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THE INCENTIVES AND DISINCENTIVES CREATED BY LEGALIZING PHYSICIAN- ASSISTED SUICIDE*

CLARKE D. FORSYTHE*

In two landmark decisions in 1997, the Supreme Court unanimously held that state laws banning assisted suicide without exception do not violate the Fourteenth Amendment. In *Washington v. Glucksberg*,¹ the Court held that Washington State's law against assisted suicide does not violate the Due Process Clause of the Fourteenth Amendment either on its face or as applied to competent, terminally ill adults. In light of the consistent, long-standing, Anglo-American tradition of prohibiting assisted suicide, "the asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause."² In *Vacco v. Quill*,³ the Court held that New York State's law does not violate the Equal Protection clause by prohibiting assisted suicide while allowing the refusal or withdrawal of lifesaving medical treatment. Such laws "neither infringe fundamental rights nor involve suspect classifications."⁴ The "distinction between assisted suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal tradition, is both important and logical; it is certainly rational."⁵ All justices joined the judgments upholding these laws.

In the aftermath of the Supreme Court decisions, the forum for this issue has begun to shift from the courts back to the public

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* B.A. Allegheny College (1980); J.D. Valparaiso University (1983). I am grateful to Nik Nikas for comments on an earlier draft.

1 117 S. Ct. 2258 (1997).

2 *Id.* at 2271.

3 117 S. Ct. 2293 (1997).

4 117 S. Ct. at 2297.

5 *Id.* at 2298.

policy arena.⁶ For that reason I would like to explore several public policy questions this afternoon, specifically the incentives and disincentives that would be created by the legalization of physician-assisted suicide. While these incentives and disincentives may not be explicit or immediate, they will be inexorable.

Public policy on this issue is really driven by three fears: Fear of uncontrolled pain; fear of catastrophic healthcare costs; and fear of abandonment, isolation, or loneliness during illness.⁷ Unfortunately the notion that has been frequently fostered is that there are really only two alternatives: The first is uncontrolled pain and suffering, and the other is ending it by assisted suicide. In fact, the Second Circuit's opinion in *Quill v. Vacco* painted just such a picture.⁸

Debates about physician-assisted suicide have a tendency to imagine a case of a terminally ill patient who is imminently dying and in great suffering. In that particular case, the difference between palliative care and an unauthorized lethal medication is significant for that patient and that doctor. The social repercussions in one case, however, are rather limited. The implications become much more profound when society legalizes assisted suicide and makes it one medical option among others in our healthcare system.

If society formally legalizes assisted suicide, the implications are dramatically broadened.⁹ As you draw back from that event in time, and sanction that act, dramatic incentives for doctors, patients, family members, healthcare institutions, insurers, and

6 See, e.g., Charles H. Baron et. al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON. LEGIS. 1, 5-10 (1996) (proposing model statute legalizing assisted suicide and discussing public policy behind it); Peter G. Daniels, Comment, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 773-80 (1997) (discussing case's impact on palliative care centers).

7 See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 120 (1994) [hereinafter N.Y.S. TASK FORCE REPORT]; see also Yale Kamisar, *Reasons Why So Many People Support Physician-Assisted Suicide—and Why These Reasons are Not Convincing*, 12 ISSUES L. & MED. 113, 113-14 (1996) (criticizing five arguments supporting physician-assisted suicide and concluding that it should be prohibited); Thomas J. Marzen et. al., *Suicide a Constitutional Right?*, 24 DUQ. L. REV. 1, 3-6 (1985) (examining arguments for and against physician assisted suicide and concluding that courts and legislatures should continue to ban practice).

8 80 F.3d 716 (2d Cir. 1996), *rev'd sub nom.*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

9 See, e.g., Thomas Maier, *Death by Choice; Oregon Voters Back MD-Aided Suicide*, NEWSDAY (New York), Nov. 6, 1997, at A5 (reporting that Oregon voters approved law allowing prescription of life-ending drugs to terminally ill patients).

society will be created.

An examination of the broad implications of legalizing assisted suicide reveals that the best course of action is to improve the care of the suffering individual while refusing to legalize assisted suicide.¹⁰ The risks simply outweigh the benefits.

