

Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession

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I. INTRODUCTION

The United States Supreme Court will soon decide whether to promulgate a new constitutional doctrine effectively ending the ability of state governments to interfere with physician-assisted suicides. If the Court takes this step, it will instantly legitimate the controversial campaign of Jack Kevorkian and ensure that countless new Kevorkians will arise. But this obvious result may be among the least important effects of such a ruling. By ousting our elected governments from the field, the Supreme Court would necessarily impose on itself (and on the lower courts that operate under its supervision) an awesome new set of regulatory tasks. The courts would henceforth become responsible for resolving some of the most difficult dilemmas facing the medical profession and some of the most delicate aspects of the relationship between physicians and their patients. There are good reasons to fear that the result would be a disaster.

Two state laws that make it a crime for physicians to assist their patients in committing suicide are now under review by the Supreme Court. We believe the statutes should be upheld. They embody a professional consensus—one that has existed for thousands of years—according to which physicians should never assist any person in committing suicide. This judgment remains entirely defensible as a matter of medical ethics and as a matter of public policy. Modern developments in medical technology have created difficult new dilemmas about the care of patients at the end of life, but these developments have emphatically not rendered the traditional bright-line rule outmoded. If anything,

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they may have made the traditional rule more important than ever. Although it is possible to imagine that altering this rule would have beneficial effects for some individuals, any claim that such alterations would have *net* benefits for our society is entirely speculative and highly dubious. For the judiciary to fashion a new rule, and impose it on the nation as a matter of constitutional law, would require recklessness of a very high order.

Fortunately, our federal system offers a ready and superior alternative to this kind of judicial adventurism. As Justice Brandeis noted long ago: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."¹ One state (Oregon) has begun to experiment with changes in the traditional rule against physician-assisted suicide, and more will undoubtedly follow should the benefits of the new rules appear to exceed their costs. If, however, as we believe likely, these experiments prove to be ill-advised, citizens in the more cautious states will not be harmed and those in the bolder states will be able to repair their mistakes. There is no reason to think that the collective judgment of our state governments about these matters is less reliable over time than the judgment of the lawyers with whom we staff our federal courts. And if those lawyers decide to substitute their own fallible judgments, all the benefits of leaving the issues to democratic processes will be lost.

The Supreme Court can and should avoid this mistake. Nothing in the Constitution or in existing constitutional law requires the judiciary to assume responsibility for determining what rules should be applied to physician-assisted suicide. Furthermore, even if the Court concludes that constitutional law should recognize both a "right to die" that protects patients from undergoing unwanted life-prolonging medical treatments and a "right to suicide" protecting individuals who wish to end their own lives, statutory bright-line rules against assisted suicide should still be upheld. To show why the Court should arrive at this conclusion, we briefly review the main legal issues, and then explore the role of the traditional ban on assisted suicide in medical practice and its effects on the medical profession. We believe that the nature of medical practice and of professional regulation in this area should persuade the Supreme Court to opt for the most modest

1. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 386-87 (1932) (Brandeis, J., dissenting).

and cautious approach it can find in this difficult and uncertain area.

II. THE LEGAL FRAMEWORK

Like most other states, New York and Washington have statutes making it a crime for any person to assist another to commit suicide. These statutes have been declared unconstitutional by the United States Courts of Appeals for the Second Circuit and the Ninth Circuit respectively, and those decisions are now being reviewed by the Supreme Court.² There are several different legal approaches that the high court might adopt, and we begin with a brief summary of each.

The Supreme Court could conclude that the Constitution simply does not create any right to commit or attempt suicide, and therefore does not create any right to assist or to obtain assistance in committing suicide. Three facts powerfully support this conclusion. First, the Constitution is silent on the subject of suicide. Second, laws against assisting in a suicide were commonplace when the Constitution and its subsequent amendments were ratified. And third, there is no Supreme Court precedent recognizing such a right. These facts, indeed, have already induced Justice Scalia to announce that "the federal courts have no business in this field."³

If a majority of the Justices join Scalia in reaching this conclusion, the issues discussed in this Essay will not bear directly on the Court's analysis. Majority support for Justice Scalia's position, however, is not certain and may not even be likely. As the Second and Ninth Circuit decisions suggest, there are several existing constitutional doctrines that might be extended so as to invalidate statutes like those in New York and Washington.

It is possible, for example, that the Supreme Court might find that statutes banning assisted suicide violate the Equal Protection Clause. This was the approach taken by the Second Circuit, which held that New York's assisted-suicide statute discriminates irrationally between terminally ill patients on life support systems (who can end their lives by ordering the termination of such treatments) and terminally ill patients who do not have this option because they are not on life support systems.⁴ The Second

2. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted* *Vacco v. Quill*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858); *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *en banc*, *cert. granted* *Washington v. Glucksberg*, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 96-110).

3. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

4. *Quill*, 80 F.3d at 729-31.

Circuit acknowledged that the classifications created by the statute could be invalidated under standard equal protection analysis only if they have no rational relationship to any legitimate state interest.⁵ When applying the rational basis test, however, the Supreme Court ordinarily gives great deference to the judgment of state legislatures, even to the extent of hypothesizing rational but unarticulated grounds on which the challenged statute could have been adopted.⁶ There is an abundance of easily identifiable legitimate reasons that justify upholding statutes that proscribe assisted suicide. Perhaps the most obvious is the state's interest, which this Essay discusses in detail, in preserving the valuable common sense distinction that physicians make all the time between allowing nature to take its course with a gravely ill patient and stepping in to kill that patient.

A different line of argument, which was developed by the Ninth Circuit when it invalidated the Washington statute, would start from the Due Process Clause. In *Roe v. Wade* and subsequent cases, the Supreme Court interpreted this constitutional provision to mean that governments are sharply constrained in their ability to interfere with women's liberty to obtain abortions. In *Casey*, the Court's most recent abortion decision, the constitutional right at stake was described at one point as "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."⁷ One might conclude on the basis of this passage that a decision to commit suicide, like a decision to have an abortion, is encompassed by a judicially recognized right to make private decisions about the mystery of human life. If the Supreme Court were to draw this conclusion, then legal restrictions on suicide, and on access to at least some forms of physician assistance in committing suicide, might well be invalidated unless they were narrowly tailored to serve clearly defined governmental interests, such as the prevention of euthanasia masquerading as assisted suicide.

Although it is conceivable that the Supreme Court might take this step, it would be a tremendous and unnecessary leap. The "mystery of human life" passage in *Casey* was obiter dicta. The *Casey* Court, moreover, emphasized that the *Casey* holding was itself dictated largely by respect for the "central holding" in *Roe v. Wade*.⁸ When the *Casey* opinions are read in their entirety, it

5. *Id.* at 729.

6. *See, e.g.,* *Kadrmas v. Dickinson Pub. Schools*, 487 U.S. 450, 462-63 (1988).

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

8. *See Casey*, 505 U.S. at 853 ("While we appreciate the weight of the arguments made on behalf of the State in the case before us, arguments which in their ultimate formulation conclude that *Roe* should be overruled, the reservations any of us may have

is clear that no extension of the due process doctrine beyond the abortion context was implied. A cautious and judicious interpretation of *Casey* seems especially appropriate in light of the fact that the *Casey* Court in fact trimmed back the right declared in *Roe v. Wade*.

A much more plausible source of guidance on the assisted-suicide issue can be found in the Supreme Court's 1990 "right to die" decision in *Cruzan*.⁹ In that case, the Court rejected the relevance of the right to privacy invoked in the abortion decisions.¹⁰ Instead, *Cruzan* held that *if* the Due Process Clause protects an individual's "liberty interest" in refusing unwanted medical treatment, state governments are still free to insist that comatose patients continue to receive life-sustaining treatments unless there is clear and convincing evidence that the patient would have wished to have the treatments withdrawn.¹¹ Although the Court did not hold that there is a constitutional right to refuse unwanted medical treatment, neither did it signal any strong reluctance to reaching that conclusion in a case where the issue might be properly presented.¹² One member of the five-Justice majority, moreover, seemed to conclude that the Constitution protects the "freedom to determine the course of [the patient's] own treatment."¹³

As a logical matter, a right to control one's own medical treatment does not imply a right to commit suicide. Intuitively, however, it is a relatively short step from recognizing a right to refuse the drugs that are necessary for the maintenance of life to

in reaffirming the central holding of *Roe* are outweighed by the explication of individual liberty we have given combined with the force of stare decisis."). See also *id.* at 871 (joint opinion of O'Connor, Kennedy, and Souter, JJ.) ("[W]e are satisfied that the immediate question is not the soundness of *Roe*'s resolution of the issue, but the precedential force that must be accorded to its holding.").

