringing about the patient's death. In other words, with treatment withdrawal, the patient's death is an unfortunate consequence of the effort to relieve the patient's suffering, while with euthanasia/assisted suicide, the patient's death is the means to the end of relieving the patient's suffering.

This argument depends on an unduly narrow view of euthanasia/assisted suicide, one in which the focus is on the implementation of euthanasia/assisted suicide rather than on the agreement to perform the act. To see how this is so, consider scenarios in which dying patients express concern about their suffering and ask their physicians about the possibility of euthanasia/assisted suicide at some point in the future. If the physicians indicate that euthanasia/assisted suicide will be available in the event that the suffering becomes unbearable and unrelievable, patients will receive a critical reassurance that can alleviate their anxiety about what lies ahead. The patients may never exercise their right to euthanasia/assisted suicide,[53] but it is important

49. *See* Marion Danis et al., *A Prospective Study of Advance Directives for Life-sustaining Care*, 324 NEW ENG. J. MED. 882, 884-85 (1991).

50. *See* Andrew L. Evans & Baruch A. Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 JAMA 2236, 2236 (1985). A do-not-resuscitate (DNR) order means that no efforts will be made to revive a patient who suffers a cardiac arrest (i.e., the heart stops beating).

51. *See* Orentlicher, *Modest Revolution*, *supra* note 5, at 461.

52. The argument in this section was previously made in *id.* at 455-57.

53. Indeed, many patients who receive a lethal supply of a drug in contemplation of assisted suicide never use it. *See* Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) (finding that 39% of 38 patients who received a prescription from their physician for assisted

to their current well-being that they know they can.[54] The patient's death, then, is not simply a means to relieving the patient's suffering. Rather, it is an unfortunate consequence of the effort to reassure the patient about the future.

The intent argument also fails to distinguish between treatment withdrawal and euthanasia/assisted suicide because many treatment withdrawals reflect an intent to die. Patients often refuse life-sustaining treatment because they perceive their life as burdensome and therefore want to die.[55] When physicians discontinue the life-sustaining treatment for these patients, they are doing so to facilitate an intent to die.[56] It is true that the patients would want to live if they were not suffering from their illness or injury, but the same can be said for ill or injured patients who request euthanasia or assistance with suicide.

In any event, arguments about the physician's subjective intent are not sufficient. The law typically holds people responsible for the foreseeable consequences of their acts, even if they had no intent to cause those consequences.[57] If lack of intent is to excuse physicians from causing their patients' deaths, we need an additional argument as to *why* lack of intent ought to matter. If the argument for treatment withdrawal is that patients cannot be required to stay alive if they are experiencing unacceptable suffering or if they have made a considered and competent decision to end their life, we are left with an argument that does not distinguish between treatment withdrawal and euthanasia/assisted suicide.

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suicide did not use the prescription); Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. MED. 1193, 1195 (1998) (finding that 41% of patients who received a prescription from their physician for assisted suicide did not use the prescription).

54. Moreover, because the reassurance depends on the promise that euthanasia/assisted suicide will be available in the future, physicians must deliver on their promise for the patients who request its fulfillment if the promise is to be effective for patients who will never ask for euthanasia/assisted suicide.

55. An example is provided by *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990), discussed by Epstein, in which a 31-year-old man who was quadriplegic and ventilator-dependent received judicial permission to disconnect his ventilator because he felt that life would be intolerable after the death of his terminally ill father. Bergstedt was concerned that others would not give him the same quality of care as his father had given him. *See* EPSTEIN, *supra* note 1, at 286.

56. Moreover, in many cases of treatment withdrawal, the physician may be harboring an independent wish to see the patient die. Nevertheless, we do not limit withdrawal of life-sustaining treatment because of that possibility. *See* John Arras, *News from the Circuit Courts: How* Not *to Think About Physician-Assisted Suicide*, BIOLAW SPECIAL SECTION, July-Aug. 1996, at S171, S181.

57. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 31, at 280-300 (5th ed. 1984).

F. Euthanasia and Assisted Suicide Imply a Positive Right[58]

Some commentators distinguish the withdrawal of treatment from euthanasia/assisted suicide on the ground that a right to refuse treatment is a negative right to be left alone while a right to euthanasia or assisted suicide would be a positive right to command aid. This argument mischaracterizes the nature of a right to euthanasia or assisted suicide. Such a right would not mean that patients could require physicians to assist suicides or perform euthanasia.[59] Rather, the right would prevent the state from interfering when a patient and physician voluntarily agree on a course of euthanasia/assisted suicide. Physicians would participate in euthanasia/assisted suicide only if they were willing to do so, just as physicians perform abortions only if they are willing to do so. A right to euthanasia or assisted suicide, too, is a negative right to be left alone.

