Are the Distinctions Drawn in the Debate about End-of-Life Decision Making "Principled"? If Not, How Much Does It Matter?

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I sometimes wonder whether some proponents of physician-assisted suicide (PAS) or physician-assisted death (PAD) think they own the copyright to such catchy phrases as "death with dignity" and "a good death" so that if you are against PAS or PAD, then *you must be against* a dignified death or a good death. If one removes the quotation marks around phrases like "aid-in-dying" or "compassionate care for the dying," I am not opposed to such end-of-life care either. Indeed, how could *anybody* be against this type of care?

I do not want to abandon dying patients anymore than Dr. Timothy Quill does.[1] Although, unfortunately, it will not always be easy to achieve the desired result,[2] I agree with him that it ought to be a goal of medicine "to help people die well, to help them receive a good death" — or at least "the best possible" death under the circumstances.[3] I part company with Professor Quill, however, when he urges us to change the law in the majority of our states so that in some circumstances patients may achieve a "good death" or a "dignified" one by means of lethal drugs.

As the co-founder of the Hastings Center, Daniel Callahan, has observed:

> Consider the phrase "death with dignity" [the title of the Oregon and Washington physician-assisted suicide legislation]. The implication of the phrase is that physician-assisted suicide is the only route to a death with dignity....Why does suicide endow a death with dignity? Does dignity depend upon control?[4]

I share the view of medical ethicist John Arras, a well-known opponent of PAS, that — without changing the prevailing law — physicians opposed to PAS can do much to bring about the best death possible:

> [They] must learn how to really listen to their patients, to unflinchingly engage them in sensitive discussion of their needs and the meaning of their requests for assisted death, to deliver appropriate palliative care, to distinguish fact from fiction in the ethics and law of pain relief, to diagnose and treat clinical depression, and, finally, to ascertain and respect their patients' wishes for control regarding the forgoing of life-sustaining treatment.[5]

In early 2010, sisters Eileen and Jeanne Fitzpatrick co-authored *A Better Way to Die*. Written by Eileen, an

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attorney, and Jeanne, a physician with extensive experience in treating seriously ill and dying patients, the book is all about how *not* to abandon dying patients. But there is no discussion of physician-assisted suicide or euthanasia — except to compare and contrast it with what the authors call "Comfort Care Only":

> Patients choosing Comfort Care Only are not asking their doctors or family members to hasten or cause death by, for example, administering sedatives or other lethal medications. They are merely asking that those interventions administered to keep them alive in the past...be withheld so that they may take advantage of their next naturally occurring opportunity to die.[6]

Allowing a "natural death" to occur is what *the Fitzpatrick sisters mean* when they write about "aid-in-dying" and "physician-assisted death."[7]

As I have discussed elsewhere, too often a reporter believes that the way to provide in-depth coverage of the general subject of PAS is not to dwell on, or even discuss, what may be best for society as a whole, but to furnish a detailed account of a particular person suffering from a particular excruciating disease and ask: "How can we deny this person the active intervention of another to bring about death?" or "What would you want if you were in this person's shoes?"[8]

However, as Professor Arras has pointed out, whether we maintain the legal status quo *or whether we legalize PAS*, "there are bound to be victims."[9] The victims of the current ban "are easy to identify; they are in the news, the talk shows [and] the documentaries."[10] By contrast, the victims of legalization "will be largely hidden from view." But they "will include the clinically depressed eighty-year-old man who could have lived for another year of good quality if only he had been treated [and] the fifty-year-old woman who asks for death because doctors in her financially stressed health maintenance organization cannot or will not effectively treat her unrelenting but mysterious pelvic pain."[11]

What do I mean by looking past some heart-wrenching individual cases and thinking about what is best for society as a whole? In 1994, the New York State Task Force on Life and the Law, a 24-person group of physicians, lawyers, religious leaders, philosophers, and medical ethicists, issued a highly influential report on "assisted suicide and euthanasia in the medical context."[12] The executive director of the task force told us that many of its members could envision some exceptional circumstances where PAS would be "ethically acceptable."[13] Nonetheless, the task force unanimously concluded that the prohibition against PAS should remain in force.[14] "At the heart of this issue," emphasized the task force director, "is the difference between individual ethics and the development of public policy."[15]

I. "Organized Obfuscation"

In 2009, "Compassion & Choices," an organization that advocates the legalization of PAS, sent out a letter to the public seeking contributions.[16] On the first page of this letter, the head of the organization, Barbara Combs Lee, wrote:

> When you shake your head in dismay and disgust over what happened to Terri Schiavo...when you read about a hospital refusing a patient's written wishes to be kept off artificial life support... Compassion & Choices is the organization you can count on to stand up for what *you* know is right.[17]

The literature accompanying this solicitation letter profiles three "clients" of the organization who benefited from its work.[18] One of them was Sandy Bush, who informed readers, shortly before he died of prostate cancer, that, thanks to Compassion & Choices, he was spared the ordeal of dying "hooked up to machines, unable to breathe or exist without a feeding tube."[19]

A person unfamiliar with the ethics and law governing end-of-life medical treatment who read this letter and the accompanying literature would have no idea that for many years there has been wide agreement among physicians, lawyers, medical ethicists, and judges that the right of a competent person to forgo life-sustaining medical treatment is "virtually absolute."[20] Although he did not cite the letter from Compassion & Choices as a specific example, this must be at least a first cousin to what Daniel Callahan had in mind when he protested recently that "many (but hardly all) advocates of euthanasia and physician-assisted suicide" have been engaging in "organized obfuscation."[21]

II. "Killing" vs. "Letting Die": The Courts Grapple with the Issue

A. The Cruzan Case

Although the *Cruzan* case[22] is often called a "right to die" case, it involved a woman (Nancy Cruzan) who had been in a persistent vegetative state for many years and was being kept alive by means of a feeding tube. Thus, she could not consent to her death nor ask anyone to help her die. Moreover, she had not made a living will nor executed any other advance directive requesting that she be allowed to die under certain circumstances.

Ms. Cruzan's parents sought to discontinue the tubal feeding, but their efforts were rebuffed — first by hospital officials and then by the state courts. In the absence of any advance directive, ruled the state supreme court, Ms. Cruzan's parents had to satisfy an unusually high burden of proof. They had to show "clear and convincing" evidence of their daughter's wish to be free of life support. This they had failed to do.[23]

By a 5-4 vote, the U.S. Supreme Court, per Chief Justice Rehnquist, affirmed the state court. However, the Chief Justice recognized that "[t]he principle that a competent person has a constitutionally protected liberty in refusing unwanted medical treatment may be inferred from our prior decisions."[24] The Court then assumed "for purposes of this case that the Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[25]

Significantly, five other members of the Court — concurring Justice O'Connor (who provided the crucial fifth vote for Rehnquist) and the four dissenters (Brennan, Marshall, Blackmun, and Stevens) — did not merely *assume* that a competent person had a right to refuse lifesaving medical treatment (including hydration and nutrition). They *asserted* that a competent person had such a right.[26]

It is worth noting that the *Cruzan* Court seems to have attached no significance whatever to the fact that Nancy Cruzan was not "terminally ill" (as that condition is usually defined). By the time her case was decided by the Supreme Court, Ms. Cruzan had been in a persistent vegetative state for seven years. Moreover, if Ms. Cruzan's parents had not been able to obtain a new hearing in the state probate court after they had lost in the Supreme Court — a hearing which soon led to the termination of Nancy's nutrition and hydration[27] — their daughter, as dissenting Justice Brennan described it, might have "remain[ed] a passive prisoner of medical technology" for another 30 years![28]

Worth noting, too, is that the author of the majority opinion in *Cruzan*, Chief Justice Rehnquist, seemed to draw no distinction between the feeding tube and other lifesaving medical treatment (LSMT). Moreover, concurring Justice O'Connor explicitly and emphatically rejected any such distinction.[29]

B. The Glucksberg and Quill Cases

Glanville Williams, whose highly influential 1957 book[30] may be said to have launched the modern era of the "physician-assisted death" movement, once said that "[a] toehold for euthanasia [or, one might add, PAS] is provided by the practice of letting die, or what is called passive euthanasia."[31] The equating of "letting die" with PAS helped produce a stirring battle cry — the "right to die."[32]

A generation later, Williams' comment looked like a gross understatement. For in 1996, within the span of a single month, two federal courts of appeals (the Second and Ninth Circuits)[33] concluded that in certain circumstances there was indeed a constitutional right to physician-assisted suicide. Along the way, both courts shattered (for 16 months, at any rate)[34] what had been a general consensus that forgoing life-sustaining medical treatment was neither suicide nor homicide.

As Alexander Morgan Capron summed up its reasoning,[35] the U.S. Court of Appeals for the Ninth Circuit viewed the right to forgo unwanted medical treatment and the right to enlist the aid of a physician in order to die by suicide as merely "*sub*categories" of *the same* broad right — "controlling the time and manner of one's death" or "hastening one's death."[36]

It would be no exaggeration to say that the Ninth Circuit disdained the distinction between "letting die" and actively intervening to promote or to bring about death:

> [W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. In fact, some might argue that pulling the plug is a more culpable and aggressive act on the doctor's part and provides more reason for criminal prosecution. To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other....[W]e see little basis for [classifying the death of patients who take lethal drugs as "suicide"] when deaths that result from patients' decisions to terminate life support systems or to refuse life-sustaining food and water, for example, are not....[37]

While the Ninth Circuit had relied on the Due Process Clause of the Fourteenth Amendment, the Second Circuit invoked the Equal Protection Clause of the same amendment. The Equal Protection Clause, observed the Second Circuit, "directs that 'all similarly circumscribed shall be treated alike,'"[38] but, it maintained, New York has failed to do so:

> Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment.…*The ending of life by these means is nothing more nor less than assisted suicide.* It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death, *but whose treatment does not include life support* are treated equally.[39]

In short, if one takes the reasoning of the Second Circuit seriously, it seems to lead to the conclusion that there is a *general* right to PAS — not one merely limited to the terminally ill.