First, there will be incentives to broaden the available class of patients.¹¹ It would not be possible to legalize assisted suicide for just one individual, although that is the way public opinion often views this issue. In the context of an extreme case of patient suffering, many will agree to allow suicide for that particular patient.

Courts and legislatures, however, do not work that way. Assisted suicide would have to be legalized for a class of patients and frankly it is just impossible to coherently limit that class.¹² This was clearly demonstrated during the oral arguments before the Supreme Court on January 8th.¹³ Several justices asked counsel for suicide advocates to define the right in question, the nature of that right, and the class to which it was applicable.¹⁴ They got a different answer every time they asked the question.¹⁵

Most of the criteria used to define a class are heavily subjective. This was the conclusion of the New York State's Task Force Report on Life and the Law. Its report is the foremost public policy document in the country on this question.¹⁶

10 See N.Y.S. TASK FORCE REPORT, *supra* note 7, at 120; see also Report of the Arizona Commission on Aging and End of Life Issues (Dec. 31, 1997) (recommending against legalization of physician-assisted suicide).

11 See Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 37-8 (1996) (comparing proposed euthanasia bills in Michigan and New York).

12 See N.Y.S. TASK FORCE REPORT, *supra* note 7, at 1.

13 See *Vacco v. Quill*, 1997 WL 13672 at *1 (U.S. Oral. Arg., Jan. 8, 1997) (NO. 95-1858) [hereinafter *Quill*, Oral Arguments] (providing transcript of arguments before Court); *Washington v. Glucksberg*, 1997 WL 13671 (U.S. Oral. Arg., Jan. 8, 1997) (NO. 96-110) [hereinafter *Glucksberg*, Oral Arguments] (same).

14 See *Quill*, Oral Arguments, *supra* note 13, at *20. Justice Souter asked whether the potential for abuse is greater in assisted suicide because the class that it applies to is greater than the class requesting withdrawal of treatment. *Id.* Justice Ginsberg asked Mr. Tribe what type of class physician-assisted suicide would be limited to. *Id.* at *39.

15 See, e.g., *Glucksberg*, Oral Arguments, *supra* note 13, at *29-31. Here, an advocate for assisted suicide limited the class to those who were terminally ill and excluded those who are in pain. *Id.* Another argued that personal autonomy to commit suicide should be limited to those that have a terminal illness and those who are merely hastening their inevitable death. *Id.*

16 See N.Y.S. TASK FORCE REPORT, *supra* note 7 (reporting findings of task force convened by New York Governor Mario M. Cuomo in 1985 to study right to die); 1997

Clearly it is not possible to limit the class to the terminally ill. The notion of terminal illness is really a social definition, not a medical definition.¹⁷ The notion that doctors clearly know who is or is not terminally ill is simply unfounded. Yet, doctors will be the ones doing the monitoring based on subjective criteria.¹⁸

Although limiting the class to the terminally ill provides the appearance of simplicity, a moment's reflection shows that it does not make sense. This is because if pain and suffering are the basis for this new right, pain and suffering are not limited to the terminally ill. Furthermore, it does not make sense legally, if the Supreme Court's autonomy jurisprudence is the basis for this new right. Just as the fifty states can not ask the reasons for, or limit the right to, an abortion, they would not be able to ask the reasons for or attempt to limit assisted suicide.¹⁹

Secondly, legalizing assisted suicide will create disincentives to properly diagnose and treat depression in the chronically and the terminally ill.²⁰ Many patients who make requests for death now are suffering from a clinically diagnosable mental illness,²¹ which if diagnosed and treated, will often result in the patient revoking the request for death.²²

SUPPLEMENT TO NEW YORK STATE TASK FORCE ON LIFE AND THE LAW (Supp. 1997); see also *House of Lords, Session 1993-94 Report of the Select Committee on Medical Ethics: Volume 1—Report: Part 3 Opinion of the Committee*, 12 ISSUES L. & MED. 193, 194 (1996) (rejecting change in Great Britain's assisted suicide prohibition).

17 See Richard M. Doerflinger, *Conclusion: Shaky Foundations and Slippery Slopes*, 35 DUQ. L. REV. 523, 525 (1996) ("Medical experts have found that the term 'terminally ill' is not only difficult to apply, but almost impossible to define."); Roger S. Magnusson, *The Sanctity of Life and the Right to Die: Social and Jurisprudential Aspects of the Euthanasia Debate in Australia and the United States*, 6 PAC. RIM L. & POL'Y J. 1, 44 (1997) (asserting that definition of terminal illness will change if assisted suicide is legalized).