Still, some argue, the distinction between treatment withdrawal and euthanasia/assisted suicide reflects the law's traditional protection against unwanted physical touchings.[60] Imposition of unwanted medical treatment is a battery and therefore unlawful. Denying someone the right to euthanasia/assisted suicide does not result in a battery and therefore does not implicate the individual's right to bodily integrity.

There are a few problems with this battery argument. First, we can characterize the right to euthanasia or assisted suicide as a right to preserve bodily integrity. Terminal illness typically ravages a person's body, and a dying person's choice of euthanasia/assisted suicide may reflect a desire to avoid further bodily deterioration.[61] Second, it is not clear that we want to rest individual autonomy on considerations of bodily integrity. If preserving bodily integrity were the critical issue, we would end up with the perverse result that an individual would have a stronger interest in refusing life-sustaining treatment without government interference than in obtaining life-sustaining treatment without government interference.[62] Similarly, a law prohibiting reproduction would be less violative of individual rights than a law prohibiting abortion. However, we should be just as troubled by a law denying procreation as a law denying abortion.

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58. The argument in this section was previously made in Orentlicher, *Modest Revolution, supra* note 5, at 457-58.

59. Epstein makes this point in another context. *See* EPSTEIN, *supra* note 1, at 306.

60. *See* Scofield, *supra* note 17, at 478-79.

61. It may be argued that the bodily invasion by disease is different from the bodily invasion by medical treatment because the invasion is "natural" in the former case. Yet, the disease may have resulted from "unnatural" causes like cigarette smoking or environmental pollution. Moreover, the right to abortion is a right based on considerations of bodily integrity in the face of a "natural" invasion.

62. If we defend the right to obtain life-sustaining treatment without government interference by pointing to other individual interests, then we have conceded that avoiding unwanted invasions of bodily integrity is not the critical issue in determining individual liberties. (The right to obtain treatment without government interference is different from a right to receive necessary medical treatment.)

Even if we agree that there is something to the fact that the right to refuse life-sustaining treatment is a right to be free from battery, it does not help us understand the distinction between treatment withdrawal and euthanasia/assisted suicide. Society recognizes a right to be free of unwanted touchings to ensure that individuals have control over their bodies and are able to exercise self-determination.[63] Yet, a right to euthanasia/assisted suicide would also ensure that individuals have control over their bodies and are able to exercise self-determination.[64] We still need to explain why considerations of personal autonomy are more important with respect to treatment withdrawal than euthanasia/assisted suicide.

III. Explaining the Distinction Between Treatment Withdrawal and Euthanasia/Assisted Suicide

As Epstein observes, none of the usual conceptual or practical arguments really justify the distinction between withdrawal of treatment and euthanasia/assisted suicide. Still, that distinction has existed for many years, and it needs to be explained. Epstein hints at an explanation that I have developed elsewhere and that fits well within his autonomy-based view of how the law should be structured.

I have argued that the withdrawal-euthanasia/assisted suicide distinction reflects an effort to sort morally justified patient deaths from morally unjustified patient deaths—that the key issue is not whether a person dies by treatment withdrawal, assisted suicide, or euthanasia, but whether the person is morally justified in choosing death over continued life.[65] Because there are serious problems with efforts to sort morally justified deaths from morally unjustified ones on a case-by-case basis, the law has relied on the bright-line distinction between treatment withdrawal and euthanasia/assisted suicide, with treatment withdrawals serving as a reasonable "proxy" for morally justified deaths and euthanasia/assisted suicides serving as a reasonable "proxy" for morally unjustified deaths. That is, we permit people to die by withdrawal of treatment because we believe that, in the vast majority of cases, deaths by withdrawal of treatment are morally justified. On the other hand, we do not permit people to die by euthanasia or assisted suicide because we believe that such deaths frequently would not be morally justified. Indeed, suicides are commonly committed by relatively young persons who could have enjoyed life for

63. *See, e.g.*, Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) (holding that surgery without consent is unlawful because "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

64. *See* Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2026-28 (1992).

65. *See* Orentlicher, *Legalization*, *supra* note 5, at 664-65; Orentlicher, *Modest Revolution*, *supra* note 5, at 462-67.

several more decades if they had undergone appropriate psychological counseling or other treatment for their despondency.[66]

This kind of bright-line approach is used often in ethics and law. For example, when we condition voting rights on reaching the age of eighteen, we do so because we think that is a reasonable way to achieve the goal of limiting voting rights to people who have sufficient maturity and judgment to cast a ballot. Most people age eighteen and over have the maturity and judgment to vote; most people under age eighteen lack that maturity and judgment. Clearly, some people will have achieved the requisite maturity and judgment before age eighteen, while other persons achieve it at a later age. Nevertheless, we employ age eighteen for all persons, and we do so because it would be highly problematic for the government to make case-by-case judgments about a person's qualifications for voting.[67]

My argument raises two important questions. First, what do I mean by "morally justified" and "morally unjustified" patient deaths? Second, why is it necessary to have a bright-line approach rather than a case-by-case approach for sorting the morally justified from the morally unjustified? The answer to the second question depends on the answer to the first question.