9. Although *Cruzan* is sometimes referred to as a "right to die" case, there is an important distinction between a right to die and a right to refuse unwanted medical treatment. The *Cruzan* Court carefully respected this distinction by noting that the case involved "what is *in common parlance* referred to as a 'right to die.'" *Cruzan*, 497 U.S. at 277 (emphasis added). A confused term, "right to die" is capable of more than intellectual mischief. For an analysis, see Leon R. Kass, *Is There a Right to Die?*, 23(1) HASTINGS CENTER REPORT 34, esp. 34-37 (Jan./Feb. 1993).

10. *Cruzan*, 497 U.S. at 279 n.7.

11. *Id.* at 278-82.

12. See *id.* at 279 ("Although we think the logic of the cases discussed above would embrace such a liberty interest [in refusing life sustaining medical treatment including artificially delivered food and water], the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.").

13. *Id.* at 289 (O'Connor, J., concurring).

accepting a right to ingest the drugs that will end one's life. If the justification for requiring the government to have a good reason for invading your body is that it is *your* body, then it seems to follow that the government should be required to offer a good reason before forbidding you to invade your own body. It thus seems fairly likely, though by no means inevitable, that the Supreme Court will find that the Constitution obliges the government to produce a good reason for interfering with a person's decision to commit suicide, at least when that decision is supported by reasons like the desire to avoid excruciating pain.

Assuming that the Court would conclude that some sort of right to suicide is protected by the Constitution, it is our contention that the Court should nonetheless uphold statutes prohibiting *assisted* suicide. Or, in other words, that the governmental interest in maintaining a bright-line rule against assisting with suicides is sufficient to outweigh whatever due process "liberty interest" an individual may have in obtaining such assistance. We do not propose to catalogue all the reasons that a state might advance in defense of its assisted-suicide statute, but rather to focus our attention on a particular set of interests that tend to be neglected or underemphasized in legal discussions of assisted suicide.

Because of the law's focus on individual rights, which are abstractions, it is easy for courts to misapprehend how decisions like the one at issue here will actually affect the very human individuals and institutions whose rights the courts must allocate. In particular, legal arguments alone will not easily reveal to the Justices how profoundly the medical profession and the practice of medicine may be changed if physicians begin participating in suicide by their patients. We turn now to an exploration of the reasons for the ethical prohibition against physician-assisted suicide and of the importance of continuing to allow that ethical prohibition to be reinforced with legal sanctions. If the Justices fully grasp those reasons, we do not believe they will take the fateful step of invalidating the New York and Washington statutes.

III. PHYSICIAN-ASSISTED SUICIDE AND THE MEDICAL ETHIC

Although the New York and Washington statutes prohibit assisted suicide generally, the practical effect of the Court's decision will be almost entirely limited to the medical profession—primarily physicians, but also those, like nurses and pharmacists, who generally operate under their supervision. It is conceivable, of course, that someone might want to induce another to shoot him in the back of the head (either because the would-be suicide lacked courage or had had his hands amputated). But

this must be extraordinarily rare. More realistically, family members are sometimes enlisted to procure (and perhaps even administer) poisons. But this phenomenon is limited both by the relative crudity of the poisons available to the general public and by the natural reluctance of most family members to get involved directly in killing their relations.

What is really at stake here is the practice of physician-assisted suicide. Doctors pretty much have a legal monopoly on the most desirable deadly drugs, and they control the settings in which people can be killed (or helped to kill themselves) with the least mess and disruption for everyone concerned, namely hospitals. Furthermore, physicians are psychologically well-placed for the role because they are commonly invested with the comforting aura created by their usual therapeutic function, while they retain enough distance from the patient to avoid the special traumas that must arise when relatives are involved in helping to bring about a sick person's death. Physician participation can sanitize and even sanctify the deed.

The Court should therefore give special attention to the effects its decision will have on the medical profession, even though the challenged state statutes forbid anyone—not just doctors or nurses—from assisting in suicide. In this section of the Essay, we discuss the reasons that support the profession's traditional ban on assisted suicide, focusing particularly on the harmful consequences that relaxing the ban would have for medical practice and on the impossibility of regulating such practices with rules that try to distinguish permissible from impermissible forms of assisted suicide and euthanasia. In the next section, we explain why statutes like New York's and Washington's (and similar statutes in 33 other states) play a valuable part in reinforcing the inherently fragile ethic that the medical profession needs and has adopted for itself.

A. The Traditional Ban on Physician-Assisted Suicide

Authorizing physician-assisted suicide would require the Supreme Court to overturn a centuries-old taboo against medical killing, a taboo understood by many to be one of the cornerstones of the medical ethic. This taboo is at least as old as, and is most famously formulated in, the Hippocratic Oath, in which it stands as the first negative promise of professional self-restraint: "I will neither give a deadly drug to anybody *if asked for it*, nor will I make a suggestion to this effect. . . . In purity and holiness I will

guard my life and my art.”¹⁴ This clearly is not a promise to refrain from abetting murder by secret poisonings or other such mischief. Rather it is a pledge to refrain from practicing euthanasia, even on request, and from assisting or even encouraging a willing patient in suicide.

This self-imposed professional forbearance, which was not required by the Greek laws or customs of the time, is rooted in several deep insights into the nature of medicine. First, it recognizes the dangerous moral neutrality of medical technique: drugs can both cure and kill. Only if the means used serve a professionally appropriate end will medical practice be ethical.¹⁵ Accordingly, the Oath rules out assisting in suicide because the end that medical technique properly serves—the wholeness and well-working of the living human body—would be contradicted should the physician engage in delivering death-dealing drugs or advice. Most importantly, this taboo against euthanasia and assisted-suicide—like the taboos against violating confidentiality and sexual misconduct, enunciated later in the Oath—addresses a prominent “occupational hazard” to which the medical professional is especially prone: a temptation to take advantage of the vulnerability and exposure that the practice of medicine requires of patients. Just as patients necessarily divulge and reveal to the physician private and intimate details of their personal lives; just as patients necessarily expose their naked bodies to the physician’s objectifying gaze and investigating hands; so patients necessarily expose and entrust the care of their very lives to the physician’s skill, technique, judgment, and character. Mindful of the meaning of such exposure and vulnerability, and mindful too of their own human penchant for error and mischief, the Hippocratic physicians voluntarily set limits on their own conduct, pledging not to take advantage of or to violate the patient’s intimacies, naked sexuality, or life itself.

The Hippocratic physicians’ refusal to assist in suicide was not part of an aggressive so-called “vitalist” approach to dying patients or an unwillingness to accept mortality. On the contrary, understanding well both human finitude and the limits of the medical art, they refused to intervene when the patient was deemed incurable, and they regarded it as inappropriate to pro-

14. Ludwig Edelstein, *The Hippocratic Oath: Text, Translation and Interpretation*, in *ANCIENT MEDICINE: SELECTED PAPERS OF LUDWIG EDELSTEIN* 3-63, at 6 (Oswei Temkin & C. Lillian Temkin eds., 1967) (emphasis added).

15. For a detailed discussion of the Oath’s treatment of appropriate medical ends and means, see Leon R. Kass, M.D., *Is There a Medical Ethic? The Hippocratic Oath*, in *TOWARD A MORE NATURAL SCIENCE: BIOLOGY AND HUMAN AFFAIRS* 224-46, esp. 228-30, 232-36 (1985).

long the process of dying when death was unavoidable.¹⁶ Insisting on the moral importance of distinguishing between letting die (not only permissible but laudatory) and actively causing death (impermissible), they protected themselves and their patients from their own possible weaknesses and folly, thereby preserving the moral integrity ("the purity and holiness") of their art and profession.

