

1998

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Recommended Citation

Emanuel, Ezekiel J., "The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy" (1998).
Minnesota Law Review. 1290.
<https://scholarship.law.umn.edu/mlr/1290>

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The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy

Ezekiel J. Emanuel*

In *Washington v. Glucksberg*¹ and *Vacco v. Quill*² the Supreme Court Justices did the right thing by rejecting a constitutional right to physician-assisted suicide (PAS) or euthanasia.³ They also reached the correct decision in not foreclosing state legalization of these interventions. The decisions will foster a lively debate in the states about the ethics and political prudence of permitting these interventions. Although a few Justices held out hope for a more narrow constitutional right to PAS or euthanasia, the majority holdings permanently shifted the forum, the arguments, the perspective, and the justifications in the debate over PAS and euthanasia. The forum is no longer the courts, but the legislatures and public squares. The arguments are no longer about constitutional rights, but ethics and prudent policies. The perspective is no longer first person, but third per-

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1. 117 S. Ct. 2258 (1997).

2. 117 S. Ct. 2293 (1997).

3. "Physician-assisted suicide" is defined as the process whereby a physician provides the a prescription or other means to a patient with the explicit understanding and intention that the patient use the medications or other means to end his or her life. When I use the term "euthanasia" without qualification, I mean voluntary active euthanasia. Voluntary active euthanasia involves a physician administering medications or other means to end the patient's life at the patient's request and with the patient's full informed consent. The primary difference between the two is that in physician-assisted suicide the patient commits the life-ending act, whereas in euthanasia the physician or some other medical provider carries out the life-ending act. See Ezekiel J. Emanuel, *Euthanasia: Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVES INTERNAL MED. 1890 (1994).

son. And the justifications no longer appeal to individual autonomy and beneficence, but to probable social goods and harms. This is as it should be in a democracy.

As the debate proceeds, however, it must be better informed. The debate needs to move away from this or that heart-wrenching case calling out for euthanasia, shake off the distortions concerning end-of-life practices that have so far informed it, and carefully examine what likely benefits and harms might result from legalization. This means that there will be even more emphasis on accurate empirical assessments of likely practices and consequences related to PAS or euthanasia. Current assumptions about PAS or euthanasia based on abstract argumentation and logical inferences will need to be tested empirically if public policy is to be prudent. Some of these assumptions already have been shattered by empirical assessment. But others will require a commitment to collect additional data to make public debate more informed.

This Article will be divided into four sections. Part I briefly states my thesis and background assumptions. Part II considers the potential situations that might lead to recognition of a narrow constitutional right to PAS or euthanasia seemingly anticipated by some of the Justices of the Supreme Court. I will argue that such situations do not arise and that the possibility of securing a constitutional right to PAS or euthanasia is dead. In Part III, I will consider two myths about PAS and euthanasia—the myth of pain and the myth of separation.⁴ We are debating the legalization of PAS and euthanasia as if the terminally ill who would want to use these interventions are those suffering from pain. Taking this as the paradigmatic case distorts the issue, because most people requesting a physician to assist them in committing suicide do so not as a result of pain but as a result of depression or concerns about being a burden on others.⁵ As Oregon's Measure 16 indicates,⁶ many people engaged in the debate also claim that we can separate PAS from euthanasia. This is practically impossible. These myths distort reality and need to be shattered. Finally, in Part IV, I will draw upon existing empirical information to consider prudential arguments for legalizing PAS or euthanasia. I will suggest that the potential benefits of

4. The myth of separation is the notion that we can separate physician-assisted suicide from euthanasia. Although this distinction can be made conceptually, in practical terms it is extremely difficult.

5. See *infra* Part III.B.

6. OR. REV. STAT. § 127.8 (1996).

permitting PAS or euthanasia are much smaller than imagined. I will finish by suggesting, however, that an adequate evaluation of benefits and harms requires much more information.

I. PHYSICIAN-ASSISTED SUICIDE, EUTHANASIA, AND END-OF-LIFE CARE

Before we begin to consider the implications of the Supreme Court decisions, we should be clear about our goal. The real objective must be to improve the care of the 2.3 million Americans who die each year.⁷ This is an enormous task. In part it is problematic because, despite their words, Americans still find it enormously difficult to face death and to comfort the dying. It is still not uncommon for people who visit a dying person to comment "I don't know what to say or to do." And this says it all—we still do not know how to be with and talk to dying people. The task is also difficult because the entire medical system itself, from education to health care delivery, is only now beginning to seriously address the issue of caring for the dying.