If one believes that a patient death is morally justified when it reflects a genuine expression of the patient's autonomy, as Epstein does,[68] we can turn to Epstein for an explanation of the need for a bright-line approach to identify morally justified and morally unjustified deaths. If one believes that a patient death is morally justified when the patient is irreversibly ill and suffering greatly, as I think most people actually do believe, we can turn to the argument that I have developed previously.

A. Genuine Expressions of Autonomy as the Moral Justification for a Patient's Death

We can derive an explanation for the law's bright-line approach by considering Epstein's response to an important argument against euthanasia/assisted suicide. As Daniel Callahan has observed, ordinarily the law does not allow a person's consent to authorize the killing of that person by another individual.[69] In his response to Callahan, Epstein discusses why consent is rejected as a defense to homicide in a

66. Fifty-seven percent of all suicides in the United States in 1995 occurred among persons younger than 45 years of age. *See* THE WORLD ALMANAC AND BOOK OF FACTS 1998, at 965 (Robert Famighetti et al. eds., 1997).

67. We might suspect, for example, that certifications of maturity to vote would look very different when Democrats controlled the approval process than when Republicans did so.

68. This argument was also made in an amicus brief filed in the Supreme Court's assisted suicide cases by six distinguished philosophers. *See* Ronald Dworkin et al., *Assisted Suicide: The Philosophers' Brief*, N.Y. REV. BOOKS, Mar. 27, 1997, at 41.

69. *See* EPSTEIN, *supra* note 1, at 299-300.

society in which the law normally gives great weight to a person's consent.[70] He points out that, when the law decides whether there is consent to a particular agreement, it can rely on "observation in the individual case" or "inference from background knowledge about general patterns and motivations of human behavior."[71] For some transactions, we assume that people act in their self-interest and that, if they agreed to a deal, they must have done so because it made them better off. In such cases, the only issue for the state is to ensure that the person did not act out of incompetence, fraud, or duress.[72] For other transactions, however, it is highly unlikely that a competent person would make the alleged deal in the absence of fraud and duress. If such transactions occur, it is much more likely that they reflect undetected incompetence, fraud, or duress than that they reflect a genuine expression of autonomy by the person who appears to be disadvantaged by the agreement.[73] Thus, for example, when a person is killed, and the killer claims consent on behalf of the victim, we believe it is highly unlikely that the victim actually consented. Moreover, Bayesian analysis tells us that efforts to ascertain whether genuine consent was given are going to be unhelpful.[74] Because our methods of ascertainment are necessarily imperfect, and the likelihood of genuine consent is very low, most cases in which we think there was genuine consent will in fact be cases in which we falsely conclude that there was genuine consent.[75] In a case of a killing, we might be fooled by the killer into believing that consent was given,[76] and we cannot turn to the victim for the other side of the story. Accordingly, we reject consent as a defense to a killing.[77] We assume that all killings are involuntary and therefore unlawful.

How does this point help us with the distinction between treatment withdrawal and euthanasia/assisted suicide? When a patient refuses life-sustaining treatment, we recognize that there are good

70. *See id.* at 300-05.

71. *Id.* at 300-01.

72. *See id.* at 301.

73. *See id.* at 301-02.

74. *See id.* at 302.

75. As indicated, this conclusion follows from the assumption that we believe it highly unlikely that the expression of autonomy is genuine *in the particular circumstances* and from the fact that we have imperfect tests for judging the authenticity of expressions of autonomy. With imperfect tests and an unlikely event, most times when the test is positive, it is falsely positive. If you are not familiar with Bayesian analysis, it works as follows: Suppose there is a test that is used to screen for a particular genetic variant. If the variant is present in 1 in 1000 people (i.e., an unlikely event), and the test is administered on people randomly, then 999 of every 1000 people tested will not have the variant. If the test is wrong 10% of the time when a person without the variant is tested, it will wrongly come up positive for 99 of the 999 people without the variant. Even if it correctly identifies the 1 in 1000 people with the variant, the test will be falsely positive 99% of the time that it comes up positive (99/(99 + 1)).