That the Oath and its ethical vision of medicine is the product of classical Greek antiquity reminds us that the ban on physician-assisted suicide was not and is not the result of religious impulses alone. The Oath is fundamentally pagan and medical, and it has no connection with biblical religion or the Judeo-Christian doctrines of the sanctity of human life. Nor is the Oath a parochial product of ancient Greek culture. Notwithstanding the fact that the Oath begins by invoking Apollo and other deities no longer worshiped, it reflects and articulates a coherent, rational vision of the art of medicine. That is why it has been widely received in the West as a document for all times and places. The Oath's survival through the centuries is attributable to the wisdom of its contents, repeatedly recognized and reaffirmed by physicians down to the present day.

The Hippocratic Oath, it should be acknowledged, also proscribes physician participation in abortions. Before *Roe v. Wade*, this taboo governed American medical practice, but it has since fallen away. For this reason, some commentators dismiss the Hippocratic Oath as passé, and regard its proscription of assisting suicide as irrelevant to our morally more pluralistic times. The Ninth Circuit, for example, asserted that after *Roe*, "doctors began performing abortions routinely and the ethical integrity of the medical profession remained undiminished."¹⁷ But the court

16. See Darrel W. Amundsen, *The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots*, 8(4) HASTINGS CENTER REPORT 23-30 (August 1978).

17. *Compassion in Dying*, 79 F.3d at 829-30. This assertion is the heart of the Ninth Circuit's rejection of the argument that overturning the statutes proscribing assisted suicide will adversely affect the moral integrity of the medical profession. The next sentence reads: "Similarly, following the recognition of a constitutional right to assisted suicide, we believe that doctors would engage in the permitted practice *when appropriate*, and that *the integrity of the medical profession would survive without blemish*." *Id.* at 830 (emphasis added).

This assertion, rejecting the medical profession's own moral self-understanding and recognition of the dangers (as presented by the American Medical Association), is then followed by the court's moral reassurance that no doctors would be compelled to violate "their individual principles." Not content to reject a particular cornerstone of medical ethics, the Ninth Circuit rejects out of hand the existence of any profession-wide medical ethic as such. Medical ethics, according to the court, is all a matter of personal choice: "A physician [note the singular] whose [private] moral or religious beliefs would prevent him from assisting a patient to hasten his death would be free to follow the dictates of his conscience. Those doctors [note the plural] who believe that terminally ill, competent,

cited no evidence to support this cheery conclusion. There are, in fact, good reasons to argue the contrary. Massive numbers of abortions are now being performed, far beyond what was originally expected, and for reasons not originally regarded as appropriate.¹⁸ Moreover, physician acceptance of abortion may in fact be partly responsible for recent weakenings in the profession's repugnance to cause death, seen in those physicians who are today willing to practice euthanasia, a majority of whom are to be found among those who have entered the profession since *Roe*. Indeed, one of the arguments offered twenty-five years ago against allowing doctors to perform abortions was that it would inevitably lead to doctors performing euthanasia. More than half-way down that slippery slope, it should be considered an open question, to say the least, whether the ethical integrity of the medical profession has "remained undiminished."

Be that as it may, the taboo against medical killing and death dealing is not tied solely to the venerable but now partly compromised Hippocratic Oath. The proscription has been reaffirmed in numerous professional codes and statements of professional principles. The American Medical Association's code of Medical Ethics, for example, very explicitly rules out physician-assisted suicide, on the grounds that "[p]hysician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."¹⁹ The AMA's policy statements have repeatedly reiterated this position, most recently in June, 1996, when the House of Delegates responded to the decisions of the Second and Ninth Circuits by overwhelmingly endorsing a resolution "that

adult patients should be permitted to choose the time and manner of their death would be able to help them do so." *Id.* The court concludes by making a mockery of the very idea of a medical ethic altogether, insisting that *permitting* assisted suicide will in fact *enhance* the integrity of the profession because it will promote what the court appears to regard as the only relevant moral principle, choice: "We believe that extending a choice to doctors as well as patients would *help protect* the integrity of the medical profession." *Id.* (emphasis added). If choice is the only publicly relevant moral principle, there can be no other basis of medical ethical integrity to be compromised. The court's treatment of the serious subject of *professional* integrity never even reaches the topic. Here we have a wonderful illustration of the mischief wrought by the typical legal and reductive approach to moral questions, which focuses almost exclusively on the individual and his rights.

18. Many physicians, distressed over this fact and the consequences of performing abortions, have stopped doing abortions on demand. Some former physician-advocates of abortion are now vehemently opposed. See, e.g., BERNARD N. NATHANSON, M.D., WITH RICHARD N. OSTLING, *ABORTING AMERICA* (1979).

19. Opinions of the Council on Ethical and Judicial Affairs, American Medical Association, Opinion 2.211.

the American Medical Association oppose physician assisted suicide."²⁰

Some now choose to characterize these teachings as merely the residue of tradition. Against these "voices of tradition," they then argue that times have changed. The received wisdom of the medical profession, never mind Hippocrates, is not wisdom for today. Today, patients die differently, the vast majority in institutions, and most deaths are connected with some decision about withholding or withdrawing technological intervention. Our population is now aged and suffers increasingly from chronic and degenerative diseases and dementias. The cost of medical care is extremely high, especially for persons in the last year of life. Many people fear an over-medicalized death and a protracted process of dying, made possible by new technological devices such as respirators, defibrillators, dialyzers, and devices for artificial feeding.

Suicide was decriminalized long ago, and we have recognized the importance of patient autonomy in medical decision-making, especially at the end of life. We have established clear legal rights to refuse and to discontinue medical intervention, even should death be a likely outcome. Living wills and advance directives, to protect our wishes should we fall incompetent, have legal force in nearly every state. But although the hospice movement and advances in pain control already make comfortable dying possible for most people, some people still want in addition the right to have medical assistance in committing suicide and also direct killing by physicians. Public opinion polls appear to indicate support for such a right.²¹ Moreover, many doctors are apparently willing not only to accede to requests for deadly drugs, but also to administer them to patients unable to take them for themselves. Some physicians, it is alleged, are already doing so in secret. In short, so the argument goes, the ancient taboo against physician-assisted suicide and euthanasia is now an obstacle to a humane death. What would be lost if the taboo fell?

20. The AMA also regards physician participation in capital punishment as incompatible with the physician's role as healer.

21. The results and significance of such polls should be viewed with caution. Much depends on how the questions are framed and worded, which alternatives are presented, and whether likely social consequences are taken into account, as well as on the differences between abstract opinions remote from the deed and real choices made when crucial decisions are necessary.

B. Harms to Patient Welfare and Medical Practice

Very likely a great deal would be lost. Simple reflection, backed by empirical evidence, makes plain some obvious, probable, and serious bad consequences for medical practice. Once it becomes possible to think of death as a "therapeutic option" in the physician's armamentarium, we shall almost certainly see a great increase in suicide and physician-assisted death, far beyond the few and limited kinds of cases now invoked to justify a change in the law. Incentives will be altered, not only for patients given a new freedom to elect death but also for physicians, families, hospitals, health maintenance organizations, and insurers.

It is especially important for the courts to focus on these incentives, which operate almost invisibly and are therefore easy to forget, whenever they are confronted with the extreme cases that are brought forth to gain sympathy for overturning the prohibition against assisted suicide. As we shall see, the relatively few patients caught up in genuinely heart-rending medical situations are very hard to separate, both logically and practically, from countless other potential "candidates" for assisted death. There may be no area of jurisprudence in which it is more ominously true that heart-rending cases make bad law.

Many families and physicians will find in the option of electable death an opportunity to relieve themselves of the emotional burdens of caring for difficult or incurable patients. Others will be able to avoid huge economic costs or to achieve financial gain connected to an earlier demise, especially where an inheritance will be jeopardized by the expense of caring for long-lingering illness. Even when relatives and physicians are not consciously aware that they are succumbing to such temptations, they will be subtly but surely pulled in that direction.