Most of the two million people who die in this country every year do so in hospitals and long-term care institutions and most of them die "after a decision to forgo life-sustaining treatment has been made."[40] Under the *Quill* court's logic, therefore, quipped George Annas, "there is an epidemic of suicide and homicide in the nation's hospitals."[41]

Nor is that all. Although I suspect many people are not aware of this, the right to forgo lifesaving medical treatment is not limited to the terminally ill. The belief that it is so limited is one of the "myths" that Alan Meisel, the leading treatise writer on the general subject, exploded nearly two decades ago.[42] This means a person with a long life expectancy may refuse to have her leg amputated even though she may die of gangrene as a result or may refuse to have a heart bypass operation performed even though it may extend her life by 10 years. Or people may refuse to go on dialysis even though they could live for many more years if they did so — or, once on it, change their minds and get off.[43]

If one adopts the Second Circuit's reasoning in the *Quill* case — i.e., *terminally ill* people *off* life support are entitled to control the time and manner of their deaths because they are "similarly situated" to terminally ill people *on* life support who do have such a right because they can reject life support — it seems to follow that *non*-terminally ill people who *do not need any* lifesaving medical treatment are entitled to control the timing of their deaths, i.e., enlist the assistance of a physician in committing suicide, because they are "similarly situated" to *non*-terminally ill patients who *do need but may reject* life-sustaining medical treatment and thereby control the timing of their deaths. In short, if one takes the reasoning of the Second Circuit seriously, it seems to lead to the conclusion that there is a *general* right to PAS — not one merely limited to the terminally ill.

The U.S. Supreme Court reversed both the Second and Ninth Circuit decisions without a single dissent. In an opinion designated as "the opinion of the Court,"[44] Chief Justice Rehnquist forcefully rejected the Ninth Circuit's reasoning in the *Glucksberg* case:

> …
>
> The right assumed in *Cruzan*…was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.[45]

Chief Justice Rehnquist also wrote the opinion of the Court in *Vacco v. Quill*, the companion case to *Glucksberg*. He was no more impressed with the Second Circuit's equal protection reasoning than he had been with the Ninth Circuit's due process analysis. He was unable to see how New York's ban on assisting suicide while permitting patients to refuse medical treatment drew any distinctions (invidious or otherwise) between people:

> *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide.[46]

As for the Second Circuit's argument that "ending or refusing lifesaving medical treatment 'is nothing more nor less than assisted suicide'":[47]

> Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational.[48]

Nor is that all:

> [T]he overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting lifesaving medical treatment by prohibiting the former and permitting the latter....[E]ven as the States move to protect and promote patients' dignity at the end of life, they remain opposed to physician-assisted suicide.[49]

C. Baxter v. Montana

In December of 2008, a district court judge in Montana decided that competent terminally ill patients and their physicians had rights under the state constitution to what the court variously called "aid-in-dying," "assisted death," and "physician-assisted suicide."[50] The ruling heartened proponents of PAS. However, a close look at the opinion reveals that, even if affirmed by the state supreme court, the district court decision is unlikely to have any impact at all on other states.

First, Robert Baxter and other plaintiffs in the case withdrew their due process claim. Second, the Montana district court rejected their equal protection argument.

> [One] who chooses to refuse life-sustaining treatment is entitled to do so based on the right to be free from an intrusion on [one's] bodily integrity without [one's] consent. What that individual seeks is essentially a negative act — that the physician refrain from action or curtail an action already taken, which permits nature to take its course. Baxter, however, seeks an affirmative act from his physician intended to hasten death.[51]

The rejection of the "equal protection" argument is significant for two reasons. One, death resulting from the withholding of life-sustaining treatment has been specifically exempted from the prohibition against homicide by the Montana legislature,[52] thus heightening the disparity in treatment between terminally ill people dependent on life-sustaining medical procedures and terminally ill people who are not dependent on such procedures. Second, as the district court noted, "Montana applies broader equal protection to its citizens than that provided by the United States Constitution."[53]

What, then, was the basis for the Montana court's ruling? Two provisions of the Montana Constitution not found in most state constitutions. One states that a human being's "dignity" is "inviolable";[54] the other tells us that "the right of privacy" "shall not be infringed without the showing of a compelling state interest."[55] As the district court saw the case, "the [state] constitutional rights to privacy and dignity are intertwined insofar as they apply to Plaintiff's assertion that competent terminal patients have the right to determine the timing of their death...."[56]

The Montana court noted that so far "no [American] court of *final jurisdiction* has determined that an individual has a right, under either federal or state constitutional protections," to "'physician-assisted suicide' under even the limited circumstances here."[57] This is still true. It remains to be seen whether the Supreme Court of Montana will affirm the district court. But even if it does — even if it becomes *the first American court* of final jurisdiction to establish a right to PAS — it will only be interpreting special, and unusual, provisions of one particular state constitution.

III. Defending the Distinction between "Killing" and "Letting Die"

A. Refusing vs. Terminating Medical Treatment

Few, if any, would deny that a terminally ill person — or for that matter *anybody* — has a right to refuse LSMT in the first place.[58] But should a line be drawn between withholding and withdrawing LSMT? It seems fairly clear that there is a psychological difference between (a) letting patients decline treatment or not selecting them for treatment and (b) "terminating" somebody already on treatment.[59]

But how much sense does it make to draw a line between (a) not starting a particular treatment and (b) stopping it after it has begun? As Professor Dan Brock has pointed out, it will often be unclear how effective a particular treatment will turn out to be. "The treatment is usually worth trying to see whether it has the hoped-for-positive effect."[60] But if the treatment proves to be of little or no benefit, there is a reason to stop it which did not exist before the treatment started.[61] This is especially true when the patient is willing to try experimental therapy.[62]

Critics of the distinction between "killing" and "letting die" like to point out that taking patients off life-sustaining treatment feels "active," not "passive."[63] But discontinuing LSMT cannot be separated from starting it. If patients could choose what might (or might not) prove to be useful LSMT, but are forced to continue treatment once it started — even though it turned out to be unhelpful and distressful — many probably would not agree to the treatment in the first place. This is why the right to choose treatment has to mean the right to discontinue it as well.

B. The Importance of the Right to Forgo Life-Preserving Treatment

As noted earlier, most of the two million people who die in this country every year do so after forgoing life-sustaining medical treatment.[64] If such treatment could not be rejected, enormous numbers of people would be "at the mercy of every technological advance."[65]

While legalizing PAS (or active voluntary euthanasia) would put the entire population at risk, a right to forgo LSMT "puts at risk only the lives of those who would die without treatment."[66] And when forgoing life support is under serious consideration, it is usually because the patient is "very bad off indeed"[67] and "likely to die soon no matter what is done."[68]

As John Arras observed a decade ago:

> [T]he practice of forgoing treatment is by now so deeply embedded in our social and medical practice that a reversal of policy on this point would throw most of our major medical institutions into a state expressing chaos. The same cannot be said of a refusal to honor requests for PAS and euthanasia. Thus while there may be many overlapping similarities between withholding treatment and participating in PAS or euthanasia, their respective denial at the level of social policy would entail vastly different individual and social consequences.[69]

Timothy Quill has emphasized that:

> [S]ometimes the same interventions that we use to keep people alive...can prolong the process of dying.... If we are going to use the wonders of modern medicine, we have to learn how not to use them, to stop using them at some point if the circumstances of the patient changes or the goals change.[70]

But 21 years ago, before Timothy Quill had become a famous name, another person was saying essentially the same thing. He was a Roman Catholic Cardinal named Joseph Bernadin.[71] Speaking at a conference held at the University of Chicago hospital, he stood up, pointed to the many people being kept alive in the floors above him, and then continued:

> We know that it is fairly easy for technology or medicine to become an end in itself, and for life to be preserved when, in fact, death should be allowed to happen....
>
> ... I am...convinced that we are not *morally* obliged to do everything that is *technically* possible.... [T]here are cases where we would not be obliged artificially to provide nutrition and hydration.... If we do not resolve this critical issue in a way that resonates with the common sense of people of good will, then we may contribute to the sense of desperation that will lead people to consider euthanasia as an alternative solution to the problem.[72]

Cardinal Bernadin and Dr. Quill have said essentially the same thing for some of the same reasons. But I venture to say they did so for different reasons as well. Dr. Quill (and his co-authors) have recognized the possibility that some day the "reasoning applied to treatment-refusal cases could also be applied to physician-assisted death."[73] On the other hand, I am confident that the Cardinal was well aware, to quote the New York State Task Force Report, that denying patients the right to forgo life-sustaining treatment would "fuel the movement for assisted suicide and euthanasia, a movement that draws considerable strength from public fears of an intolerable death prolonged by medical advances."[74]

C. Can the "Killing"/"Letting Die" Distinction Be Defended on Pragmatic Grounds?

At least since the publication of James Rachels's influential paper[75] on what has been called the "moral equivalence hypothesis" (the view that PAS or active voluntary euthanasia must be as moral, or as immoral, as allowing a patient to die by forgoing LSMT), a goodly number of ethicists and philosophers have rejected the distinction between "killing" and "letting die."[76] This was bad enough. But for me the worst was yet to come. Several years before the U.S. Supreme Court handed down its decisions in *Glucksberg* and *Quill*, a renowned law professor, Sanford Kadish, concluded that the "killing"/"letting die" distinction could not "withstand principled analysis."[77]

I had to wince. When someone calls your views on any issue "unprincipled," it hurts — and it especially does when the person making that charge is probably the greatest American criminal law scholar of his generation. However, Professor Kadish was quick to add:

> I do not mean to suggest that the law cannot justifiably make distinctions on pragmatic grounds; it frequently does so for all kinds of prudential considerations. I mean only to suggest that the distinctions under discussion cannot be defended *except* on pragmatic grounds....[78]

> It isn't hard to surmise why courts have drawn back from the conclusion that there is no difference between suicide and refusal of treatment. To accept it would be to acknowledge a radical break with the received tradition and open the door to positions the courts are not yet willing to adopt: for example, that the state may not act to prevent suicide (except perhaps temporarily to assure competent consent), or to prevent a person from assisting another's suicide, or conceivably even to prevent one person from killing another who competently consents to being killed.... [By] not distinguishing suicide and consensual euthanasia [from refusal of treatment], the courts would by implication be endorsing these positions in principle. Yet this would be the greatest affront to the moral tradition. The courts, therefore, have chosen to improvise lines of distinction, even at the cost of some coherence....[79]

Since the Karen Ann Quinlan era, the medical profession "has made great strides prolonging life." As Timothy Quill has recently reminded us, "while the array of medical choices faced by patients and families has grown more complex, ethics and law remain clear that patients have a right both to forgo such treatments and to stop them once started." I doubt this would have occurred if a line had not been drawn between "killing" and "letting die." Nor am I alone in this belief.