76. Some people are very persuasive liars.

77. *See* EPSTEIN, *supra* note 1, at 304. This argument by Epstein is a very important one that is frequently overlooked by commentators on assisted suicide.

reasons for a patient to do so. The patient may find the side effects of the treatment intolerable, may feel that the benefits of continued life are outweighed by its burdens, or may have religious objections to the treatment. Given these reasons why patients may refuse treatment, we allow a right to refuse treatment as long as we are comfortable that the withdrawal is consistent with the patient's wishes or best interests. In other words, we can rely on "observation in the individual case."

With euthanasia or assisted suicide, on the other hand, we have good reason to suspect that the person's choice is not a genuine expression of autonomy. Treatable depression is a common reason for patients to attempt, or seek help with, suicide. We worry that the same would be true for euthanasia. Because we will make mistakes in deciding whether a person is choosing euthanasia/assisted suicide genuinely or not, we choose to prohibit the practices entirely. In other words, we rely on "inference from background knowledge about general patterns and motivations of human behavior."[78]

B. Irreversible Illness and Great Suffering as the Moral Justifications for a Patient's Death

There is a second important argument for categorical rules rather than case-by-case analysis when the issue is whether a patient may choose to die by treatment withdrawal, assisted suicide, or euthanasia. This argument depends on a different theory of morally justified and morally unjustified deaths than that proffered by Epstein. Although autonomy might be the appropriate principle for establishing the morality of a patient's desire to die, I believe our society actually operates on the basis of a different principle. We in fact respect decisions to refuse life-sustaining treatment out of the moral sense that people should be able to choose death when they are irreversibly ill and suffering intolerably. Choosing death is generally a moral wrong even when the choice is made autonomously,[79] but, when life becomes sufficiently miserable, a person can reasonably believe that continued life

78. *Id.* at 300-01.

79. There are several reasons why one might believe that choosing death is morally wrong and therefore that the state should intervene to prevent a patient from choosing death. For example, there are important concerns about preserving the moral worth of society. If patients are allowed to die when they consent, people may have less respect for life and be less troubled when death comes about involuntarily. There are also concerns about avoiding the domination of one group in society by other groups (here, preventing the victimization of severely disabled persons). *See* David Orentlicher, *Physician-Assisted Dying: The Conflict with Fundamental Principles of American Law*, *in* MEDICINE UNBOUND: THE HUMAN BODY AND THE LIMITS OF MEDICAL INTERVENTION 256 (Robert H. Blank & Andrea L. Bonnicksen eds., 1994).

Even if one believes in individual autonomy as the prevailing ethic, one still might conclude that the state should intervene to prevent a patient from choosing death. We do not permit people to take action that defeats autonomy because we believe that it is important to preserve freedom of choice in areas of profound consequence to happiness. Thus, for example, we do not permit people to become a slave or renounce their right to a divorce. *See id.* at 260.

is worse than death.[80] As the Massachusetts Supreme Court has written:

> There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended. Even if we assume that the State has an additional interest in seeing to it that individual decisions on the prolongation of life do not in any way tend to "cheapen" the value which is placed in the concept of living, . . . we believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness.[81]

Under a regime of case-by-case judgments, some representative of the state would have to possess authority for deciding whether the treatment withdrawal or the euthanasia/assisted suicide should be permitted. Someone would have to decide whether the person's suffering is severe enough such that society should allow the person to die. It is not likely an authority that physicians would welcome, nor is it an authority that we would likely trust to physicians or other representatives of the state.[82] The judgment that a person would be better off dead is a judgment that can be made only by individuals for themselves.[83] Accordingly, although the right to refuse life-sustaining treatment once was viewed as existing only when a patient's prognosis was deemed by society as suitably dim and when the patient was refusing care that was deemed by society as particularly burdensome,[84] it has become a right of virtually any patient to refuse virtually any treatment.[85] We can permit all patients to refuse life-sustaining treatment because the typical withdrawal case in fact involves a patient

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80. I base my view on the arguments that have been made by courts, scholars, and religious authorities to justify a right to refuse life-sustaining treatment. I have explained my view in greater detail in Orentlicher, *Modest Revolution*, *supra* note 5, at 450-51.

81. Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425-26 (Mass. 1977) (involving the right of a profoundly mentally retarded 67-year-old man to have chemotherapy withheld for leukemia that would respond poorly to treatment).

82. *See* Callahan, *supra* note 20, at 55.

83. *See* LAURENCE H. TRIBE, AMERICAN CONSTITUTIONAL LAW 1367-68 (2d ed. 1988) (observing that "having the state regularly make judgments about the value of life" is "the worst kind of state paternalism"). To be sure, decisions to withdraw life-sustaining treatment are made for incompetent persons. There, however, it is generally a family member, friend, or guardian who decides on the person's behalf, not someone representing the state's interests.