18 See Callahan & White, *supra* note 11, at 45-49 (describing criteria to be used and methods of observation).

19 See *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 869 (1992) (reaffirming constitutional right to abortion including "health" abortions); *Roe v. Wade*, 410 U.S. 113, 159 (1973) (ruling that right to abortion includes "health" abortions after viability); *Doe v. Bolton*, 410 U.S. 179, 192 (1973) (defining "health" to include physical as well as mental well being).

20 See Herbert Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285, 285 (1996) (noting close to ninety-five percent of individuals who seek suicide have diagnosable psychiatric illness).

21 See Annette E. Clark, *Anatomy and Death*, 71 TUL. L. REV. 45, 129 (1996) (stating "[t]he presence of depression is relevant if it is distorting rational decision making and is reversible in a way that would substantially alter the situation."); Jody B. Gabel, *Release From Terminal Suffering? The Impact of AIDS on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 379 (1994) (pointing out that many AIDS patients who seek assisted suicide suffer from mental dementia); Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 OR. L. REV. 449, 531 (1995) (stating that ninety percent of those who commit suicide have mental disorder).

22 See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2273 (1997) (citing HERBERT

Obviously one solution here should be access to good counseling. A recent edition of the New York Times contained a good article that exemplified the contrasting tendencies here.²³ By socially sanctioning this new right, the behavior will always appear to be rational because, after all, people will just be "exercising their rights." The social and economic incentives will all be in favor of taking the request at face value and acting upon it.²⁴ Two studies from the Netherlands reinforce this conclusion.²⁵ For example, cases in the Netherlands demonstrate that depression is no longer seen as a mental illness needing diagnosis and treatment for those requesting death.²⁶ Instead, it is considered a legitimate reason for requesting death.²⁷

Third, legalizing assisted suicide will create disincentives against developing and providing palliative care. A basic tenet of medical ethics is to cure whenever possible and provide comfort care when cure is not possible.²⁸ Medicine is labeled the "healing profession" because the basic function of medicine is healing.²⁹

HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CURE 24-25 (1997) (explaining that suicidal, terminally ill patients who receive depressive illness medication usually have positive feelings about their lives); Clark, *supra* note 21, at 129 (asserting that physicians should seek help from psychiatric professionals in treating mental illness when patients request assisted suicide); Grant & Linton, *supra* note 21, at 130-32 (stating that there is correlation between depression, terminal illness and assisted suicide); *see also* N.Y.S. TASK FORCE REPORT, *supra* note 7, at 144 (noting high correlation between depression and suicide).

23 See Thomas Friedman, *Profession Divided Over Assisted-Suicide*, N.Y. TIMES, Mar. 13, 1997, at A1. One doctor discussed his decision to ease a patient's pain by quickening their death after listening to the patient. *Id.* By contrast, another stated:

I have had patients say to me, "can't you just give me a pill and get this over with?"

But on further exploration there is almost always something remedial behind it. It is often related feeling like a burden, or being incapacitated or social isolation. So, I am very worried about a doctor affirming that the behavior is rational.

Id. at A16.

24 See Doerflinger, *supra* note 17, at 528 (stating that freedom to provide lethal drugs is convenient solution for rising healthcare costs).

25 See Carlos F. Gomez, M.D., REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS 1 (1996) (analyzing trends in Netherlands and concluding that too many people are choosing to commit suicide); Herbert Hendin, SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CARE 1 (1997) (examining Dutch experience with physician-assisted suicide and predicting that if physician-assisted suicide is legalized United States it will likewise be abused).

26 See Gomez, *supra* note 25, at 27-35 (pointing out increase in numbers of depressed who are seeking assistance in dying).

27 See Hendin, *supra* note 25, at 140-47 (discussing high number of depressed patients are seeking assisted suicide).

28 See Peter M. McGough, M.D., Symposium: *Physician-Assisted Suicide Medical Concerns About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 521, 523-30 (1995) (describing healing as medical professionals' primary goal).