I for one am not prepared to defend the distinction between "killing" and "letting die" on "principled" grounds. (I hasten to add, however, that, as I try to spell out in the next section, some of the distinctions drawn by PAS proponents cannot be defended on principled grounds either.) But for reasons I shall discuss below, I do believe that, as Professor Kadish has suggested, the distinction can be defended on plausible pragmatic grounds.

Since the Karen Ann Quinlan era, the medical profession "has made great strides prolonging life."[80] As Timothy Quill has recently reminded us, "while the array of medical choices faced by patients and families has grown more complex, ethics and law remain clear that patients have a right both to forgo such treatments and to stop them once started."[81] I doubt this would have occurred if a line had not been drawn between "killing" and "letting die." Nor am I alone in this belief.

Norman Cantor, a proponent of PAS,[82] recognizes that "constructive changes" in medical ethics "have won the acceptance of legal authorities in part because the new pattern strives to preserve the pre-existing legal framework."[83] By "constructive changes," Professor Cantor means changes brought about by "extraordinary advances in medical technology" which have rendered the traditional medical approach — utilize all possible means to forestall death — "inhumane because of its capacity to extend existence beyond all 'natural bounds.'"[84] Cantor continues:

> A sharp distinction between managing medical intervention and introducing external death-causing agents is an integral part of the existing legal framework. Physicians, patients, courts and legislatures have become increasingly comfortable with this distinction....
>
> None of [various] adaptations of legal doctrine could have occurred if active euthanasia [and, I would add, PAS] had been the issue.
>
> ... Giving content and precise meaning to humane medical treatment (or non-treatment) is challenge enough without adding complications by altering the existing legal framework.[85]

Another proponent of PAS, Alan Meisel, has observed:

> [The consensus that has emerged from the *Quinlan* case] acknowledge[s] a clear awareness of the distinction between passively and actively hastening death. Courts and legislatures are mindful of this distinction and have taken special pains to distinguish the two forms of hastening death. In fact, it is fair to say that this distinction has been the bedrock of the consensus. Without this distinction, it is doubtful...that the legal consensus about forgoing life-sustaining treatment would have evolved....[86] As proponents embarked on the legitimation of passively hastening death, courts recog-

> nized that making and emphasizing the distinction between passively and actively hastening death met a symbolic, and perhaps real, need to preserve the fundamental societal prohibition of killing innocent human beings.[87]

Professor Meisel is hardly the only commentator in the field to speak of symbolism.

Norman Cantor has observed that "the best moral and ethical justification for different treatment of withdrawal of life support and provision of a poison is the promotion of society's symbolic interest in the sanctity of life."[88] David Orentlicher has suggested that initially the prohibition against PAS served as "a useful proxy for separating morally valid and morally invalid" patient requests for a physician's assistance in dying.[89]

Dr. Ezekiel Emanuel has gone so far as to say — and I suspect this will discomfit more than a few — that to a large extent the entire debate is about the symbolism of *the physician*. After observing that dying or seriously ill patients "do not live with empty medical cabinets"[90] — many, especially those dying of cancer and AIDS, "have more than enough narcotics and sleeping pills to end their own lives"[91] — Emanuel maintains that the physician's involvement in assisted suicide (or voluntary euthanasia) "*medicalizes* the suicide" and thus "legitimizes" it:

> Professional medical assistance for suicide does not dignify the means so much as it does the act itself. Professional assistance medicalizes the suicide in a manner that legitimizes the act. By providing the life-ending prescription or injecting the life-ending drug, the doctor in the white coat, the authority figure imbued with elevated social standing and prestige, adds social sanction to the act of intentionally ending one's life. By participating as a recognized authority figure, the physician conveys society's view that this action is appropriate and worthy.[92]

IV. Are Some Distinctions Drawn by PAS Proponents "Unprincipled"?

A. The Distinction between PAS and Active Voluntary Euthanasia (AVE)

In 1996, nine authors from the fields of law, medicine, philosophy, and economics proposed a model statute to authorize and regulate PAS.[93] But they did not address active voluntary euthanasia (AVE) because they told us that "we disagree among ourselves" as to whether there is "an important difference" between PAS and AVE.[94] The nine authors gave two reasons why they chose to authorize only PAS: (1) restricting the statute to PAS "provides in many cases a stronger assurance of the patient's voluntary resolve to die" and (2) there would be "greater acceptance" of the proposed model statute if it were limited to PAS "partly because of the public perception of voluntariness and partly because of the strong ethical objections of some physicians and others to euthanasia."[95]

Professor Kadish likes to remind me that the fact that the proponent of a principle (or policy) stops short of the principle's ultimate logic does not necessarily mean that the proponent is "strategizing." The proponent may have simply decided that the social consequences of the principle in the real world justify a shorter stopping point. Nevertheless, in this instance I cannot resist the conclusion that proponents of PAS *were* "strategizing."

"Euthanasia," Professor Dan Brock once observed, is a term that has "strong emotionally laden connotations."[96] This strikes me as an understatement. Although when it first appeared in the English language centuries ago, it meant "a gentle, easy death"[97]; for many, it has long since become an offensive, scary term. PAS proponents are likely to fear, and with good cause, that their proposal would be unpalatable if it were linked to AVE.

The unattractiveness of the label "euthanasia" could not have escaped the notice of PAS proponents. They are quite sensitive about terminology.[98] For example, although the term "physician-assisted suicide" is itself a relatively new neologism — perhaps no more than 20 years old[99] — a number of its proponents have been unhappy with it for some time. They consider "suicide" too harsh a term to use to describe the "bring[ing] about [of] a peaceful and dignified death."[100] As Kathryn Tucker, the Director of Legal Affairs for Compassion & Choices, has recently observed:

> The term "assisted suicide" has been replaced with more accurate and value-neutral terms such as "aid in dying" or "physician-assisted dying." The only active opponents of this evolution in terminology are opponents of the practice who continue to malign the choice for aid in dying by labeling it "suicide."[101]

But isn't "physician-assisted suicide" or "physician-assisted death" or "aid-in-dying" or whatever one calls it likely to slide into euthanasia?

During the oral arguments in the *Quill* case, Justice Ginsburg wondered why a patient who is so weak or helpless — or in so much agony — that she is unable to swallow the lethal pills herself should be denied the death she seeks because she *cannot participate* in her own suicide. She suggested that such a patient is "in a *more sympathetic* situation," i.e., has a stronger claim to the death she seeks, than a person who *is able* to end her life with the preliminary assistance of a physician.[102]

Then there is the problem of botched suicides. As Professor Cantor has pointed out:

> Because physicians are not skilled at killing by poisons, some instances will occur where a patient's suicide attempt fails and a physician will be called upon to administer a coup de grace. In the Netherlands, approximately 18% of assisted suicides result in serious complications or fail to work. The imperative of ending suffering then leads to an alternate mode of causing death, usually a lethal injection.[103]

In 1992, Professor Quill and his co-authors drew a firm line between PAS and AVE. They stopped short of AVE "because of the risk of abuse it presents."[104] They favored only PAS because in that situation "the final act is solely the patient's" and therefore "the risk of subtle coercion" from physicians and family members is "greatly reduced," and the "balance of power" between physician and patient "is more nearly equal."[105]

Daniel Callahan and Margot White sharply challenged the grounds Quill and his co-authors gave for distinguishing between PAS and AVE:

> To insinuate the idea of suicide into the mind of someone already grievously suffering can surely be no more difficult than insinuating the idea of euthanasia....
>
> As for the power of doctors, their general prestige as professionals, who with training and experience are widely thought to understand better matters of life and death than the rest of us, and their capacity to give or withhold lethal drugs, already establishes the power differential between themselves and their patients.[106]

Callahan and White are both opponents of PAS. Dan Brock, on the other hand, is a leading proponent of PAS. Yet Professor Brock attacked the line Professor Quill and his colleagues had drawn between PAS and AVE even more emphatically than did Callahan and White.

Brock perceived "no significant, intrinsic moral distinction" between PAS and AVE.[107] He found it "hard to see why public or legal policy should permit one but not the other."[108] He maintained that "worries about abuse or about giving anyone dominion over the lives of others applies equally to either":[109]

> In physician-assisted suicide the patient acts last... whereas in euthanasia the physician acts last by performing the physical equivalent of pushing the button. In both cases, however, the choice rests fully with the patient. In both the patient acts last in the sense of retaining the right to change his or her mind until the point at which the lethal process becomes irreversible....[110]

A short two years after he had balked at doing so, Dr. Quill crossed the line between PAS and AVE. Along with four colleagues he endorsed "physician-assisted death" (PAD), a term that embraces both PAS and AVE:

> To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so. The method chosen is less important than the careful assessment that precedes assisted death.[111]

Quill was not the only co-author of the 1994 article who, shortly after drawing a line short of AVE, decided to cross it. Two other commentators who co-authored the 1994 article — Lawrence Gostin and Diane Meier — also changed their views, feeling the need to cross the line in certain instances.[112]

The fact that in a short span of time three well-known commentators decided they could no longer rule out AVE completely — because doing so "unfairly discriminates" against certain patients — strikes me as further evidence that if and when PAS is widely adopted, the thin line between PAS and AVE is unlikely to hold.

B. Limiting the Right to PAS to the Terminally Ill

Both in their briefs and during their oral arguments before the Supreme Court, the lawyers for Doctors Glucksberg and Quill emphasized that they were seeking PAS only for "terminally ill" patients (often defined as a condition or illness that will result in death within six months' time) or for those at "the threshold of death" or those "facing imminent and inevitable death."[113] This led Justice Ginsberg to comment that "[a] lot of people [other than the terminally ill] would fit this category," i.e., would rather die than experience continued pain, suffering, or indignity.[114] How, she asked, "do you...leave out the rest of the world who would fit the same standards?"[115] If, as one of the most eloquent proponents of PAS, Dan Brock, has maintained, "the right not to be killed, like other rights, should be waivable when the patient makes a competent decision" that continued life is "worse than no further life at all,"[116] why should this right be limited to the terminally ill?