It is true that the government has to establish the bright-line distinction between withdrawal of treatment and assisted suicide, but that is done in an open process with full public awareness and participation. Moreover, because *all* persons are permitted to refuse life-sustaining treatment, there is no suggestion that some lives have greater value than others.

84. *See, e.g.*, *In re* Quinlan, 355 A.2d 647, 664 (N.J. 1976) ("[T]he State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.").

85. *See supra* note 22.

who is irreversibly ill and suffering.[86] However, we cannot permit assisted suicide or euthanasia as a general right because many people who are not irreversibly ill would choose to die by suicide or euthanasia.

C. *Changes in the Law*

Given the important reasons for choosing bright-line rules and categorical judgments over case-by-case analysis, it is not surprising that changes in the law permitting assisted suicide do so by adopting a new bright-line, categorical approach to distinguishing between permissible and impermissible patient deaths. When Oregon and the U.S. Courts of Appeal for the Second and Ninth Circuits recognized a right to assisted suicide,[87] they did so only for terminally ill persons. Under the approaches of Oregon and the two circuit courts, all terminally ill patients may choose a lethal dose of medication whether or not they are suffering greatly; neither the statute nor the two decisions qualify their grant of a right to assisted suicide in terms of the patient's degree of suffering.[88] Conversely, no nonterminally ill patients may choose to end their lives with a lethal dose of medication even if they are suffering greatly.[89] In addition, as before, all patients who desire withdrawal of life-sustaining treatment may choose that course whether or not they are suffering greatly. With the infeasibility of case-by-case determinations, the Second and Ninth Circuits and Oregon chose a new rule to distinguish between permissible and impermissible patient deaths, and the new rule essentially reflects the view that the typical case in which a terminally ill patient desires suicide is a case in which the patient's death is morally justifiable.[90]

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86. If a patient refuses life-sustaining treatment but is not irreversibly ill, treatment will often be imposed in violation of the person's legal rights. *See, e.g.*, Stamford Hosp. v. Vega, 674 A.2d 821, 825-26, 832 (Conn. 1996) (holding that the plaintiff's "common law right of bodily self-determination was entitled to respect" and that it was error for the trial court to allow the hospital to administer blood transfusions against the patient's wishes); *In re* Dubreuil, 629 So. 2d 819, 821, 828 (Fla. 1993) (same); Fosmire v. Nicoleau, 551 N.E.2d 77, 79, 84 (N.Y. 1990). *Dubreuil* is particularly striking because the Florida Supreme Court had previously held that a young woman could refuse blood transfusions. *See* Public Health Trust v. Wons, 541 So. 2d 96, 97-98 (Fla. 1989).

87. The two circuit courts were later reversed by the U.S. Supreme Court in *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997), and *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

88. *See* Oregon Death with Dignity Act, OR. REV. STAT. § 127.800 (1996); Quill v. Vacco, 80 F.3d 716, 731 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997); Compassion in Dying v. Washington, 79 F.3d 790, 793-94 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, 117 S. Ct. 2258 (1997).

89. *See* Oregon Death with Dignity Act, OR. REV. STAT. § 127.805; *Quill*, 80 F.3d at 731; *Compassion in Dying*, 79 F.3d at 793-94.

90. The point about bright-line, categorical approaches also explains the emphasis in the law on physical, rather than psychological, pain as a justification for patients ending their lives. *See, e.g.*, *Glucksberg*, 117 S. Ct. at 2311 (Breyer, J., concurring) (observing that the core of a right to die with dignity would involve "personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe *physical* suffering—combined") (emphasis added). When people claim physical pain from physical illness, we can be more confi-

Epstein makes a similar point. In his discussion of why it makes sense to have a categorical prohibition against killing, which is outlined above, Epstein observes that a categorical prohibition on euthanasia/assisted suicide no longer makes sense when we are talking about terminally ill persons.[91] We may doubt the sincerity of a suicide wish by a twenty-eight-year-old, physically healthy person, but we have good reason to respect the choice of euthanasia or suicide by someone with a metastatic cancer who is suffering great pain and indignities and who has only a few weeks of life left. Accordingly, concerns about the genuineness of consent do not apply to euthanasia/assisted suicide in the context of terminal illness.