29 See C. Everett Koop, *Introduction to Symposium on Physician-Assisted Suicide*, 35 DUQ. L. REV. 1 (1996) (examining Hippocratic oath); Michael H. Cohen, *Holistic Health*

The rule of Hippocratic medicine, as Dr. Bristow pointed out, prohibits the killing of patients.³⁰ That rule is a key incentive that focuses physicians on healing, both in their minds and in the minds of their patient, and most importantly, in the minds of society as a whole.³¹

The noted social anthropologist Margaret Mead aptly summarized this situation.³² The worst part of the notion of assisted suicide is involving the medical profession to sanctify the process. The most powerful incentives are those that focus physicians on healing and alleviating suffering.

At the University of Chicago, a hospice physician by the name of Steven Miles, who is widely published in the medical literature, had a deep understanding of this relationship. He has emphasized, "[o]nly because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying."³³

All of us are better off by having physicians with an individual ethic and an undivided focus on healing and alleviating suffering. At a time when long-standing physician-patient relationships are becoming more and more uncommon, the disincentives against

Care: Including Alternatives and Complementary Medicine in Insurance and Regulatory Schemes, 38 ARIZ. L. REV. 83, 160 (1996) (stating that primary role of all health professionals is patient care); Stacy A. Ragon, Comment, *A Doctor's Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA's Code of Medical Ethics*, 20 U. DAYTON L. REV. 975, 998 (1995) (describing doctor's role as care giver).

³⁰ See Lonnie Bristow, M.D., *Physician's Role as Healer: American Medical Association's Opposition to Physician-Assisted Suicide*, 12 ST. JOHN'S J. LEGAL COMMENT. 653 (1997).

³¹ See Ben Rich, *Postmodern Medicine: Reconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 85-90 (1993) (describing oath in modern practice of medicine). *But see* Clark, *supra* note 21, at 88 (arguing that Hippocratic oath is not followed in all cases and thus does not have to be followed with regard to physician-assisted suicide).

³² See MARGARET MEAD, *MALE AND FEMALE: A STUDY OF THE SEXES IN A CHANGING WORLD* (1949); MARGARET MEAD, *SEX AND TEMPERAMENT IN THREE PRIMITIVE SOCIETIES* 1 (1935).

Throughout the primitive world the doctor and the sorcerer tend to be the same person. He with the power to kill had the power to cure. With the Greeks, [referring to Hippocratic oath,] the distinction was made clear. One profession was to be dedicated completely to life under all circumstances regardless of rank, age or intellect. This, is a priceless possession which we can not afford to tarnish.

But society is always attempting to make the position into a killer. To kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient, it is the duty of society to protect the physician from such requests.

Id.

³³ See Steven H. Miles, *Physician-Assisted Suicide and the Profession's Gyrocompass*, 25 HASTINGS CENTER REP., 1, 17-18 (1995) (questioning necessity for physician involvement in assisted suicide).

thorough counseling will grow.³⁴ Therefore maintaining a clear line on this issue becomes all the more compelling.

Fourth, legalizing assisted suicide would create enormous incentives against regulation.³⁵ This was also demonstrated in the January oral arguments in the Supreme Court.³⁶ Proponents for assisted suicide urged the court to strike down these total prohibitions on assisted suicide and leave the state legislatures unfettered in regulating it.³⁷ But, as many justices noted, that is not the way constitutional rights work.³⁸ There is a presumption against regulating constitutional rights.³⁹

The Dutch experience demonstrates the futility of reliance on legal regulations to maintain such limits.⁴⁰ The guidelines established by Dutch courts have not been followed.⁴¹ The practice of euthanasia has moved from the terminally ill to the chronically ill, from untreatable physical illness to cases of treatable psychological distress, and from voluntary euthanasia to involuntary euthanasia.⁴² Rather than regulate, the incentives will be to-

34 See, e.g., Amicus Brief of American Ass'n of Homes & Services for the Aging et. al. at 1, *Vacco v. Quill*, 117 S. Ct. 2293 (1997) (No. 95-1858) (arguing that issue of physician-assisted suicide undermines already fragile physician-patient relationship).

35 See generally Callahan & White, *supra* note 11, at 1 (reviewing and critiquing various regulatory schemes); Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L.REV. 969, 971 (1958) (stating that legal condemnation of mercy-killings turns physicians and relatives away from euthanasia in doubtful cases).