Ronald Dworkin and five other prominent moral philosophers who filed an *amicus* brief in *Glucksberg* and *Quill* argued, on behalf of the patient-plaintiffs, that "individuals have a constitutionally protected interest in making those grave judgments for themselves [about how they should confront their death or when it is appropriate to ask others for help in hastening their death] free from the imposition of any religious or philosophical orthodoxy by court or legislature."[117] If so, why should the right — and how can it — be limited to the terminally ill?

It is worth recalling that until their rulings were overturned by the U.S. Supreme Court, both the Second and Ninth Circuit Courts of Appeals proceeded on the premise that there is no significant difference between PAS and the right to forgo LSMT.[118] But the right to forgo LSMT has not been limited to the terminally ill. Indeed, it is "virtually absolute."[119] As Norman Cantor has emphasized:

> [A] medical patient's prerogative — grounded in self-determination and bodily integrity — to reject life-sustaining medical interventions....attaches no matter how slight the bodily intrusions contemplated, no matter how long the patient's existence could potentially be preserved, and no matter how foolish the patient's decision might seem to health care providers and others.[120]

So if and when a right to PAS is established in a case involving a terminally ill patient, presumably on the ground that there is no significant legal or ethical difference between PAS and the right to forgo LSMT, why would we expect the ruling to be limited to the terminally ill?

In his introduction to *The Philosophers' Brief*, Professor Dworkin does recognize that the states may set some limits on the right to PAS: because people sometimes make life-and-death decisions "when their act does not reflect their enduring convictions," states may be allowed "to overrule that right in order to protect citizens from mistaken but irrevocable acts of self-destruction."[121] The states may do this, explains Dworkin, "to prevent assisted suicide by people who — it is plausible to think — would later be grateful if they were prevented from dying."[122]

Dworkin tells us that he had in mind "a state's protecting a disappointed adolescent from himself."[123] That is an easy case. What about the hard ones: The person paralyzed from the chest down who has ten years to live? The badly disabled and disfigured survivor of a car accident or fire who has 20 years to life? Someone in the early stages of Alzheimer's disease, anticipating and fearing mental deterioration several years down the road?

Also in the introduction of his book, Dworkin takes notice of the fact that during the oral arguments one or more Supreme Court Justices wondered whether, if the right to PAS for the terminally ill were granted in *Glucksberg* and *Quill*, the right could or should be confined to that relatively small group.[124] Professor Dworkin then framed the question: why should PAS be denied "to patients who are not dying but face years of intolerable physical or emotional pain or crippling paralysis or dependence?"[125]

But Dworkin never really answers his own question. All he has to say about it is that if his side had prevailed in the Supreme Court, "the federal courts would no doubt be faced with a succession of cases in years to come testing whether, for example, it is plausible to assume that a desperately crippled patient in constant pain but with years to live, *who has formed a settled and repeatedly stated wish to die*, would one day be forced to stay alive."[126]

But if the right to PAS for the terminally ill had been established in *Glucksberg* and *Quill*, and the "desperately crippled person" with "a settled and repeatedly stated wish to die" had tried to apply the new ruling to her situation, what would there have been left to argue about? We have already been told that in the hypothetical case the person had "a settled and repeatedly stated wish to die." How many *more times* does she have to repeat her wish to die before the court is convinced she will not change her mind?

I venture to say that because he believes that the right to PAS ought to be regarded as a constitutionally protected "momentous personal decision" comparable to getting married or having children,[127] Professor Dworkin cannot bring himself to say that if *Glucksberg* and *Quill* had been decided in his favor, then the person in his hypothetical would have been denied relief because he was not terminally ill. On the other hand, Dworkin seems unwilling to say (for now, at any rate) that if the PAS cases had been decided in his favor, the non-terminally ill person in his hypothetical would almost certainly have gained such a right as well. (I believe this is so.) This may explain why Dworkin falls back on the state's authority to prevent assisted suicide by those who might "later be grateful if they were prevented from dying."

Such an argument may be persuasive when the state is "protecting a disappointed adolescent from himself."[128] But the argument loses much of its force when we are dealing with someone like the person in Professor Dworkin's hypothetical — a non-terminally ill person who no longer wants to continue living in the intolerable existence she has already been dealing with for months or years.

In recent years, most PAS proponents have concentrated on the terminally ill. It is not hard to figure out why. A PAS right limited to the terminally ill would cause less alarm and command more support than would a broader right. As nine PAS proponents noted more than a decade ago, terminally ill patients "have generally been seen as the least controversial candidates for the recognition of the right to die."[129]

As a matter of principle, however, it is difficult to see how one could limit PAS to the terminally ill. In many instances the non-terminally ill person will have been thinking that death is better than continued life for a longer time than the terminally ill patient. In many, perhaps most, cases the non-terminally ill person who prefers death over continued life (a) may have already suffered more pain, indignity and degradation than the terminally ill person or (b) will surely do so if forced to stay alive.[130]

Up to this point, I have assumed that "terminally ill" is a manageable classification. But there are serious doubts about this. Daniel Callahan and Margot White have warned us that "[t]he few studies that have been done indicate that the designation of six months as a terminal period is entirely arbitrary and that physicians vary drastically in their interpretation of what constitutes this terminal phase of illness."[131] A five-hospital empirical study by Professor Joanne Lynn and five other health professionals led them to issue another warning: "[d]eciding who should be counted 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting [PAS]."[132]

I could not end this section without recalling that when more than a decade ago, nine persons from law, medicine, and philosophy joined together to draft a model state act authorizing and regulating PAS, one of the issues they had to resolve was whether to limit PAS to the terminally ill. What did they decide?

Although the nine authors recognized that "the restriction of the right to the terminally ill establishes a boundary that helps to address slippery slope concerns,"[133] they went beyond that boundary. Concerned about people who suffer greatly from such illnesses "as AIDS, advanced emphysema, some forms of cancer, amyotrophic lateral sclerosis (Lou Gehrig's disease), multiple sclerosis, and many other debilitating conditions" — but "who are not likely to die from their illnesses within six months"[134] — "a bare majority of us agreed to allow anyone to be eligible whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death."[135]

V. Palliative Care, the Principle of Double Effect, and Terminal Sedation

It is difficult to be precise about the Supreme Court's rulings in the 1997 *Glucksberg* and *Quill* cases for two reasons: (1) although Justice O'Connor purported to join Chief Justice Rehnquist's four-person opinion, thus making it "the opinion of the Court," it is doubtful she really did so;[136] and (2) the four remaining members of the Court wrote either cryptic or wide-ranging concurring opinions.

However, some things are clear. For example, it is clear that the Court approved the principle of double effect (PDE) — the view that "it is moral [and lawful] to administer high-dose narcotics to dying patients, even though there may be some risk of hastening death, whereas it is not moral to administer an overdose of such drugs deliberately to cause death."[137]

In the case that came to be known as *Glucksberg*, the Ninth Circuit had, as Professor Howard Brody described it, "dismiss[ed]" the double effect principle as "moral hypocrisy."[138] The Ninth Circuit could "see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and...with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life."[139]

The U.S. Supreme viewed the matter very differently. It left no doubt that it is permissible for a physician to provide "painkilling drugs [even though they] may hasten a patient's death" so long as "the physician's purpose and intent is, or may be, only to ease his patient's pain."[140] It also quoted with approval a statement from the New York State Task Force Report that the PDE is "widely recognized" as "ethically and professionally acceptable."[141]

Whatever position a person takes on PAS or euthanasia, everyone should welcome the Supreme Court's approval of the PDE in the medical context. As Professor Brody pointed out shortly after the Ninth Circuit handed down its decision (and shortly before the Supreme Court overturned it):

> [I]f the court is allowed to make the case that double effect deaths are morally no different from assisting a patient's suicide, then a large number of practitioners — perhaps one-third — would have strong moral grounds for refusing to treat terminal pain with adequate doses of opiods. The impact on medicine's already suboptimal level of compassionate care of terminal suffering could be disastrous.[142]

In a way, however, the High Court's approval of the PDE was a special victory for those opposed to PAS and euthanasia. For they have long defended the principle.[143] But some proponents of PAS have criticized the PDE, condemning the supposed hypocrisy in permitting the use of pain relief to hasten death while prohibiting PAS (or voluntary euthanasia).[144]

As the American Medical Association and some 40 other medical and health care organizations maintained in the *amicus* brief they filed in the *Glucksberg* case, "properly trained health care professionals can effectively meet their patients' needs for compassionate end-of-life care without acceding to requests for suicide."[145] The PDE makes the goal of health care professionals more attainable — and weakens the case for PAS.

How far does the "double effect" principle extend? For example, does it have any bearing on a procedure called "terminal sedation" which was mentioned in the *Quill* oral arguments? Those who talk or read about "terminal sedation" are likely to run into a flurry of words and phrases. To avoid, or at least minimize confusion, we should use terminology carefully.

How far does the "double effect" principle extend? For example, does it have any bearing on a procedure called "terminal sedation" (TS) which was mentioned in the *Quill* oral arguments? Those who talk or read about "terminal sedation" (TS) are likely to run into a flurry of words and phrases. To avoid, or at least minimize confusion, we should use terminology carefully.

To begin with, neither sedation of the terminally ill nor heavy sedation nor sedation to the point of unconsciousness is TS. When most commentators refer to TS, when I do, and most important, I think when Dr. Quill's lawyer, Professor Laurence Tribe, did in his Supreme Court argument, what we all mean is a two-step procedure: (1) sedating the patient to unconsciousness and (2) withholding artificial nutrition and hydration (ANH).