IV. CONSTITUTIONAL ISSUES

On the constitutional issue, Epstein is correct. As he observes, the law is indeterminate. Powerful arguments can be launched both for and against a constitutional right to euthanasia or assisted suicide.[92] Indeed, if anything, Epstein underestimates the indeterminacy of constitutional principles. He assumes that, if one accepts tradition as the basis for locating constitutional rights, then one must reject a constitutional right to euthanasia or assisted suicide.[93] Yet, the argument from tradition depends on whether one defines the right at stake as a right to euthanasia or assisted suicide without governmental interference, or a right to obtain relief from intolerable suffering without governmental interference. If we frame the issue as involving a right to obtain relief from intolerable suffering, then we can locate a right to euthanasia or assisted suicide within that tradition.[94]

Given the indeterminacy of the issue, and especially the uncertainty about which risks are greater—the risk of too many deaths from allowing euthanasia or assisted suicide, or the risk of too much suffering from denying euthanasia or assisted suicide—Epstein would defer to the judgment of legislatures.[95]

This is a reasonable position. It is true that proponents of a right to assisted suicide or euthanasia reject the argument that risks of abuse are sufficient to maintain the prohibitions on those practices. Still, these proponents might be concerned enough by the risks that

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dent that the pain is real, and therefore that the desire for death is legitimate, than when the patient claims psychological pain from psychological illness.

91. *See* EPSTEIN, *supra* note 1, at 304-05.

92. *See id.* at 329-43.

93. *See id.* at 329.

94. This argument was made in the brief of the United States in *Glucksberg*. Brief for the United States as Amicus Curiae Supporting Petitioners, Washington v. Glucksberg, 117 S. Ct. 2258 *passim* (1997) (No. 96-110), *reprinted at* Center for Bioethics at the University of Pennsylvania, *Physician Assisted Suicide Amicus Briefs* (visited July 6, 1998) <http://www.med.upenn.edu/~bioethic/PAS/43a.htm/> (on file with the *University of Illinois Law Review*).

95. *See* EPSTEIN, *supra* note 1, at 329-31.

they would rather have the practices allowed at first on a limited basis to ensure that their suppositions are correct. Moving state-by-state rather than all at once, as this country did for fourteen years with the withdrawal of life-sustaining treatment,[96] makes sense on matters of life and death.

A. The Existence of a Right to Euthanasia

Still, it is not possible to maintain an argument against a constitutional right to euthanasia. That battle has already been lost. Once the Supreme Court recognized a constitutional right to refuse life-sustaining treatment in *Cruzan v. Director, Missouri Department of Health*,[97] it effectively recognized a constitutional right to euthanasia. A right to refuse life-sustaining treatment necessarily implies a right to euthanasia because patients are entitled both to receive medications that will relieve their suffering without killing them and to refuse any life-sustaining treatment, including artificial nutrition and hydration. With some terminally ill patients, these two entitlements together become a right to euthanasia.[98]

This implication of *Cruzan* was made clear by the debate that surrounded the Court's physician-assisted suicide cases. During the debate, proponents of a constitutional right to assisted suicide argued for its recognition on the ground that it is not always possible to relieve the suffering of terminally ill patients.[99] In some cases, it was argued, assisted suicide is a necessary means for the relief of suffering. In response to that argument, Justice Breyer in his *Glucksberg* concurrence observed that, for terminally ill patients who are suffering intolerably, physicians can sedate the patient so that the patient is no longer able to sense the suffering.[100] Indeed, if necessary, physicians can sedate the patient into a coma.[101] Once a terminally ill patient is about to be sedated into a coma (i.e., "terminal sedation"), the patient is likely to see no point in receiving food and water[102] and therefore will ask that food and water be withheld or withdrawn.[103] It is the

96. The New Jersey Supreme Court first recognized such a right in 1976 in *In re Quinlan*, 355 A.2d 647 (N.J. 1976), and the U.S. Supreme Court recognized the right in 1990 in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

97. 497 U.S. 261.

98. My argument here draws on David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1236, 1238 (1997), and David Orentlicher, *The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia*, HASTINGS CONST. L.Q., Summer 1997, at 947.

99. *See Glucksberg*, 117 S. Ct. at 2311-12 (Breyer, J., concurring).

100. *See id.* at 2311.

101. *See id.* at 2311-12.

102. In some cases involving terminal sedation, the patient will already be unable to eat.

103. While in practice, terminal sedation seems to be limited to terminally ill patients, there is no reason in principle why it must be so limited. For discussions of terminal sedation, see Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10(2) J. PALLIATIVE CARE 31 (1994); William R. Greene & William H. Davis, *Titrated Intravenous Barbiturates in the Control of Symptoms in*

combination of a physician-induced coma and the withholding or withdrawal of food and water that constitutes euthanasia. The physician is intentionally engaging in action that will inevitably result in the patient's death.[104]

One might try to recharacterize sedation plus the withholding of food and water as a form of treatment withdrawal rather than as a form of euthanasia. However, that approach will not work. As discussed earlier, treatment withdrawals are justified on the ground that the patient dies from the natural progression of the underlying disease rather than from the physician's active intervention.[105] Nancy Cruzan died when her feeding tube was withdrawn because her automobile accident left her in a persistent vegetative state that in turn deprived her of the ability to eat food and drink water.[106] Kenneth Bergstedt died when his ventilator was withdrawn because his swimming injury left him quadriplegic and unable to breathe on his own.[107] In contrast, when a terminally sedated patient dies for lack of a feeding tube, it is the physician-induced coma rather than the patient's underlying disease that makes the patient unable to eat or drink.