Because the quick-fix of suicide is easy and cheap, it will in many cases replace the use of hospice and other humanly-engaged forms of palliative care, for there will be much less economic incentive to continue building and supporting social and institutional arrangements for giving humane care to the dying. Lack of medical insurance already keeps many people from adequate end-of-life care. Indeed, cost-cutting pressures already exerted on physicians by insurers and hospitals now produce sub-optimum care even for many who have insurance coverage. In this new medico-economic climate, with for-profit hospital corporations and HMOs, the removal of the ban against physician-assisted suicide becomes even more dangerous: a quick death will often be the most cost-effective "therapeutic option" and will

therefore be ever more frequently employed, especially should our society move, as seems likely, toward some form of explicit rationing of medical care at the end of life.

Proponents of assisted suicide will counter these concerns by reminding us that it is the patient alone who will be legally entitled to initiate the request for lethal medication. They will point out that concern for the economic well-being of one's heirs is not a contemptible incentive for electing an earlier death, that it is not irrational to try to keep money saved for a granddaughter's education from being squandered on a miserable additional six months of life. But such arguments, though well-taken in theory, naïvely idealize the usual situation of patients who are severely ill.

The ideal of rational autonomy, so beloved of legal theorists, rarely obtains in actual medical practice. Illness nearly invariably means dependence, and dependence means relying for advice on physician and family. This is especially true with the seriously or terminally ill, where there is frequently also depression or diminished mental capacity that clouds one's judgment or weakens one's resolve. With patients thus reduced—helpless in action and ambivalent about life—someone who will benefit from their death need not proceed by overt coercion. Rather, requests for assisted suicide can and will be subtly engineered. To alter and influence choices, physicians and families need not be driven entirely by base motives or even be consciously manipulative. Well-meaning and discreet suggestions, or even unconscious changes in expression, gesture, and tone of voice, can move a dependent and suggestible patient toward a choice for death.²² Simply by making assisted suicide an option available to gravely ill persons, will we not “sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel that they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act?”²³ Anyone who knows anything at all about the real life of the elderly and the incurable knows that many of them will experience—and be helped to experience—their right to choose physician-assisted death as a *duty* to do so.

22. “[T]he most successful form of manipulation is to lead a person to think that someone else's idea is actually his or her own, or to nudge that person's already existing ambivalence one way or the other.” Daniel Callahan & Margot White, *The Legalization of Physician Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICHMOND L. REV. 1, 7 (1996).

23. Yale Kamisar, *Some Nonreligious Views Against Proposed “Mercy Killing” Legislation*, 42 MINN. L. REV. 969, 990 (1958).

The idealistic assumptions of doctor-patient equality and of patient autonomy in medical decision-making are in fact false in the vast majority of medical situations. This is so even in the best of circumstances, when the patient is in relatively good health and where there is an intimate doctor-patient relationship of long standing. But with the seriously ill, the hospitalized, and, even more, with the vast majority of patients who are treated by physicians who know them little or not at all, many choices for death by the so-called autonomous patient will not be truly free and fully informed. Physicians hold a monopoly on the necessary information—regarding prognosis, alternative treatments, and their costs and burdens. Like many technical experts, they are masters at framing the options to guarantee a particular outcome.²⁴ This they almost always do already in presenting therapeutic options to the “autonomous patient” for his decision, and there is no reason to think this will change should one of those options now become “assistance for death.” When the physician presents a depressed or frightened patient with a horrible prognosis and includes among the options the offer of a “gentle quick release,” what will the patient likely choose, especially in the face of a spiraling hospital bill or resentful children? The legalization of physician-assisted suicide, ostensibly a measure enhancing the freedom of dying patients, will in fact in many cases be a deadly license for physicians to recommend and prescribe death, free from outside scrutiny and immune from possible prosecution.

Partly for this reason, the practice of physician-assisted suicide is likely soon to erode the trust that patients give to physicians. True, some patients may be relieved to know that their old family doctor will now be able to provide suicide-assistance when asked. But many patients—especially those who are not socially strong or who lack a close relationship with a trusted personal doctor—will be rightly suspicious. For how can you trust a stranger-doctor to be wholeheartedly devoted to your best interests once he has a license to kill? Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital after a fall with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. Never mind that, for now, death can be *legally* prescribed only on request. How soundly will you sleep?

24. See, e.g., NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 121-22 (1994).

Trust will suffer profoundly in more subtle ways. Should physician-assisted suicide become a legal option, it will enter unavoidably—sometimes explicitly, sometimes tacitly—into many a doctor-patient encounter. Though there may be some regulatory attempts to prevent physicians from introducing the subject, once it exists as a patient's legal right there will be even stronger pressures to make sure that patients know they have the option.²⁵ Ineluctably, patients will now be forced to wonder about their doctor, regardless of how he handles the situation: Did he introduce the subject because he secretly or unconsciously wishes to abandon me, or worse, because he wishes I were dead? Does he avoid the subject for the same reason, fearing to let me suspect the truth, or conversely, is it because he wants me to suffer? Few patients will openly express such fears and doubts. Because they must rely on their doctors, patients do not want to risk alienating them by seeming to distrust their motives and good will. Anyone who understands even a little of the subtle psychodynamics of the doctor-patient relationship will see immediately the corrosive effects of doubt and suspicion that will be caused by explicit (or avoided) speech about physician-assisted death.²⁶

Trust is not just a moral nicety, humanly desirable, perhaps, but medically dispensable. On the contrary, a patient's trust in the physician is a necessary ingredient in the therapeutic relationship and, at least indirectly, in the healing process. One does not happily follow advice from people one does not fully trust. Mistrust produces stress, anger, and resistance to treatment. In the increasingly impersonal world of modern medicine, patients

25. Analogous pressures now operate in the matter of abortion: even obstetricians opposed to abortion are often compelled to discuss it, if only to avoid later lawsuits should the child be born with abnormalities. But unlike the case of abortion, here it is the patient's own demise that is under consideration.

26. Such explicit speech may be damaging to more than trust. Usually ignored is the direct harm to the patient's morale. Forgotten is the sage advice of Thomas Percival, author of the famous code of professional conduct:

A Physician should not be forward to make gloomy prognostications; because they savour of empiricism, by magnifying the importance of his services in the treatment or cure of the disease. But he should not fail on proper occasions to give to the friends of the patient timely notice of danger when it really occurs, and even to the patient himself, if absolutely necessary. This office, however, is so peculiarly alarming when executed by him, that it ought to be declined whenever it can be assigned to any other person of sufficient judgement and delicacy; for the Physician should be the minister of hope and comfort to the sick, that by such cordials to the drooping spirit he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies, which rob the philosopher of fortitude, and the Christian of consolation.

Thomas Percival, *Of Professional Conduct*, in MEDICAL ETHICS (JOHN HENRY PARKER ED., 1849), reprinted in STANLEY JOEL REISER, ARTHUR J. DYCK, & WILLIAM J. CURRAN, EDs., ETHICS IN MEDICINE: HISTORICAL PERSPECTIVES AND CONTEMPORARY CONCERNS 22 (1977).

must without any direct evidence presume that their care-givers are trustworthy, even before they have shown that they deserve to be trusted. Especially under these conditions, the trust given to each physician stems largely from the trustworthiness attached to the profession as a whole. Thus, with the taboo against physician-assisted suicide broken, legitimate fears of deadly abuse of the new license to prescribe death will attach even to the most honorable physicians, whose ability to heal and comfort will therefore often be compromised.

Once physician-assisted suicide becomes acceptable, moreover, the practice will almost certainly be expanded beyond the narrow range now envisioned. Physicians will inevitably come to "assist" the non-terminally-ill and the less-than-fully-competent, and to engage in active euthanasia, both voluntary and non-voluntary. None of the boundaries among these closely related practices is clearly definable or practicably defensible against expansion and erosion.