At the risk of complicating matters further, I have to add that at least one prominent commentator, Norman Cantor, has used the term "deep sedation" to cover several different procedures, at least one of which appears to be what others call "terminal sedation."[146] To make matters still more confusing, as Professor Margaret Battin has pointed out, TS has also been called "palliative sedation," "continuous deep sedation," and "slow euthanasia."[147]

The second step of TS — the withholding of ANH — is a crucial component of the procedure. It is the feature that makes the permissibility of the procedure problematic. This point did not escape Professor Quill and his co-authors:

> [T]he doctrine of double effect distinguishes between effects that a person intends (both the end sought and the means taken to the end) and consequences that are foreseen but unintended....
>
> ... [I]t seems implausible to claim that death is unintended when a patient who wants to die is sedated to the point of coma, and intravenous fluids and artificial nutrition are withheld, making death certain. Although the overarching intention of the sedation is to relieve the patient's suffering, the additional step of withholding fluids and nutrition is not needed to relieve pain, but is typically taken to hasten the patient's wished-for death. In contrast, when patients are similarly sedated to treat [other conditions] therapies such as fluids and mechanical ventilation are continued with the goal of prolonging life.[148]

I share the view that TS is a worrisome practice.[149] I also understand why, "because the sedated patient often dies from the combination of two intentional acts by the physician — the induction of stupor or unconsciousness and the withholding of food and water"[150] — Professor David Orentlicher calls it "essentially 'slow euthanasia.'"[151] But I have great difficulty following Professor Orentlicher when he arrives at the conclusion that in the 1997 PAS cases, the U.S. Supreme Court "accept[ed]," "embrac[ed]," "endors[ed]," and "encourage[ed] the availability of" TS.[152] *Where* and *how* did the Court do this?

Pointing at footnote 11 to Chief Justice Rehnquist's opinion in *Vacco v. Quill*, Orentlicher tells us that "the five-justice majority opinion expressly reject[ed] the claim that terminal sedation 'is covert physician-assisted suicide.'"[153] As I read footnote 11, however, the Court did no such thing.

The Court simply quoted *the argument* in Dr. Quill's brief ("Respondents...argue that the State irrationally distinguishes between physician-assisted suicide and 'terminal sedation,' a process respondents characterize as 'induc[ing] barbiturate coma and then starv[ing] the person to death'") and *the response* to that argument in New York's brief ("[a]lthough proponents of physician-assisted suicide and euthanasia contend that terminal sedation is covert assisted-suicide or euthanasia, the concept of sedating pharmacotherapy is based on informed consent and the principle of double effect").[154]

New York State rejected the claim that TS is "covert physician-assisted suicide" — not the Court.[155] Nowhere in footnote 11 does Rehnquist say anything about TS.

After quoting from the opposing briefs, Chief Justice Rehnquist did embark on a brief general discussion of palliative care (consisting of nine lines in the official reports). But he discussed only the permissibility of palliative care "which may have the foreseen but unintended 'double effect' of hastening the patient's death."[156] In the course of this general discussion, Rehnquist quoted with approval from the New York State Task Force Report, once again referring to the "double effect" principle: "[T]he provision of pain medicine is ethically and professionally acceptable even when the treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death."[157]

But what does all this "double effect" talk have to do with TS? "If one *intends* to hasten death, one is no longer employing the principle of double effect, and one can no longer seek shelter under its moral umbrella."[158] Professor Orentlicher is well aware of the necessarily intentional quality of TS and the inapplicability of the PDE when evaluating the practice.[159] This is why he calls TS "slow euthanasia."[160]

The repeated references to the "double effect" principle in footnote 11 lead me to conclude that Rehnquist did not have the special TS procedure in mind when he discussed palliative care generally. If Rehnquist had been trying to defend TS on "double effect" grounds, one would have expected him to *explain* how a medical practice which *combined* sedating a patient to unconsciousness *and* the withholding of ANH could be reconciled with the PDE. But Rehnquist did not do this. Nowhere in footnote 11 did he focus on or even indicate he was aware of the special problems raised by the special process known as TS.

Rehnquist may have been led astray by the quotation from Paul Rousseau's article, which did invoke the PDE. It is also possible that Rehnquist may have failed to grasp the distinction between (1) sedation that causes unconsciousness and hastens death and (2) such sedation *plus* the withholding of ANH.[161] But I fail to see how one can say, on the basis of footnote eleven, that the Supreme Court approved TS.

Professor Orentlicher also maintains that "three concurring Supreme Court Justices endorse[d]" TS,[162] pointing to Justice O'Connor's concurring opinion in *Glucksberg* and *Quill*.[163] But much of what I have said about footnote 11 to Chief Justice Rehnquist's opinion applies to Justice O'Connor's concurring opinion as well. She never refers to TS or any of its synonyms, such as "deep sedation." Although she talks about the availability of palliative care to relieve suffering, "even to the point of causing unconsciousness and hastening death,"[164] she has nothing whatsoever to say about the "withholding of ANH" component to such sedation.

As Norman Cantor notes, "[n]one of the sources that Justice O'Connor cites with regard to hastening death confirms the legality of withholding ANH in the course of long-term sedation."[165] Justice O'Connor does say at one point that the states involved in the litigation (New York and Washington) "agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication…to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[166] But if O'Connor were including TS, then this statement would not be accurate, for New York had argued that if TS were taking place in its state (which it doubted), it would "unquestionably [be] outside the bounds of accepted medical practice."[167]

Orentlicher also told us that concurring Justices Ginsburg and Breyer, as well as Justice O'Connor, approved TS. But I am unable to find any support for that conclusion either.[168]

In short, to conclude, as Professor Orentlicher does, that either the Court (on the basis of footnote 11) or the three Justices "endorsed" the medical procedure known as TS strikes me as quite a leap.

Some day the Court will have to focus on TS. When it does, will it uphold its legality? One may argue that TS is essentially an embellished form of forgoing ANH. After all, if patients so desire, they can have ANH withheld or withdrawn. So why should TS be prohibited? On the other hand, one may argue that the second component of TS — the withholding of ANH — colors the first component — sedation to the point of unconsciousness. The second component indicates that the overall purpose of TS is not to relieve the pain, but to kill the patient.

Although physicians trying to "kill the pain" may provide pain relief which increases the risk of death, they may not purposely "kill *the patient*" in order to kill the pain. "The uniform judicial position in the United States that euthanasia is always unjustified homicide reflects a view that pain relief can never outweigh the harm of purposely causing a premature death."[169]

When the Court does resolve the issue, we can be sure of one thing — the decision will involve some fine line-drawing. In the meantime, I believe that *the best* that can be said for TS is what Norman Cantor has said — the sequence of sedation to the point of unconsciousness *followed by* the withholding of ANH takes us into "legally uncharted territory."[170]

VI. Some Concluding Remarks

A decade ago, in an effort to get a better grasp of how physicians and medical ethicists would react to a heart-wrenching case — one that seemed to call out for PAS/euthanasia — I studied the writings of three of the staunchest opponents of PAS: John Arras, Ezekiel Emanuel, and Mark Siegler.[171] It soon became clear that none of them objected to physicians helping their patients commit suicide in extraordinarily compelling cases; what they were opposed to was *the enactment of laws* formally authorizing PAS under any circumstances.

Thus, Siegler balked at "tak[ing] the chance of legalizing assisted suicide and euthanasia" in order to satisfy the needs of a small group of patients suffering "bad" death despite the best efforts of health professionals.[172] These patients, added Professor Siegler, "can often find appropriate care from physicians who are sympathetic to their needs.... Prosecutors have used considerable discretion in acknowledging the rights of patients and doctors to reach certain agreements between themselves."[173]

As for Ezekiel Emanuel, he does not think that a relatively few heart-wrenching cases can justify the legalization of PAS or euthanasia, but neither does he believe that physicians should turn their backs on patients in exceptionally compelling circumstances: "The question is not about whether intervention [i.e., PAS or euthanasia] is right for this or that particular patient. In any given case it may be the ethical thing to do, *whatever the law says — and should be done*."[174]

As for John Arras, he defends the current situation in the great majority of states. But how does he *define* the current situation? "[A] regime that does not legally sanction PAS and euthanasia, but nevertheless *covertly permits some particularly compassionate and courageous physicians to violate the law in fear and trembling*."[175]

It is one thing to close your eyes or turn away when another violates a law you support. But Professor Arras comes close to applauding the physician who violates the prohibition against PAS or euthanasia in the heart-wrenching case.

A proponent of PAS is likely to protest that neither the views of Arras, Emanuel, or Siegler are consistent.[176] But their views provide striking evidence of how the PAS/euthanasia issue has confounded and divided physicians, lawyers, judges, and medical ethicists.

The debate over PAS/AVE may be seen as a clash of fundamental beliefs — personal dignity and autonomy versus the laudable view that the law protects all innocent human life, no matter how poor its quality — a view based on the need to "protect the vulnerable and to affirm their connection to society."[177] As Professor (now Judge) Guido Calabresi once pointed out, when fundamental beliefs are in conflict we are forced to make "tragic choices" (he specifically mentioned euthanasia) — and when we do make them, we often try to have it both ways.[178]

The debate over PAS/AVE may be seen as a clash of fundamental beliefs — personal dignity and autonomy versus the laudable view that the law protects all innocent human life, no matter how poor its quality — a view based on the need to "protect the vulnerable and to affirm their connection to society." As Professor (now Judge) Guido Calabresi once pointed out, when fundamental beliefs are in conflict we are forced to make "tragic choices" (he specifically mentioned euthanasia) — and when we do make them, we often try to have it both ways.

Adamant resistance to legalizing PAS or AVE, but a willingness to tolerate the underground practice of PAS/AVE, is one means of having it both ways. Even if we put aside the underground practice, however, the current legal regime in the great majority of states — prohibiting the "medical introduction of outside lethal forces,"[179] but (1) allowing patients to forgo all life-sustaining treatment and (2) permitting physicians to provide pain relief that increases the risk of death — is another means of having it both ways.

The current state of affairs in most states with respect to PAS/AVE illustrates another point. When we must make tragic choices we prefer to do so "in a soft light subdued by history, rather than in the bright spotlight of utmost analytic clarity."[180]

Postscript

Two months after this author presented his paper at the 16th Annual Pitts Lectureship, the Montana Supreme Court affirmed the district court ruling in *Baxter v. Montana*, 224 P.3d 1211 (Mont.Sup.Ct. 2009). (The district court ruling is discussed at notes 50-57 of this paper.) However, the state supreme court based its decision on narrower grounds than the lower court had.

In an opinion signed by four of the seven state supreme court justices, the Montana Supreme Court vacated the district court's ruling on the state constitutional issues and affirmed the lower court's decision on the alternative ground that under state statutory law (which provides that the consent of the victim constitutes a defense to the charge of homicide), the consent of the patient to his physician's "aid in dying" also constitutes a defense to a homicide charge against the physician. The state supreme court recognized that the consent of the victim is not a defense if it is "against public policy" to permit the conduct or the resulting harm. But the court could find nothing in the case law or the state statutes indicating that physician aid in dying is against public policy.