One might also try to distinguish terminal sedation from euthanasia by citing the principle of double effect. Under that principle, physicians may take steps that might hasten a patient's death as long as the steps are a reasonable effort to treat the patient's suffering, and the patient's death is not intended.[108] For example, it is permissible to give analgesics or sedatives to alleviate a patient's pain even if the drugs might sufficiently diminish the patient's respiratory drive such that the patient is no longer able to breathe. However, the principle of double effect justifies only the sedation part of terminal sedation.

Patients with Terminal Cancer, 84 S. MED. J. 332 (1991); Timothy E. Quill et al., *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099, 2100 (1997); Timothy E. Quill & Robert V. Brody, *"You Promised Me I Wouldn't Die Like This!": A Bad Death as a Medical Emergency*, 155 ARCHIVES INTERNAL MED. 1250 (1995); Subha Ramani & Anand B. Karnad, *Long-Term Subcutaneous Infusion of Midazolam for Refractory Delirium in Terminal Breast Cancer*, 89 S. MED. J. 1101 (1996).

104. It is true that the withholding of food and water is an "omission" and therefore a different kind of action than an injection of a drug, and it is also true that the law often distinguishes "acts" from "omissions." Nevertheless, as Justice Antonin Scalia has observed, the line between appropriate and inappropriate patient deaths is not defined simply by the distinction between action and inaction. *See* Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 296 (1990) (Scalia, J., concurring) (observing that if "one may not kill oneself by walking into the sea," then one may also not "sit on the beach until submerged by the incoming tide").

Moreover, ethicists have long argued that withholding life-sustaining treatment is worse than treatment withdrawal because treatment withdrawal at least comes after a trial of the therapy, while withholding denies the chance for an unexpected recovery.

105. *See supra* text accompanying note 15.

106. *Cf. In re* Conroy, 486 A.2d 1209, 1226 (N.J. 1985) ("[R]ejecting . . . artificial means of feeding would not constitute attempted suicide, as . . . death would result, if at all, from [the] underlying medical condition, which included [an] inability to swallow.").

107. *See* McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

108. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 206-11 (4th ed. 1994).

We cannot justify the withdrawal of food and water part of terminal sedation, for that step does nothing to relieve the patient's suffering; it serves only to bring on the patient's death. If it is argued that withdrawal of food and water is a permissible act, then we are back to the previous response that it is permissible only because the patient's inability to eat or drink results from an underlying disease.

A third potential basis for distinguishing terminal sedation from euthanasia—the physician's intent—also fails. Although I have argued that considerations of intent do not help us distinguish among treatment withdrawal, assisted suicide, and euthanasia,[109] arguments about intent are still unhelpful even if we really could distinguish treatment withdrawal from euthanasia in terms of the physician's intent. For just as euthanasia is problematic because the patient's suffering is relieved only by ending the patient's life, sedation plus the withholding of food and water is problematic because the patient will, with certainty, die. The withholding of food and water will inevitably cause the patient's death, because no one can survive very long without sustenance. Thus, unlike other cases of treatment withdrawal, there is no possibility that the physician will have misjudged the patient's dependence on the treatment.[110] Moreover, the sedation will preclude the possibility of patient survival from a mistaken prognosis. Even if there is an improvement in the patient's underlying condition, the sedation will prevent the patient from starting to eat or drink.[111] In short, if the physician's intent is the key, terminal sedation is still more like euthanasia than it is like the withdrawal of treatment.

Finally, it might be asserted that, with terminal sedation, the patient's death really is the result of the underlying disease rather than the physician's action. According to this argument, it is the patient's illness that creates the need for the sedation. The underlying disease is responsible for the patient's suffering and for the patient's request for palliative care. But this logic would also justify euthanasia (and assisted suicide). With euthanasia or assisted suicide, it is the patient's underlying disease that causes the patient to ask for a life-ending drug.

It is not only the case that the right to refuse life-sustaining treatment leads to a right to euthanasia, it is also the case that we would not want to allow a right to refuse treatment without a right to euthanasia in the form of terminal sedation. With a strict ban on euthanasia, patients who are suffering so greatly that they need sedation into a coma would have to waive their right to refuse life-sustaining treatment once they had accepted heavy sedation. These patients would

109. *See supra* text accompanying notes 52-57.