Terminal illness is notoriously difficult to define precisely and almost as difficult to predict accurately. For example, the frequently used estimate of "less than six months to live" leaves unanswered whether it means six months *with* or *without* specific forms of treatment. Besides, a newly-discovered constitutional right to determine the time and manner of one's death would, if limited to the terminally ill, seem to discriminate unfairly against those who are fated to suffer their illnesses for longer periods of time. Patients with early Alzheimer's disease or so-called Lou Gehrig's disease (amyotrophic lateral sclerosis) are not considered terminally ill, yet they are frequently mentioned as leading candidates for assistance in dying. Almost none of Kevorkian's "patients" has been, by anyone's definition, terminally ill.

Autonomy, choice, and liberty interests are no respecters of arbitrary limitations on their exercise. If suicide and its assistance are legally justified by the principle of autonomy and choice, then the whole matter is too personal, intimate, and subjective to be governed by *any* objective or demonstrable criteria, such as certifiable terminal illness or truly intractable pain. For who is to say what makes suffering or life "unbearable" or death "electable" for another person? The autonomy argument favored by so many legal theorists sooner or later will undermine all criteria proposed for evaluating the patient's choice. Further, if the courts refuse to see a meaningful distinction between withholding or withdrawing treatment and taking deadly drugs, it will be impossible legally to deny non-terminally ill patients a right to the latter when they already clearly have a right to the former.

It will, for similar reasons, be impossible to confine the new right to assistance in suicide to those who will themselves administer the deadly drug the doctor has prescribed. What if the patient's infirmity prevents him from putting the pills into his mouth or from swallowing them? What if he vomits them up or if, for some other reason, the usually "lethal dose" does not produce death in his case? The physician will surely not stand idly by: now committed to the patient's death, the doctor will certainly lend a hand.²⁷ By this obvious route, physician-assisted suicide will lead quickly and inevitably to voluntary euthanasia performed by physicians.

The courts are also naïve if they believe that one can draw and hold a line between physician-assisted suicide and voluntary active euthanasia (practiced by doctors on willing patients) on one hand and *non*-voluntary euthanasia (where physicians perform mercy-killing *without the patient's request*) on the other. Legal theories that rely on the supremacy of autonomous patient choice offer purely theoretical reassurance unwarranted by what will actually happen in practice. Almost no physician is going to accede to a patient's request for deadly drugs unless the physician believes that there are good reasons to justify the patient's choice for death: too much pain, loss of dignity, lack of self-command, poor quality of life. Only if the physician accepts the patient's verdict that "life is no longer worth living" will he comply with the request; otherwise, he will try to persuade the patient to accept some other course of treatment or palliation, including psychotherapy for his suicidal wishes. Physician-assisted suicide *in practice* will be performed by physicians not out of simple deference to patient choice but for reasons of mercy: this is a "useless" or "degrading" or "dehumanized" life that pleads for active merciful termination, and therefore deserves my medical assistance.

But once suicide and assisting suicide are okay, for reasons of "mercy," then delivering the dehumanized is okay, whether chosen or not. Physician-assisted suicide, once legalized, will not remain confined to those who freely and knowingly elect it—and the most energetic backers of euthanasia (including some members of the medical profession) do not really want it thus restricted. They see the slippery slope and eagerly embrace the principle that will justify the entire downward slide. Why?

27. Should physicians be disinclined to do so, courts, citing equal protection arguments like those advanced by the Second Circuit, will force their hand: why should someone be denied equal access to suicide assistance just because he is quadriplegic, and cannot administer the chosen drug to himself?

Because the vast majority of candidates who "merit" an earlier death cannot request it for themselves. Persons in a so-called persistent vegetative state; those suffering from severe depression, senility, mental illness, or Alzheimer's disease; infants who are deformed; and retarded or dying children—all are incapable of requesting death, but are equally deserving of the new humane "aid-in-dying."

Lawyers and doctors, subtly encouraged by the cost-containers, will soon rectify this inequality. Invoking the rhetoric of equal protection, they will ask why the comatose or the demented should be denied the right to assistance-in-dying just because they cannot claim it for themselves. With court-appointed proxy consenters, we will quickly erase the distinction between the right to choose one's own death and the right to request someone else's—as we have already done in the termination of treatment cases.²⁸ But doctors and relatives will not even need to wait for such changes in the law. Who will be around to notice when the elderly, poor, crippled, weak, powerless, retarded, depressed, uneducated, demented, or gullible are mercifully released from the lives their doctors, nurses, and next of kin deem no longer worth living?

C. *The Impossibility of Effective Regulation*

The specter of unauthorized euthanasia is no mere scare-mongering. Recent reports on the practice of euthanasia in Holland provide ample proof. Although assisted suicide and voluntary euthanasia by physicians are technically still against the law there, their practice has been tolerated, even encouraged, for nearly twenty years, under guidelines established by the medical profession. Although the guidelines insist that choosing death must be informed and voluntary, a 1989 survey of three hundred physicians (conducted by the supporters of euthanasia) disclosed that over 40% had performed *non*voluntary euthanasia and over 10% had done so five times or more.²⁹ The survey commissioned

28. If the recent decision of the Second Circuit were to be affirmed it would seem that no sensible distinctions are safe under equal protection clause jurisprudence. That court held that New York discriminates unconstitutionally in favor of those who can elect to pull the plug on life-supporting machinery and against those who want to die but who have no plug to pull. *Quill*, 80 F.3d at 729. This has the look of a constitutional tort claim made against fate or nature! A similar claim could equally well be made on behalf of those who wish to die but who are not terminally ill, or on behalf of those whose condition merits merciful aid-in-dying but who, ill-fated ones, cannot ask for it themselves.

29. John Keown, *Some Reflections on Euthanasia in the Netherlands*, in EUTHANASIA, CLINICAL PRACTICE AND THE LAW 193, 209 (Luke Gormally, ed., 1994) [hereinafter Keown, *Some Reflections*] (citing F.C.B. VAN WIJMEN, ARTSEN EN HET ZELFGEKOZEN LEVENSEINDE (DOCTORS AND THE SELF-CHOSEN TERMINATION OF LIFE) 24, Table 18 (1989)).

by the Dutch Government's Committee to Investigate the Practice of Euthanasia provides even more alarming data: In 1990, besides the 2,300 cases of voluntary euthanasia and 400 cases of physician-assisted suicide per year, there were over 1,000 cases of active *nonvoluntary* euthanasia performed without the patient's knowledge or consent,³⁰ *including roughly 140 cases (14 percent) in which the patients were mentally totally competent.*³¹ (Comparable rates of nonvoluntary euthanasia for the United States would be roughly 20,000 cases per year.) In addition, there were 8,100 cases of morphine overdose with the intent to terminate life, 68 percent (5,508 cases) without patient knowledge or consent.³²

And why are Dutch physicians performing nonvoluntary euthanasia? "Low quality of life," "the relatives' inability to cope," and "no prospect of improvement" were reasons that physicians gave for killing patients without request; pain or suffering was mentioned by only 30 percent.³³ Is there any reason to believe that Dutch physicians are less committed than their American counterparts to the equal dignity of every life under their care?

Even proponents of physician-assisted suicide concede that there are dangers of misuse and abuse of the sort mentioned above. But, they believe, as did both the Second and Ninth Circuits, that physicians and state governments can establish guidelines and regulations that will prevent such abuses and curtail undesirable extensions of the practice:

State laws or regulations governing physician-assisted suicide are both necessary and desirable to ensure against errors and abuse, and to protect legitimate state interests. Any of several model statutes might serve as an example of how these legitimate and important concerns can be addressed effectively. . . . [W]e believe that sufficient protections can and will be developed by the various states, with the assistance of the medical profession and the health care industry, to insure that the possibility of error will be remote.³⁴

But this confidence in regulation is a mere assertion. Indeed, it is no more than a pious hope, and one that flies in the face of both existing evidence and common sense.

30. Data are from P.J. VAN DER MAAS, ET AL., EUTHANASIA AND OTHER MEDICAL DECISIONS CONCERNING THE END OF LIFE (1992), as reported in John Keown, *Further Reflections on Euthanasia in The Netherlands in the Light of the Rummelink Report and the Van Der Maas Survey*, in EUTHANASIA, CLINICAL PRACTICE AND THE LAW 219, 224 (Luke Gormally, ed., 1994) [hereinafter Keown, *Further Reflections*].