A fifth state supreme court justice agreed with the majority's analysis of the consent statute, but would have also ruled that "physician aid in dying" is protected by the "dignity" and "privacy" provisions of the state constitution. The remaining two state supreme court justices dissented.

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2. S. B. Nuland, *How We Die* (New York: A.A. Knopf, 1994): at xvii (introduction).
3. See Quill, *supra* note 1, at 483.
4. D. Callahan, "Organized Obfuscation: Advocacy for Physician-Assisted Suicide," *Hastings Center Report* 38, no. 5 (September/October, 2008): 30-32, at 31.
5. J. D. Arras, "Physician -Assisted Suicide: A Tragic View," *Journal of Contemporary Health Law & Policy* 13 (1997) 361-89, at 388.
6. J. Fitzpatrick and E. M. Fitzpatrick, *A Better Way to Die* (New York: Penguin 2009): at 41.
7. Noteworthy, too, is A. F. Conard, "Elder Choice," *American Journal of Law & Medicine* 19 (1993): 233-283. Conard, an emeritus professor of law at the time he wrote this article, believed that more "debilitated elders" could be "emancipat[ed]" in ways "compatible with prevalent laws and morals "if there were greater awareness and use of advance health care directives." *Id.*, at 233-235. He "bypassed" both euthanasia and assisted suicide without debating their intrinsic merits or demerits because he believed the resistance to these procedures would be so great that they would not be widely available for the foreseeable future. See *id.*, at 235.
8. Y. Kamisar, "The Reasons So Many People Support Physician-Assisted Suicide – and Why These Reasons Are Not Convincing," *Issues in Law & Medicine* 12 (fall 1996): 113-131. See also C. S. Campbell, "Ten Years of Death with Dignity," *The New Atlantis* 22 (fall 2008): 33-46, at 38: "Supporters of the [Oregon Death with Dignity Act] often invoked 'hard cases' – nightmarish scenarios of terminally ill patients tortured by unrelenting pain."
9. See Arras, *supra* note 5, at 386-87.
10. *Id.*, at 386.
11. *Id.*, at 386-387. A case very similar to the one suggested by Professor Arras (and perhaps the very one he had in mind) occurred in Michigan in 1993. A woman named Ellen Ruth Ward suffered so much from a persistent pelvic pain that forced her to stay at home that she considered suicide. At first Medicare refused to cover the cost of an implantable pump that would bathe Ms. Ward's spinal column in morphine. However, when a Detroit newspaper published an article about her sad situation, Medicare changed its position. At this point, Ms. Ward became quite happy. See S. Andrews, "Woman in Pain Gets OK for Pump," *Detroit Free Press*, March 2, 1993, at 3A.
12. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York State Task Force on Life and the Law, 1994).
13. C. H. Coleman, "The New York State Task Force on Life and the Law: Why It Concluded Physician-Assisted Suicide Should Not Be Legalized," *St. John's Journal of Legal Commentary* 12 (1997): 647-52 at 647-648.
14. *Id.*, at 648-649.
15. *Id.*, at 649. See also Arras, *supra* note 5, at 368.
16. The letter is undated, but it was mailed to me in the spring of 2009. The letter is on file at the University of Michigan law library and with the guest editor of this symposium issue, Robert M. Sade.
17. Compassion & Choices letter, at 1. The Terri Schiavo case, mentioned in the letter, is ably discussed in T. E. Quill, "Terri Schiavo – A Tragedy Compounded," *New England Journal of Medicine* 352 (April 21, 2005): 1630-1633. The case illustrates what may happen when politicians cannot resist "getting into the act" when a person is in a persistent vegetative state and relatives disagree over what should be done about it. To summarize briefly: A cardiac arrest left Ms. Schiavo in a persistent vegetative state. As so often happens, she had not written any advance directive. Her husband, who had been made her legal guardian under Florida law, maintained that his wife would not have wanted to receive life-prolonging treatment under the circumstances. After a long hearing, the trial court agreed and this ruling was affirmed. However, the Florida legislature created "Terri's Law" to override the court's decision. The feeding tube was reinserted, but the law that permitted this to happen was subsequently held to be an unconstitutional violation of the separation of powers. In 2005 the trial court ordered Ms. Schiavo's feeding tube removed again. This time the U.S. Congress passed an "emergency measure," signed by the President, requiring the federal courts to review the case (and perhaps order the feeding tube reinserted). A federal district court in Florida refused to re-examine the case and this ruling was affirmed. Ms. Schiavo died shortly thereafter. In early 2009, a case quite similar to Terri Schiavo's took place in Italy. It involved Eluana Englaro, an Italian woman who had been in a persistent vegetative state for many years. Her father maintained, and several Italian courts had agreed, that his daughter would not have wanted to be kept alive under the circumstances. As the Italian government rushed to pass legislation prohibiting feeding tubes from being removed from patients dependent on them, Ms. Englaro died. See Y. Kamisar, "The Right to Forgo Treatment," *National Law Journal* (March 2, 2009): at 20.
18. The literature is also on file at the University of Michigan law library and with the guest editor of this symposium issue, Robert M. Sade.
19. See Compassion & Choices literature, *supra* note 17, at 2.
20. A. Meisel, *The Right to Die*, 2nd ed. (New York: Wiley Law Pub., 1995): at 470. See also N. L. Cantor, "The Permanently Unconscious Patient, Non-Feeding and Euthanasia," *American Journal of Law & Medicine* 15 (1990): 381-437, at 427-428. I should disclose that in his article, *id.*, at 383, Professor Cantor expressed his strong disagreement with a commentator named Yale Kamisar who, as Cantor described it, had called judicial endorsement of ending artificial nutrition "'intentional killings' of 'biologically tenacious' persons bringing America to 'the brink' of active euthanasia." I soon changed my position on this issue.
21. See Callahan, *supra* note 4, at 31.

22. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990).
23. *Cruzan v. Harmon*, 760 S.W. 2d 408 (Mo. 1988) *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). Although it is settled that a competent person has the right to refuse unwanted medical treatment, in *Cruzan*, as Professor Quill and his co-authors have pointed out, the U.S. Supreme Court ruled that in the absence of any advance directive, the states could set their own standard of evidence about an incompetent patient's wishes to terminate medical treatment. See A. Meisel, L. Snyder, and T. Quill, "Seven Legal Barriers to End-of-Life Care," *JAMA* 284 (November 15, 2000): 2495-2501, at 2496. However, the states are not required to establish as high a burden of proof as Missouri did – and most have not done so. See *id.* After the U.S. Supreme Court handed down its decision in the *Cruzan* case, Nancy Cruzan's parents asked for, and were granted, a second hearing before the state probate court. At the new hearing, three of Nancy Cruzan's former co-workers recalled conversations in which she said she never would want to live "like a vegetable" on medical machines. See *New York Times*, November 2, 1990, at A14, col. 3. The probate court ruled that there was "clear evidence" that if Ms. Cruzan had been mentally able she would have wanted to terminate her nutrition and hydration. The Court then authorized the cessation of nutrition and hydration. See *New York Times*, December 15, 1990, at sec. 1, at 1, col. 2. Twelve days later, and nearly eight years after she had lost consciousness, Nancy Cruzan died.
24. *Cruzan*, 497 U.S. at 278.
25. *Id.*, at 279. Seven years later, writing for the Court in *Washington v. Glucksberg*, quoted in the text at note 44, *infra*, Chief Justice Rehnquist looked back at *Cruzan* as a case where the Court had "assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment." *Glucksberg*, 521 U.S. at 720.
26. See *Cruzan*, 497 U.S. at 287, 289 (Justice O'Connor, concurring); *id.*, at 305, 307 (Justice Brennan, joined by Justices Marshall and Blackmun, dissenting); *id.*, at 331 (Justice Stevens dissenting).
27. See note 23 *supra*.
28. Justice Brennan, joined by Marshall and Blackmun, JJ., dissenting, 497 U.S. at 302.
29. See Justice O'Connor, concurring, 497 U.S. 288-289.
30. G. Williams, *The Sanctity of Life and the Criminal Law* (New York: A.A. Knopf, 1957).
31. G. Williams, "Euthanasia," *Medico-Legal Journal* 41 (1973): 14-34, at 18.
32. "[W]hen we think about a social problem," my colleague Carl Schneider has observed, "we in America today tend to think about it in terms of rights, a mode of thinking we find accessible, convenient and comfortable." C. E. Schneider, "Rights Discourse and Neonatal Euthanasia," *California Law Review* 76 (1988): 151-76, at 154. However, "defining an interest as a right makes accommodation seem to be the breaching of a right or the defining of a right or the defining away of a right and thus, a moral and political wrong." *Id.*, at 172.
33. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc) *rev'd sub nom.* Washington v. Glucksberg, 521 U.S. 702 (1997); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997).
34. This was how long it took for the U.S. Supreme Court to overturn both rulings. *Glucksberg*, as the Ninth Circuit decision came to be known, was decided on March 6, 1996. The Second Circuit handed down its decision in *Quill* on April 2, 1996. Both rulings were reversed by the U.S. Supreme Court on June 26, 1997.
35. A. M. Capron, "Liberty, Equality, Death!," *Hastings Center Report* (May/June 1996): 23-24, at 23 (emphasis added).
36. See 79 F. 3d at 802.
37. *Id.*, at 824.
38. *Quill* 80 F.3d at 725.
39. *Id.*, at 729 (emphasis added).
40. Justice Brennan pointed this out in his *Cruzan* dissenting opinion. See 497 U.S. at 302-03.
41. G. J. Annas, "The 'Right to Die' in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian," *Duquesne Law Review* 34 (1996): 875-97, at 896.
42. A. Meisel, "Legal Myths about Terminating Life Support," *Archives of Internal Medicine* 151 (August 1991): 1497-1502, at 1498. After the *Cruzan* case, observes Meisel, "it is virtually indisputable that competent patients have a right to refuse treatment whether terminally ill or not." *Id.*, at 1499.
43. Ronald Dworkin, a well-known proponent of PAS, makes this point quite forcefully in R. Dworkin, "The Right to Death," *New York Review of Books* (January 31, 1991): 14-17, at 17. He deems it "bizarre to classify as suicide someone's decision to reject treatment that would keep him alive but at a cost he and many other people think too great." *Id.*
44. As I have discussed elsewhere, see Y. Kamisar, "Can *Glucksberg* Survive *Lawrence*? Another Look at the End of Life and Personal Autonomy," *Michigan Law Review* 106 (2008): 1453-78, at 1461-63, although formally Justice O'Connor provided the fifth vote, allowing the Chief Justice to say he was speaking for five members of the Court, it is not at all clear that she really joined Rehnquist's opinion.
45. 521 U.S. at 725.
46. 521 U.S. at 800.
47. *Id.*
48. *Id.*, at 800-801.
49. *Id.*, at 805-806.
50. *Baxter v. Montana* (unpublished opinion, dist. ct. Mont., December 5, 2008). Robert Baxter, the lead plaintiff in the case, was a terminal cancer patient. I should disclose that in the appeal of this case to the Montana Supreme Court, I signed my name to one of the *amicus* briefs filed on behalf of the State of Montana. I did not participate in the writing of the *amicus* brief.
51. *Baxter*, at 13.
52. *Id.*, at 11.
53. *Id.*, at 12.
54. *Id.*, at 13 (referring to Article II, section 4 of the Montana Constitution).
55. *Id.*, at 15 (referring to Article II, section 10 of the Montanan Constitution). The Montana court concluded that neither "the interest in protecting and defending human life" (*id.*, at 19-20), nor the need to protect vulnerable groups from abuse (because the state legislature can provide various safeguards to prevent such abuses; *id.* at 20-21), nor the interest in "protecting the integrity of the medical profession" (*id.*, at 20-22), constitutes "a compelling state interest." The Montana district court pointed out that although the U.S. Supreme Court "needed only to find a legitimate basis" for prohibiting PAS, the Montana Constitution requires a Montana court to find "a compelling state interest." *Id.*, at 20.
56. *Id.*, at 16.
57. *Id.*, at 6 (emphasis added).
58. See text at *supra* notes 42-43.
59. Cf. R. C. Fox and J. P. Swazey, *The Courage to Fail* (Chicago: University of Chicago Press, 1974): at 314 (in the early 1960s, when Seattle became the mecca of dialysis centers, there was less difficulty in selecting candidates for the limited number of kidney machines available than in "terminating a patient" once his treatment had gotten underway).
60. D. W. Brock, "Death and Dying," in R. M. Veatch, ed., *Medical Ethics*, 2d ed. (Sudbury, MA: Jones and Bartlett, 1997): 363-92, at 375.
61. *Id.*
62. See Quill, *supra* note 1, at 485-86 (discussing a case when the patient agreed to experimental treatment only after being assured she could stop it if the going became too hard).
63. See T. E. Quill et al., "Palliative Options of the Last Resort," *JAMA* 278 (1997): 2099-2104, at 2102. See also M. Angell, "Helping Desperately Ill People to Die," in L. L. Emanuel, ed., *Regulating How We Die* (Cambridge, MA: Harvard University