110. When a ventilator is withdrawn, it is possible that the patient will be able to breathe without assistance.

111. This fact distinguishes the terminally sedated patient from other patients, like Nancy Cruzan, whose feeding tubes are withheld. In theory, it was possible for Ms. Cruzan to recover her ability to eat and drink after her feeding tube was removed.

have to choose between obtaining relief from suffering and retaining their right to refuse treatment. Such a Hobson's choice would be profoundly unfair to dying patients.

B. Assisted Suicide as a Preferred Right

Given the existence of a right to euthanasia through terminal sedation, a right to assisted suicide looks very different. Although we should be concerned about the increased risks to patients if assisted suicide is legalized in a world without assisted suicide or euthanasia, assisted suicide is more likely to reduce the risks to patients in a world with euthanasia because euthanasia is more subject to abuse than assisted suicide.

Like other forms of euthanasia, terminal sedation not only raises *all* of the risks of assisted suicide—any patient who could die by assisted suicide could also die by terminal sedation[112]—it raises an additional important risk. Assisted suicide has a built-in safeguard to protect the incompetent patient. Because the patient committing suicide must fill a prescription and ingest the death-causing drug, it is difficult or impossible to coerce most mentally incompetent persons to choose suicide.[113] However, any incompetent person can be sedated and have food and water withdrawn.

Assisted suicide and other forms of euthanasia (e.g., lethal injections) also provide greater benefit to patients than terminal sedation. Dying patients often want to end their lives because of the indignities of a prolonged death and the distorted memories that they will leave behind. Assisted suicide and lethal injections allow patients to end the dying process very quickly rather than waiting for dehydration or starvation to end their lives.

Accordingly, although the Supreme Court had no choice but to permit euthanasia in the form of terminal sedation, it did have a choice whether to permit the potentially safer and more beneficial practice of assisted suicide. Its decision not to do so is a potentially serious flaw in the Court's reasoning.

V. CONCLUSION

As the debate over legalizing assisted suicide moves to the states, Richard Epstein's insights will provide an important resource for scholars, legislators, judges, and the public. Although many of his ar-

112. In other words, if assisted suicide and euthanasia are problematic because they kill the healthy as well as the sick, then terminal sedation is similarly problematic because it can kill the healthy as well as the sick. Similarly, if assisted suicide is problematic because we cannot trust physicians to limit it to patients who are truly dying and suffering intolerably, then we cannot trust physicians to limit terminal sedation to such patients. Whatever guidelines physicians observe in concluding that a patient is a candidate for terminal sedation, they can also observe in concluding that a patient is a candidate for euthanasia or assisted suicide.

113. *See* Angell, *supra* note 21, at 51.

guments will not persuade policy makers (e.g., the view that the terms of the patient-physician relationship are entirely a matter to be decided by patients and their physicians),[114] he offers alternative arguments that do not rely so heavily on his own world view (e.g., the physician's professional role as healer cannot refute a right to assisted suicide because physicians cause patients' deaths when they withdraw life-sustaining treatment).[115]

Of particular value is Epstein's response to the important concern that society has no principled basis for granting terminally ill patients a right to assisted suicide or euthanasia without granting other persons such a right. If terminally ill patients can choose suicide because they are irreversibly ill and suffering greatly, why cannot other patients so choose if they are irreversibly ill and suffering greatly? Indeed, it is observed, the patient who is not terminally ill has more time in which to suffer and therefore arguably has a stronger basis for choosing suicide. This concern has been raised by the Supreme Court in the physician-assisted suicide cases and by many scholars.[116] Epstein responds to this concern with his important point about judging whether an autonomous decision has been made by "observation in the individual case" or "inference from background knowledge about general patterns and motivations of human behavior."[117] As Epstein suggests, it is possible to permit a limited right to assisted suicide without automatically becoming committed to an expansive right to assisted suicide.[118] Accordingly, it is reasonable for states to recognize a right to assisted suicide without having to fear an inevitable slide down the slippery slope to a world with unconstrained physician-assisted suicide or euthanasia.

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114. *See* EPSTEIN, *supra* note 1, at 307.

115. *See id.* at 290-92.

116. *See, e.g.*, Washington v. Glucksberg, 117 S. Ct. 2258, 2274 (1997) (recognizing that "the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia"); Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 744-54 (1995) (discussing why it is likely that a right to assisted suicide would be extended to include patients who are not terminally ill).

117. EPSTEIN, *supra* note 1, at 300-01; *see supra* text accompanying notes 75-77.

118. *See also* Orentlicher, *Modest Revolution*, *supra* note 5, at 471-75 (making the same point from a different perspective).