31. *Id.* at 230.

32. *Id.* at 224.

33. *Id.* at 230.

34. *Compassion in Dying*, 79 F.3d at 832-33; see also *Quill*, 80 F.3d at 730.

The guidelines that have been proposed are, in fact, defective and ineffective. The evidence from Holland already shows that they are not being followed: the rather comprehensive regulations that include requirements of voluntariness, thoughtfully considered and persistent requests, unacceptable suffering, consultation with a second physician, and accurate reporting of the cause of death are all being neglected in many cases.³⁵ There are many known cases of non-voluntary euthanasia, and many more that go unreported. In the majority of cases, Dutch physicians illegally certify that death was due to natural causes.³⁶ Moreover, in several court cases where the guidelines were clearly ignored, the Dutch have been willing to set aside the established criteria and regulations, in the name of mercy and in the name of an alleged medical duty to relieve suffering that is said to outweigh the duty not to kill.³⁷

The problem is not peculiar to the Dutch regulations or to Dutch social prejudices and legal arrangements. As Daniel Callahan and Margot White have shown, in their magisterial article on the subject of regulating assisted-suicide, *any* guidelines and regulations that have been or *could be* proposed are likely to be equally defective and ineffective.³⁸ Callahan and White analyze in considerable detail the 1995 Oregon law that permits assisted suicide, as well as other state legislative proposals and some model guidelines proposed in the academic literature. They offer compelling arguments why the usually mentioned safeguards of consent, mental competence or capacity, voluntariness, limited or restricted eligibility, witnesses, clear definitions of what constitutes abuse, and specific requirements to report, investigate, and punish abuse are inadequate to the task.

The real difficulty does not lie in fashioning the right procedural rules, but in the impossibility of making any procedural rules effective. The practice of assisted-suicide is *in principle* unregulable, insofar as it will occur in the privacy of the doctor-patient relationship: "[M]aintaining the privacy of the physician-patient relationship and the confidentiality of these deliberations is fundamentally incompatible with meaningful oversight and adherence to any statutory regulations."³⁹ As Callahan and

35. See CARLOS F. GOMEZ, M.D., REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); HERBERT HENDIN, M.D., SEDUCED BY DEATH: DOCTORS, PATIENTS, AND THE DUTCH CURE (1996); Keown, *Some Reflections*, *supra* note 29; Keown, *Further Reflections*, *supra* note 30.

36. Keown, *Further Reflections*, *supra* note 30, at 235-36.

37. Callahan & White, *supra* note 22, at 15.

38. Callahan & White, *supra* note 22.

39. *Id.* at 9. The text continues:

White show in detail, legalization of physician-assisted suicide will not lead to regulation of the practice, but to deregulation of the physicians, who will now have more power than ever over the life and death of their patients.⁴⁰

Courts should be very wary of establishing a constitutional right to a dangerous practice on the basis of an ill-considered confidence that states can find proper safeguards to reduce the dangers, especially when there are powerful reasons to believe that such safeguards will be difficult, if not impossible, to provide. If individual states feel brave enough to experiment in this area, they are now free to do so through legislation. The citizens of Oregon, by a narrow margin, have recently expressed the wish to experiment with assisted-suicide using what they believe—in our view, foolishly—are adequate safeguards. Many other states have recently rejected proposals for such experiments. If Oregon's experiment works, other states may follow their lead. Should it turn out, however, that the people of Oregon come to believe that they made a mistake, they can reverse course. But if the Supreme Court makes a similar mistake by fashioning an ill-considered new constitutional doctrine, *stare decisis* will make the process of correcting the mistake slow, uncertain, and almost surely incomplete.

IV. PROFESSIONAL ETHICS AND THE LAW

Precisely because the effectiveness of any guidelines regulating physician-assisted suicide will depend on the unsupervisable willingness of physicians to comply with them, it is clear that prevention of misuse, abuse, and unauthorized extension of legalized assisted-suicide will rest almost entirely on the fragile virtue of the medical profession and of its (largely unregulable) individual practitioners. Yet the legalization of assisted-suicide, apart from other possible bad consequences for medical practice, will surely undermine the very ethical integrity of the medical profession on which any supposedly proper practice of helping-to-die depends. Society therefore has a deep interest in preserving

What if a physician decides not to come forward? A patient might want to keep his suicide private. Or the doctor may decide that the regulatory specifications have not been met, but nonetheless be sympathetic to the patient's request. It is not difficult to imagine many circumstances in which either the physician or the patient, or both, would prefer to keep the agreement secret. How can that situation be monitored or regulated? How could abuses be detected if a physician wrongly decided to induce someone to consider, and then use, PAS [physician-assisted suicide]? . . . Precisely the principle that allows doctors and patients to reach private agreements—doctor-patient confidentiality—no less assures them that PAS decisions can continue to be effectively hidden.

Id.

40. *Id.* at 64; Keown, *Further Reflections*, *supra* note 30, at 238-39.

the ethical integrity of medicine and its allied professions in matters having to do with suicide and euthanasia. What is too little appreciated in almost all these discussions is the fragility of medical professionalism and hence the need for legal reinforcement of the profession's ethical norms.

Medicine is a profession. It is not merely a trade, despite the fact that its practice provides its practitioners with a livelihood that is usually quite handsome. A profession, as etymology suggests, is an activity or occupation to which its practitioner publicly professes—that is, confesses—his devotion. Specialized learning is, of course, required of the professional, who may also obtain social prestige and even compensation that exceeds what an unfettered market system would provide for the professional services. But it is the profession's goal that calls, that learning serves, and that prestige honors. Each of the ways of life to which the various professionals profess their devotion is a way of life worthy of such devotion. This is true for teachers, devoted to assisting the learning of the young. It is true for attorneys, devoted to assisting clients in the pursuit of their lawful rights and interests. It is true for the clergy, devoted to the spiritual care of their congregations. And it is true of the physician, devoted to healing and comforting the sick.

Being a professional is thus more than being a technician or tradesman. It is rooted in our moral nature. It is a matter not only of the mind and hand but also of the heart, not only of intellect and skill but also of character. For it is only as a being willing to become devoted to the well-being of others and to serve some high good that a person makes a genuine public profession of a way of life.

The practice of medicine, as an ethical professional activity, is extremely demanding, quite apart from the long hours and the rigorous requirements to gain and keep up technical competence. Physicians are ethically obliged always to put their patients' interests ahead of their own. Physicians are ethically obliged to ensure that their enormous powers over life and death, powers tied to increasingly esoteric knowledge and increasingly potent technologies, are not misused or abused. Physicians are ethically obliged to respond not only to illness but also to its meaning for each individual, who, in addition to his symptoms, may suffer from self-concern—and often fear and shame—about weakness and vulnerability, neediness and dependence, loss of self-esteem, and the fragility of all that matters to him. Physicians are ethically obliged to recognize the limits of their craft, given that all their patients will necessarily decay and die sooner or later, with or without medicine. Physicians are ethically obliged always

to care for, never to abandon, their patients. This remains true even when a cure is impossible, even—indeed, especially—when death is near.

These ethical obligations, essential to the meaning of professing the art of medicine, are not easily met. The moral disposition to fulfill them cannot be produced by market forces alone or by the ordinary legal prohibitions against force and fraud. Rather, the formation of the moral physician is the work of medical ethics, a partly explicit and partly tacit set of attitudes, sentiments, dispositions, principles, and beliefs devised over centuries and tested by experience, that are inculcated both formally and informally during the lengthy socialization of new physicians into the profession.

Among its major purposes, medical ethics seeks to protect physicians against both their strengths and their weaknesses. To protect against the danger of professional arrogance arising from technical power and expertise that is in fact very great, physicians are taught about the need for humility concerning the limits of their own specialized competencies and their ability to offer precise prognoses or to effect permanent cures. They are warned against prideful overconfidence and the belief that they always know better than the patient what is in the patient's best interest. They are taught to seek outside consultation, to be modest in their predictions and promises, to secure informed consent for all procedures, and to respect their patients' prerogatives in refusing treatment or hospitalization. They gradually, and no doubt imperfectly, learn how limited is their ability to preserve health, prolong life, and forestall death.