Press, 1998): 3-20, at 6; A. Meisel, "Physician-Assisted Suicide: A Common Law Roadmap for State Courts," *Fordham Urban Law Journal* 24 (1997): 817-57, at 829.

64. See text at *supra* note 40.
65. New York State Task Force Report, *supra* note 12, at 75. See also F. G. Miller et al., "Can Physician-Assisted Suicide Be Regulated Effectively?" *Journal of Law, Medicine & Ethics* 24, no. 3 (1996): 225-232, at 229.
66. S. F. Kreimer, "Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die," *American University Law Review* 24 (1996): 803-854, at 841.
67. See Arras, *supra* note 5, at 381.
68. See Brock, *supra* note 60, at 367.
69. See Arras, *supra* note 5, at 381.
70. See Quill, *supra* note 1, at 482.
71. At the time Cardinal Bernadin spoke, Catholic bishops and theologians were divided on whether artificially provided food and water could be withdrawn from patients, and the Vatican had not taken a clear position on this issue. See P. Steinfels, "Prelate Assails 'Useless' Aid to Dying," *New York Times*, May 27, 1988, at A12. However, two decades later, when the Eluana Englaro case arose in Italy (see note *supra* 17), the Vatican left no doubt that it strongly opposed the removal of a person's feeding tube under any circumstances. See R. Donadio, "Death Ends Coma Case that Set Off Furor in Italy," *New York Times*, February 10, 2009, at A7; R. Donadio, "Italy: First Report on High-Profile Death," *New York Times*, February 12, 2009, at A10.
72. J. Bernadin, "Euthanasia: Ethical and Legal Challenges," in T. A. Nairn, ed., *The Seamless Garment* (Maryknoll, NY: Orbis Books, 2008): 154-63, at 157, 162. I should disclose that I was a member of the panel at which Cardinal Bernadin spoke in 1988 and criticized him for not condemning "'indirect' or 'passive' euthanasia,'" such as discontinuing nutrition and fluids. I changed my mind on this issue shortly thereafter. See note *supra* 20.
73. F. G. Miller et al., "Regulating Physician-Assisted Death," *New England Journal of Medicine* 331 (1994): 119-23, at 120.
74. See Task Force Report, *supra* note 65, at 148. A year after the Cardinal gave his talk, Daniel Callahan ventured to say that "the most potent motive for active euthanasia and assisted suicide stems from a dread of the power of medicine" – the power that "seems to take on a drive of its own regardless of the welfare or wishes of patients." D. Callahan, "Can We Return Death to Disease?" *Hastings Center Report* 19, no. 21 (January 1989): 4-7, at 5.
75. J. Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (January 9, 1975): 78-80.
76. See the discussion in H. Brody, "Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice," *Minnesota Law Review* 82 (1998): 939-963, at 939-945.
77. S. H. Kadish, "Letting Patients Die: Legal and Moral Reflections," *California Law Review* 80 (1992): 857-888, at 865, 867.
78. *Id.*, at 867.
79. *Id.*, at 868-889.
80. T. E. Quill, "Physician-Assisted Death in the United States: Are the Existing 'Last Resorts' Enough?" *Hastings Center Report* 38 (September/October 2008): 17-22, at 19.
81. *Id.*
82. See Cantor, *supra* note 20, at 398.
83. *Id.*, at 433. See also S. M. Wolf, "Holding the Line on Euthanasia," *Hastings Center Report* 19, Special Supplement (January/February 1989): 13-15.
84. See Cantor, *supra* note 20, at 432-433.
85. *Id.*, at 433-34.
86. See Meisel, *supra* note 63, at 823.
87. *Id.*, at 824-825.
88. N. L. Cantor, *"Glucksberg*, the Putative Right to Adequate Pain Relief, and Death with Dignity," *Journal of Health Law* 34 (Summer 2001): 301-338, at 306.
89. D. Orentlicher, "The Legalization of Physician-Assisted Suicide," *New England Journal of Medicine* 335 (1996): 663, at 664.
90. E. J. Emanuel, "The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy," *Minnesota Law Review* 82 (1998): 983-1014, at 992.
91. *Id.*
92. *Id.*
93. C. H. Baron et al., "A Model State Act to Authorize and Regulate Physician-Assisted Suicide," *Harvard Journal on Legislation* 33 (1996): 1-34.
94. *Id.*, at 10.
95. *Id.*
96. D. W. Brock, *Life and Death* (New York: Cambridge University Press, 1993): at 170.
97. See Y. Kamisar, "Some Non-Religious Views against Proposed 'Mercy-Killing' Legislation," *Minnesota Law Review* 42 (1958): 969-1042, at 969 n.3.
98. See Callahan, *supra* note 4.
99. See S. Bok, in G. Dworkin, R. G. Frey, and S. Bok, eds., *Euthanasia and Physician-Assisted Suicide* (New York: Cambridge University Press, 1998): 128-139, at 129.
100. K. L. Tucker, "In the Laboratory of the States: The Progress of *Glucksberg*'s Invitation to States to Address End-of-Life Choice," *Michigan Law Review* 106 (2008): 1593-1611, at 1596.
101. *Id.*
102. *Id.*, at 791-792.
103. N. L. Cantor, "On Kamisar, Killing, and the Future of Physician-Assisted Death," *Michigan Law Review* 102 (2004): 1793-1842, at 1817-1818. See also E. J. Emanuel, "The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy," *Minnesota Law Review* 82 (1998): 983-1014, at 1002.
104. T. E. Quill et al., "Care of the Hopelessly Ill – Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* 327 (November 5, 1992): 1380-1383, at 1381.
105. *Id.*
106. D. Callahan and M. White, "The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village," *University of Richmond Law Review* 30 (1996): 1-83, at 6.
107. D. W. Brock, "Voluntary Active Euthanasia," *Hastings Center Report* (March-April 1992): 10-22, at 10.
108. *Id.*
109. *Id.*
110. *Id.*
111. See Miller et al., *supra* note 73, at 120. I do not fault Professor Quill for changing his position. As I have pointed out along the way, see note 20 *supra*, I have done so myself. If anything is surprising, it is that commentators who try to keep up with the vast literature on this subject do not change their minds more often.
112. See the discussion in Y. Kamisar, "Against Assisted Suicide – Even a Very Limited Form," *University of Detroit Mercy Law Review* 72 (1995): 735-769, at 747-749.
113. See Y. Kamisar, "On the Meaning and Impact of Physician-Assisted Suicide Cases," *Minnesota Law Review* 82 (1996): 895-922, at 911-912. For more on the meaning and usefulness of the term "terminally ill," see text at *infra* notes 130-131.
114. *Id.* (Kamisar), at 918.
115. *Id.*
116. R. Dworkin et al., "Assisted Suicide: The Philosophers' Brief," *New York Review of Books*, (March 27, 1997): 41-47, at 41. Professor Dworkin's introduction to the Philosophers' Brief was written after the Court heard oral arguments in *Glucksberg* and *Quill*, but before the cases were decided.
117. D. W. Brock, "Voluntary Active Euthanasia," *Hastings Center Report* (March-April 1992): at 10, 14.
118. See text at *supra* notes 35-41.
119. See Meisel, *supra* note 20, § 8.2 at 470.