36 See *Quill*, Oral Arguments, *supra* note 13 (providing transcript of arguments before Court); *Glucksberg*, Oral Arguments, *supra* note 13 (same).

37 See *Quill*, Oral Arguments, *supra* note 13, at *44 (stating that New York already has system designed regulate those utilizing physician-assisted suicide); *Glucksberg*, Oral Arguments, *supra* note 13, at *38 (arguing that there should be code of regulations).

38 See *Quill*, Oral Arguments, *supra* note 13, at *44 (admonishing that constitutional rights are not as malleable as Petitioner's contend).

39 See, e.g., *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 352-59 (1987) (finding that regulation of prisoners constitutional rights was subject to scrutiny).

40 See Gomez, *supra* note 25, at 52-58 (arguing that legal regulations have not worked in Netherlands); Hendin, *supra* note 25, at 140-47 (describing chaos surrounding Dutch system); see also Grant & Linton, *supra* note 21, at 499 (asserting that Dutch experience is out of control).

41 See Julia Belian, Comment, *Deference to Doctors in Dutch Euthanasia Law*, 10 EMORY INT'L L. REV. 255, 273-77 (1996). The author asserts that the courts can not handle the role of regulator. *Id.*; Wesley J. Smith, *Sliding Down Euthanasia's Slippery Slope*, LEGAL TIMES, June 13, 1994, at 26. A Dutch court recently dismissed a murder charge against a doctor accused of killing a severely deformed baby girl. *Id.* The court ruled he had no choice, even though he did not meet the formal guidelines for prescribing assisted suicide. *Id.*

42 See Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 DUQ. L. REV. 395, 412-13 (1996) (stating that reports of euthanasia in Holland show that there were 2,300 voluntary euthanasia cases, 400 cases of physician-assisted suicide and over 1,000 case of involuntary euthanasia in 1990).

ward making sure that every patient has the fullest knowledge of this new right and option.

Finally, legalizing assisted suicide will create incentives against alternatives for the chronically and the terminally ill. Some of these will be medical. As Solicitor General Walter Delinger aptly told the Supreme Court, the least costly treatment for any illness is lethal medication.⁴³ Likewise, Justice Breyer pointed out that Great Britain, where assisted suicide is prohibited, has many palliative care centers, while the Netherlands, where assisted suicide is allowed, has few.⁴⁴

Other disincentives will be social. Certainly legalization will change the incentives and the psychodynamics for patients and family members. While this may be overt in a case or two, it is most likely to be subtle and unconscious in most cases.

Still others will be economic. At a time when managed care is more and more common, and some form of explicit rationing seems more and more likely, the disincentives against alternatives should be fought rather than promoted.⁴⁵ The economic pressure for assisted suicide will be heightened if assisted suicide is publicly subsidized, as Oregon has moved to do.⁴⁶ Because of these incentives and disincentives, I think it is appropriate to say that legalizing assisted suicide would simply create more physical and psychological suffering than it would alleviate.

Ironically, legalizing assisted suicide would both aggravate the primary fears that drive public opinion on this issue and create disincentives for addressing those fears. It would do this in four ways: By undermining the provision of pain medication and the developments of new treatment; by undermining incentives for the diagnosis and treatment of depression; by increasing financial pressures on patients to opt for assisted suicide; and by creating financial and social pressures on family members, which will be inevitably deflected onto patients. Consequently, legalizing assisted suicide for any will undermine healthcare for everyone.⁴⁷

⁴³ See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2272-80 (1997) (explaining that death is always cheapest alternative).

⁴⁴ See *Glucksberg*, 117 S. Ct. at 2312 (citing British House of Lords report).

⁴⁵ See Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 Cal.L.Rev. 371, 419-25 (1997) (arguing that economic incentives will foster assisted suicide).

⁴⁶ See WALL ST. J., Feb. 27, 1998, at 1.

⁴⁷ See Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 738 (1995) ("Before there can be such truly voluntary choice to termi-

Two positive results have come from the nationwide debate on assisted suicide over the last several years. One is the renewed focus on enhancing alternatives for the chronically and terminally ill. The second has to be a reminder of the many compelling reasons for having and retaining the laws against assisted suicide. The solution to this problem that we have been discussing is good medicine, not bad law.

Thank you.

nate life, there must be universal access to affordable health care. The lack of access to or the financial burden of health care hardly permits voluntary choice for many.”).