Perhaps even more important are those aspects of medical ethics that protect physicians against their ordinary human weaknesses: their tendencies to allow their own self-interest (regarding time, money, or competing concerns) to undermine their devotion to their patients' needs; their own distastes, dislikes, and frustrations regarding difficult or incurable patients, any of which might lead them to shortchange their patients' care, to become indifferent to their needs and complaints, or even to neglect and abandon them outright; the physicians' own fear of death, which might prevent them from accepting the likely death of their patients and might keep them from allowing patients to die without added indignities. Physicians are taught to devote themselves wholeheartedly to the benefit of the sick, to battle their personal distastes and frustrations, to recognize their own fears, and to know when and how to keep company with the dying. These lessons—and especially the last—are very difficult to learn and faithfully practice, for taking care of the sick and

dying places extraordinary and unrelenting demands on one's patience, equanimity, and strengths of character.

The venerable taboo against physician-assisted suicide and medical killing protects simultaneously against both human frailty and physician arrogance. Despite the medical ideal and despite all exhortations to the contrary, physicians do in fact get tired of treating patients who are hard to cure, who resist their best efforts, who are on their way down—especially when they have had no long-term relationship with them over many years. "Gorks," "gomers," and "vegetables" are only some of the less-than-affectionate names such patients receive from the interns and residents. Once assisting suicide becomes legal, many physicians will be much less able to care wholeheartedly for these patients.

With death now a legitimate "therapeutic option," it will be tempting for the exhausted medical resident to think that death is the best treatment for the little old lady "dumped" again on the emergency room by the nearby nursing home. Should she get the necessary penicillin and respirator one more time, or, perhaps, this time just an overdose of morphine? Even if the morphine is not given, the thinkability of doing so, and the likely impossibility of discovery and prosecution, will greatly alter the physician's attitude toward his patients. Today, hospital patients whose charts contain "Do Not Resuscitate" orders are very often treated differently from the rest. This happens not because of official policy, but despite it. A subtle message is silently conveyed that such patients are less worthy of continued life. Should lethal drugs become a legal option, such psychological changes in physicians will be even more difficult for them to resist. And the consequences will often be deadly.

Even the most humane and conscientious physicians psychologically need protection against themselves and their weaknesses, if they are to care fully for patients who entrust them with their lives. One physician who has worked for many years in a hospice caring for dying patients put the matter most convincingly: "Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying."⁴¹

The taboo against physician-assisted suicide is perhaps even more crucial as protection against physicians' arrogance, namely, their willingness to judge, on the basis of *their own private prejudices and attitudes*, whether this or that life is unworthy of

41. Steven H. Miles, M.D., Associate Professor, Department of Medicine and Center for Biomedical Ethics, The University of Minnesota (personal communication).

continued existence. This most important point is generally overlooked in public and legal discussions of assisted suicide because so much attention is focused on the patient's voluntary request for death. But in order to comply with such a request, the physician must, willy-nilly, play the part of such a judge. To be sure, physicians could decide as a matter of principle always to suspend their own judgment and dispense the requisite deadly drug to any patient who requests it, regardless of the patient's stated reasons or medical circumstances: give the customer what he wants. But to do so would be to abandon their professional obligation to seek the patient's benefit and best interest, certainly in most cases of requests for poison.

In fact, almost no physician will always, or even often, suspend his own judgment. On the contrary, in order to dispense the requested deadly drugs physicians will invariably be judging, *on the basis of their own personal and private standards*, that such and such a life is indeed a life not worth living. Their judgments will be decidedly non-medical and non-professional. One physician will choose to assist death over against moderate or impending senility, another against paraplegia, a third against severe pain or blindness or prolonged depression. Only those requests resonating with the physician's own criteria of "intolerable" or "unworthy" lives will be honored.

The problem is not primarily that physicians believe some lives are more worthy or better lived than others. Nearly all people, whether they admit it or not, hold such opinions and make such judgments. The danger comes when people *act* on these judgments, and especially when they do so under the cloak of professional prestige and compassion, and of course with deadly result. Medical ethics, mindful that medicine is a profession with notorious powers over life and death, has for centuries prevented physicians from enacting professionally any such personal judgment of "unworthy life." In this respect, medical ethics encourages physicians to offer all people the equal security and care to which their common humanity entitles them.

Attitudes opposing the taking of life and affirming equal respect for life, like the rest of medical ethics, are taught to each new generation of physicians, sometimes explicitly, more often tacitly. Medical students, interns, and residents are taught—and acquire—a profound repugnance to medical killing, as a major defense against committing—or even contemplating—the worst action to which their arrogance and/or their weaknesses might lead them. At the same time, they are taught not always to oppose death. Because death is part of life, because patients inevitably die, physicians must not hate death as they abhor killing.

They must be taught—and it is a lesson not easily learned—when they should abandon interventions, cease interfering with the dying process, and give only care, comfort, and company to the dying patient. But in order to be able to keep their balance, physicians have insisted on the absolute distinction between deliberate killing and letting die. Non-medical laymen (including lawyers and judges) may not be impressed with this distinction, but for practicing physicians it is morally crucial.

From the point of view of medical ethics, ceasing medical intervention, or allowing nature to take its course, differs fundamentally from assisted suicide, active euthanasia, and mercy-killing. For one thing, death does not necessarily follow the discontinuance of treatment. Karen Ann Quinlan lived more than ten years after the courts allowed the “life-sustaining” respirator to be removed. Not the physician, but the underlying fatal illness becomes the true cause of death. The result in the Quinlan case shows that the right to discontinue treatment cannot be part of some larger right to “determine the time and manner of one’s own death.”⁴² Indeed, it is both naïve and thoughtless to believe that we can exercise a right to “control the time and manner of one’s death,” since these aspects of death, like death itself, display the *limits* of human control. Only by killing oneself or by arranging to be killed on schedule can such control in fact be exercised. Such a result exposes the shallowness of our exaggerated belief in mastery over nature and fortune, a belief that informs the Ninth Circuit’s opinion and, indeed, our entire technological approach to death. The so-called right to die, allegedly a remedy for the excesses of technicism, is in fact technicism’s ultimate triumph.

What is most important *morally* is that the physician who ceases treatment does not intend the death of the patient, even if death follows as a result of his action or omission. His intention is to avoid useless and degrading medical additions to the already sad end of a life. He intends also no longer to interfere with the normal process of dying, which is, in fact, still a part of the patient’s life. In contrast, in assisted suicide and all other forms of direct killing, the physician must necessarily and indubitably intend primarily that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death. This remains true even if he is merely an assistant in suicide. A physician who provides the pills or lets the patient plunge the syringe after he leaves the room is morally no different from one who does the deed himself. As the Hippocratic

42. *Compassion in Dying*, 79 F.3d at 793.

Oath put it, "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."

The same prohibition of physician killing continues to operate in other aspects of palliative care where some have sought to deny its importance. For example, physicians often and quite properly prescribe high doses of narcotics to patients with widespread cancer in an effort to relieve severe pain, even though such medication carries an increased risk of death. But it is wrong to say that the current use of intravenous morphine in advanced cancer patients already constitutes a practice of medical killing. The physician here intends only the relief of suffering, which presupposes that the patient will continue to live in order to be relieved. Death, should it occur, is unintended and regretted.

The well-established rule of medical ethics that governs this practice is known as the principle of double effect, a principle badly misunderstood by the Ninth Circuit. It is morally licit to embrace a course of action that intends and serves a worthy goal (like relieving suffering), employing means that may have, as an unintended and undesired consequence, some harm or evil for the patient. Such cases are distinguished from the morally illicit efforts, like those of Jack Kevorkian, that indirectly "relieve suffering" by deliberately providing a lethal dose of the same drug—that is, by eliminating the sufferer. Here we have a deliberate embrace of deadly harm, which is never sanctioned by medical ethics.