120. N. L. Cantor, "Twenty-Five Years after *Quinlan*: A Review of the Jurisprudence of Death and Dying," *Journal of Law, Medicine & Ethics* 29, no. 2 (2001): 182-196, at 193.
121. See Dworkin, *supra* note 116, at 41.
122. *Id.*
123. *Id.*
124. *Id.*
125. *Id.*
126. *Id.* (emphasis added).
127. *Id.*
128. *Id.*
129. See Baron et al., *supra* note 93, at n.39.
130. See Callahan and White, *supra* note 106, at 45.
131. One might reply that the longer the projected lifespan, the better the possibility that a new cure or new kind of pain relief may eventually be found. However, as Felicia Ackerman has observed in response to this argument, "respect for privacy and autonomy would seem to require that it be each pain-wracked patient, rather than his government, who gets to decide in his own case whether it is worth going for such a long shot." F. Ackerman, "Assisted Suicide, Terminal Illness, Severe Disability, and the Double Standard," in M. P. Battin, R. Rhodes, and A. Silvers, eds., *Physician Assisted Suicide: Expanding the Debate* (New York: Rutledge, 1998): 149-161, at 150.
132. J. Lynn et al., "Defining the 'Terminally Ill': Insights from SUPPORT," *Duquesne Law Review* 35 (1996): 311-336, at 334.
133. See Baron et al., *supra* note 93, at 10-11, n.39.
134. *Id.*, at 11.
135. *Id.* One of the reasons the authors rejected a more objective definition of the patient's suffering is "that whether one's suffering is sufficiently unbearable to make death preferable to continued life is an inherently subjective determination on which people differ, and for which no objective standard should be imposed on everyone." *Id.*
136. See the discussion in *supra* note 44. See also R. A. Burt, "The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care," *New England Journal of Medicine* 337 (October 23, 1997): 1234-1247.
137. See Brody, *supra* note 76, at 939.
138. *Id.*, at 951.
139. 79 F.3d at 823-24.
140. *Vacco v. Quill*, 521 U.S. at 802.
141. *Id.*, at 807 n.11, quoting from the New York Task Force Report, *supra* note 12, at 163.
142. H. Brody, "*Compassion in Dying v. Washington:* Promoting Dangerous Myths in Terminal Care," *BioLaw* 2, Special Section (July-August 1996): S:154- S:159, at S:157.
143. See, e.g., Brief of the American Medical Association, the American Nurses Association, and the American Psychiatric Association et al. as Amicus Curiae in Support of Petitioners at 4, *Glucksberg* (No. 96-110), available in 1996. WL 656263.
144. See the discussion in N. L. Cantor and G. C. Thomas, "Pain Relief, Acceleration of Death, and Criminal Law," *Kennedy Institute of Ethics Journal* 6 (1996): 107-127, at 109.
145. See Brief of the American Medical Association et al., *supra* note 8, at 3.
146. See Cantor, *supra* note 88, at 315-327. Professor Cantor describes "deep sedation" or terminal sedation into two categories, short-term and long-term. When the procedure occurs in the last few days of the dying process, he tells us, "it is impossible to establish that withholding of ANH causes death, as opposed to the underlying disease." *Id.*, at 319. Moreover, "there is often a palliative justification for withholding ANH as part of end-stage care. For example, ANH may be contraindicated because it would contribute to pulmonary edema. Both because the withholding of ANH at the end stage creates little risk of hastening death and because there is a palliative justification for taking the risk, [this particular procedure] is not akin to euthanasia." *Id.* Professor Cantor goes on to discuss what he calls long-term deep sedation, i.e., the "initiation of deep sedation at an earlier point in a dying process, perhaps weeks or more before the patient would normally die from the underlying disease." Id. He observes that Professor Tribe "presumably meant this version of deep sedation." See id.
147. See M. Battin, "Terminal Sedation: Pulling the Sheet over Our Eyes," *Hastings Center Report* 38, no. 5 (September-October 2008): 27-30.
148. T. E. Quill et al., "Palliative Options of Last Resort," *JAMA* 278 (December 17, 1997): 2099-2104, at 2101. However, elsewhere in the same article, Quill and his co-authors maintain that "TS probably requires no change in the law" and that the Supreme Court's 1997 PAS decisions "gave strong support to TS, saying that pain in terminally ill patients should be treated, even to the point of rendering the patient unconscious or hastening death." *Id.*, at 2100. I find these comments puzzling. As I try to show, see text at *infra* notes 153-170, the Supreme Court does not appear to have given any support to the two-step TS procedure. The Court did approve of the PDE, but as Quill and his co-authors themselves seem to recognize, the second step of the procedure – the withholding of ANH – cannot be justified by the PDE.
149. Professor Margaret Battin has recently criticized TS on various grounds. For one thing, she maintains, "because the assumption is that sedation is used just to end pain without the *intention* of ending life, the patient cannot be asked for consent to end his or her life, but only to relieve his or her pain." Moreover, the new euphemism, "palliative sedation," makes matters worse. "By avoiding the word 'terminal' and hence any suggestion that death may be coming, the most important feature of this practice is obscured and terminal sedation is confused with 'palliative care.'" See Battin, *supra* note 147, at 28.
150. D. Orentlicher, "The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia," *Hastings Constitutional Law Quarterly* 24 (Summer 1997): 947-68, at 956.
151. *Id.*, at 955. "It is 'slow' euthanasia," explains Orentlicher, "because the patient dies after a few hours or days rather than almost immediately." *Id.*, at 955 n.50.
152. *Id.*, at 948, 954, 967 and 968.
153. D. Orentlicher, "The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia," *New England Journal of Medicine* 337 (October 23, 1997): 1236-1239, at 1238.
154. In the reply brief it filed, New York had quoted an extract of an article by Paul Rousseau. See P. Rousseau, "Terminal Sedation in the Care of Dying Patients," *Archives of Internal Medicine* (1996): 1785-1786. This was the only part of New York's brief the Court quoted in footnote eleven.
155. On the same page of the brief quoted by the Supreme Court, see *Reply Brief for Petitioners Vacco and Patako*, at 12, the State of New York also maintained that the claim that the two-step procedure known as TS is being utilized in the state "is utterly without support in the record and [if it were being used] unquestionably outside the bounds of accepted medical practice."
156. *Vacco v. Quill*, 521 U.S. at 808 n.11.
157. *Id.*, quoting the New York State Task Force Report, *supra* note 12, at 163.
158. See Brody, *supra* note 76, at 948 (emphasis in the original).
159. See Orentlicher, *supra* note 150, at 959 (a physician providing TS must intend the patient's death).
160. See *id.*, at 957 (the PDE "cannot justify the withdrawal of food and water component" of TS).
161. However, Orentlicher specifically rejects this possible explanation. See Orentlicher, *supra* note 150, at 965.
162. See Orentlicher, *supra* note 153, at 1238.
163. See 521 U.S. at 736-50. Justices Ginsburg and Breyer joined Justice O'Connor's concurring opinion.
164. 521 U.S. at 737.
165. See Cantor, *supra* note 88, at 320.
166. 521 U.S. at 736-37.
167. See *supra* note 155.

168. Justice Ginsburg did not write a separate concurring opinion. Justice Breyer told us that he would not be adverse to considering whether there were a right like a "right to die with dignity." But he soon added that "the avoidance of severe physical pain (connected with death) would have to constitute an essential part" of any such right, and that, "as Justice O'Connor points out, the laws before us do not *force* a person to undergo that pain," 521 U.S. at 791. Breyer did note that in a "very few" instances "the ineffectiveness of pain control medicines can mean not pain, but the need for sedation which can end in a coma." *Id.*, at 791-792. But he did not discuss the acceptability of a process which *combines* sedation to the point of unconsciousness *and* the withholding of ANH.
169. See Cantor and Thomas, *supra* note 144, at 111.
170. See Cantor, *supra* note 120, at 187.
171. See Y. Kamisar, "Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case," *Journal of Law & Criminology* 88 (1998): 1121-1146, at 1124-1126, 1136.
172. *Id.*, at 1125 n.17.
173. *Id.* See also C. R. Sunstein, "The Right to Die," *Yale Law Journal* 106 (1997): 1123-1163, at 1130: "The content of law depends not merely on the statute books but also on prosecutorial practice, and it is safe to say that in many cases prosecutors do not and will not deviate their limited resources to the most benign causes of voluntary active euthanasia."
174. See Kamisar, *supra* note 171, at 1124 (emphasis added).
175. *Id.*, at 1126 (emphasis added). Noteworthy, too, is the proposal to achieve "a middle ground" by James Tulsky, Ann Alpers, and Bernard Lo. They would keep PAS a crime, but make it an affirmative defense to criminal charges if certain conditions were satisfied. This proposal is discussed at some length, but ultimately rejected in Kamisar, *supra* note 171, at 1138-1141.
176. The argument for formally prohibiting PAS/AVE, but allowing the practice to take place in extraordinary cases is not as inconsistent as it may appear at first blush. The argument is similar to the one made for refusing to carve out any formal or official exception to the prohibition against torture: A refusal to acknowledge officially that we should "balance" the reluctance to resort to torture against other interests is bound to strengthen the presumption against torture and increase the likelihood that it will only take place in the rarest and most extraordinary instances. See the discussion in G. Calabresi, *Ideals, Beliefs, Attitudes, and the Law* (Syracuse: Syracuse University Press, 1985): at 167, n.240. Moreover, the availability of informal practice in the most compelling cases is likely to relieve some of the pressure for legalizing or constitutionally protecting some forms of PAS/AVE. See Sunstein, *supra* note 173, at 1130.
177. See Kreimer, *supra* note 66, at 853.
178. See Calabresi, *supra* note 176, at 88-89. See also G. Calabresi and P. Bobbitt, *Tragic Choices* (New York: W.W. Norton, 1978): at 17-19, 57-58.
179. At this point, I am using Norman Cantor's language. See Cantor, *supra* note 88, at 305.
180. Letter from the late Harold Leventhal, Judge of the U.S. Court of Appeals for the District of Columbia Circuit, to Professor Yale Kamisar, May 18, 1978, on file in the Bentley Historical Library, University of Michigan and with the guest editor of this symposium issue, Robert M. Sade. Judge Leventhal was responding to criticism of the reasoning of the New Jersey Supreme Court in *In re Quinlan*, 355 A 2d. 647 (1976).