We hasten to point out that it is not, in fact, very easy to distinguish the two cases from the outside when death occurs from respiratory depression following morphine administration. The outcome—a dead patient—is the same, and the proximate cause—morphine—may be the same. Physical evidence alone, obtained after the fact, will often not be able to tell us whether the physician acted with intent to ease pain or with intent to kill. But that is exactly why the ethical principle of double effect is so important. Only the physician's ethic opposing the intent to kill, which is reinforced by the current law outlawing such actions, keeps the physician from such deliberate deadly acts.⁴³

43. Those who want the law overturned often argue that, since the patient dies in both cases, the physician's intent is irrelevant. Others even ridicule the principle of double effect, claiming that it is a ploy to salve doctors' consciences, enabling them to kill while pretending that they do not mean to do so. But should this view prevail, we will reap the evils wrought by legitimating and promoting such a corruption of physician intention, for doctors will then be encouraged, rather than discouraged, to deliberately choose death for their patients.

One cannot exaggerate the importance of the distinction between withholding or withdrawing treatment and directly killing, especially in light of the casual and dismissive way it was treated in the two recent court of appeals opinions.⁴⁴ Both as a matter of law and as a matter of medical ethics, the right to refuse unwanted medical intervention is properly seen not as part of a right to become dead but rather (like the rest of the doctrine of informed consent) as part of a right protecting how we choose to *live*, even while we are dying. Doctors and patients choose whether to begin treatment on the basis of a prudent judgment weighing benefits and burdens. In the event of doubt, we almost invariably err on the side of life and hope for recovery. But after a proper trial, when recovery seems beyond reasonable possibility, when the patient's condition deteriorates, one is medically and morally free to abandon the therapeutic efforts, even if death results. It would be improper to say that the intent of this discontinuance—whether by a physical act of omission or commission—is that the patient become dead. Rather, we intend to cease doing useless and futile or degrading things to the patient when he no longer stands to benefit from them.⁴⁵

It is therefore false to say (as the Second Circuit says) that physicians who turn off a respirator or remove a feeding tube are already practicing assisted-suicide, or to say (as the Ninth Circuit says) that physicians who today run increased risks of death in order to provide adequate pain medication are knowingly and intentionally killing their patients.⁴⁶ No doubt, some physicians, already far down the slippery slope to involuntary euthanasia, may be abusing the principle of double effect, and may secretly be intending death when appearing to be administering pain

44. See, e.g., *Quill*, 80 F.3d at 729; *Compassion in Dying*, 79 F.3d at 822-24.

45. The distinction between killing and withdrawing treatment holds up perfectly well in the case of artificial feeding tubes, about which there has been much confusion and controversy. It is sometimes suggested that the removal of these tubes constitutes an act of assisted-suicide or euthanasia because it amounts to killing by starvation. See, e.g., *Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring); *Quill*, 80 F.3d at 729; *Compassion in Dying*, 79 F.3d at 822-23. To see why this is a mistake, we should begin by noting that the decision to insert a feeding tube in the first place is often not medically or morally obligatory, and subsequent decisions about removing the tube are similarly a matter of medical and moral judgment. It is reasonable to insert a feeding tube when there is some reasonable hope that the patient will improve. But if improvement does not occur after an appropriate trial, artificial feeding can become not only a useless exercise but even a burdensome and unwelcome interference in the process of dying. Removing the tube at that point does not entail a decision to "starve the patient to death." Only those who mistakenly assume that the indefinite prolongation of life is the goal of medicine can fail to see that there always comes a time when the right course of action is to avoid causing further harm and indignity to a dying patient. To yield before the inevitable is not the same as endorsing or choosing it.

46. See *Quill*, 80 F.3d at 729; *Compassion in Dying*, 79 F.3d at 824.

relief. But such abuse in no way invalidates the moral centrality of the distinction, and in no way justifies blurring the only line that can morally and clearly be drawn in this difficult area.

The relation between law and medical ethics is necessarily indirect. The law cannot teach or inculcate the right attitudes and standards that professionals need if they are to preserve the fragile moral integrity on which the proper practice of medicine depends. But the law can support that ethic by enacting and upholding a bright line rule that coincides with the morally necessary prohibition against doctors becoming agents of death. Especially where there is grave doubt that there can be adequate substitutes for such a rule, or that there can be enforceable guidelines and safeguards for medical practice in the absence of such a rule, the state has a powerful interest in preventing the healing profession from becoming also the death-dealing profession. A state law proscribing assisted suicide, among its other purposes, prevents corrosive effects on the medical profession and curbs the ever-present danger of the corruption of professional judgment.

Though some have argued that recent changes in medical practice now call for the removal of legal obstacles to physician-assisted suicide, we think these obstacles are more important than ever. Given the great pressures threatening medical ethics today—including, among other factors, a more impersonal practice of medicine, the absence of a lifelong relationship with a physician, the push toward managed care, and the financially-based limitation of services—a bright line rule regarding medically-assisted death is a bulwark against disaster. That many physicians are already tempted to assist in suicide, and to perform euthanasia, is *not* a reason for changing the traditional rule. On the contrary, it may very well be a warning of how weakened the fragile medical ethic has already become, and how important it is to help shore it up. Where our state governments have decided to uphold this ethic by proscribing assisted suicide, and where the authoritative voices of the medical profession urge them to continue to do so, courts should not be in the business of undermining their efforts.

V. CONCLUSION

Some of the most difficult lessons that young physicians must learn involve the limits of their own therapeutic powers. Sadly, there are times when physicians should stop interfering with the natural process of dying. But it is also sometimes better to let nature take its course because the body has powers of *self-healing* that will be frustrated by medical intervention. The assisted-

suicide cases now before the Supreme Court offer the Justices an opportunity to show that they have learned the proper limits of their own judicial powers, and that they recognize something about the self-healing powers of democratic institutions. Almost all of our state governments have adopted a bright-line prohibition against assisted suicide, either by statute or by common law. One state has begun to experiment with new rules authorizing this practice. We believe that this experiment will prove to be a failure. More important, however, we believe that this natural process of experimentation and self-correction by the states is far healthier than intervention from the federal courts could possibly be.

Intervention by the courts is likely to be especially pernicious if it involves overturning the centuries-old prohibition against physician-assisted suicide. Such a decision would have terrible, and quite possibly incurable, effects on medical practice and on the very patients whose rights the courts were trying to protect. Incentives to care properly for dying patients would be jeopardized. Choices for death would start to be subtly engineered. Patients' trust in their doctors would be eroded. And the practice of assisted suicide would inevitably be extended to those who are not terminally ill and to those who are not competent. It will even spill over into *non*-voluntary euthanasia, as it already has in Holland.

The hope that such problems and abuses can be prevented by regulatory guidelines is wildly unrealistic, for the privacy of the doctor-patient relationship makes the practice inherently unregulable. Decent medical conduct regarding dying patients must therefore depend decisively on the fragile virtue of the medical profession. The age-old rule that sharply separates deliberate killing from letting patients die in appropriate circumstances enables physicians to handle death by abhorring killing. Without that rule, human weakness and professional arrogance will destroy the hard-won ethos of the profession. Our state governments have a powerful interest in preserving that ethos, and in preventing the healers of human beings from becoming also technical dispensers of death.

Some may find it paradoxical that we are defending a law on the ground that it allows the people whose conduct it restricts to practice self-regulation. But this is exactly where law is often most important and useful. Under the growing economic, legal, and technologically driven pressures that trouble modern American medicine, it is increasingly difficult for the medical profession to uphold its own ethical standards and for individual physicians to keep their moral balance. Regarding no matter is it

more important to maintain professional ethics than in the delicate and dangerous area of care for the dying. Regarding no matter is there greater danger to patients, physicians, and the whole fabric of their relationship. State governments, recognizing the importance of medicine's moral standards in general and of the ancient taboo against medical killing in particular, reasonably and rightfully elect to support the profession with a law banning all physician-assisted suicide. Far from being paradoxical, it is the course of wisdom.