There is no logically necessary reason why advocating or legalizing PAS or euthanasia will improve the way we care for dying patients. Care for the dying is much more complex than ending a patient's life. Furthermore, there is good sociological reason to think that the focus on PAS or euthanasia creates a curve in the shape of an inverted U. That is, while *some* attention to PAS and euthanasia may increase commitment to making improvements in end-of-life care, *significant* attention to PAS and euthanasia is likely to have the opposite effect. This is because our society possesses limited resources—limited time, intellectual focus, political capital, media attention, and managerial acumen. Some focus on the issues of PAS and euthanasia might be draw attention to persistent problems in our social practices of, say, pain management, treatment of depression, or use of hospice. These revelations, in turn, might lead to improvements in the way we care for the dying. Too much focus on PAS and euthanasia, however, will displace care for the dying as the central issue and absorb limited resources that might be devoted to real change. I fear that more litigation, more campaigns for referenda to legalize PAS and euthanasia, and more conferences on PAS and euthanasia will distract our attention and consume

7. See Robert N. Anderson et al., *Report of Final Mortality Statistics, 1995*, in NAT'L CENTER FOR HEALTH STATISTICS, 45 MONTHLY VITAL STAT. REP. tbl.7 (Supp. 2 1997).

energy that should be focused on the broader issue of caring for the dying. And in this regard, I may be as guilty as anyone in the country.

II. AFTER *GLUCKSBERG* AND *QUILL*, IS THERE STILL ROOM FOR A RIGHT TO PHYSICIAN-ASSISTED SUICIDE OR EUTHANASIA?

In concurring opinions, several of the Supreme Court Justices did not completely reject the idea of a constitutional right to PAS or euthanasia. By imagining certain factual circumstances and legal arguments not before the Court, these Justices left space open for a more limited right to PAS or euthanasia than that argued for by the respondents in *Quill* and *Glucksberg*. These potential exceptions, as articulated by Justices O'Connor⁸ and Breyer,⁹ seem to fall into two broad categories: (1) situations in which PAS or euthanasia is the only alternative to a slow and painful death because the state does not permit adequate pain relief, and (2) situations in which "death with dignity" requires facilitation of death by a physician. The specter of such exceptions will tempt proponents of PAS or euthanasia to consider additional courtroom challenges. A close examination reveals, however, the factual predicates of these exceptions are so unlikely to occur that it is virtually certain they will never be used to affirm even a narrow constitutional right to PAS or euthanasia. If the Supreme Court does some day affirm a right to the assistance of a physician in dying, the decision will merely be a reactive ratification of what has already become an entrenched state law right. In other words, the constitutional avenue for legalizing PAS or euthanasia has reached a dead end.

A. THE O'CONNOR EXCEPTION—THE SADISTIC STATE

In her concurring opinion, Justice O'Connor argued that consideration of a generalized right to PAS or euthanasia could be avoided because currently dying patients who are experiencing great pain and suffering can obtain whatever palliative care modern medicine has to offer, even to the point of "unconsciousness and hastening death."¹⁰ The O'Connor opinion implies that if the state imposed significant barriers to prevent dying patients from

8. See *Washington v. Glucksberg*, 117 S. Ct. 2303 (1997) (O'Connor, J., concurring).

9. See *id.* at 2310 (Breyer, J., concurring).

10. *Id.* at 2303 (O'Connor, J., concurring).

receiving adequate palliative care and forced them to endure unnecessary pain, then the Court might consider a more narrow right to PAS or euthanasia.

While this potential exception seems principled in a hypothetical sense, it fails to comport with reality. No advanced state would want its dying people to experience unremitting pain that could be relieved. It is difficult to imagine what set of circumstances would compel a state to force dying patients to suffer pain. Only a "sadistic" state, interested in using the physical pain and suffering of its citizens as a method of oppression and political suppression, would obstruct palliative care for no substantive reason. It is hard to imagine that one of the fifty United States—or any democratic state—would trade in such "sadistic" practices. A reasonable state might restrict appropriate palliative care for dying patients only if, in some way, providing the palliative care created or substantially contributed to other serious social problems—drug addiction, elder abuse, murder. Under such circumstances, the state might have good reason to balance the interests of dying patients against other state interests. And while the Court would carefully examine such balancing, it would likely show deference to the judgment of state legislatures, which have much better access to the empirical data needed to balance interests.¹¹

Justice O'Connor's exception seems to suggest that radical changes in social practices would be necessary to get her to reconsider the Court's holdings. Because these requisite changes are almost unimaginable, it seems very unlikely that Justice O'Connor's line of analysis can result in a constitutionally protected right to PAS or euthanasia.

11. As Justice Souter noted in his opinion:

While an extensive literature on any subject can raise the hopes for judicial understanding, the literature on this subject is only nascent. Since there is little experience directly bearing on the issue, the most that can be said is that whichever way the Court might rule today, events could overtake its assumptions Legislatures, on the other hand, have superior opportunities to obtain the facts necessary for a judgment about the present controversy. Not only do they have more flexible mechanisms for factfinding than the Judiciary, but their mechanisms include the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions.

Id. at 2292-93.

B. THE BREYER EXCEPTION—DEATH WITH DIGNITY

In his concurring opinion, Justice Breyer stated that there might “roughly” be a “right to die with dignity” encompassing a right to PAS or euthanasia.¹² In his view, this right would be justified by the Fourteenth Amendment’s protection of certain fundamental liberty interests encompassing privacy as well as “personal dignity, medical treatment, and freedom from state-inflicted pain.”¹³ Assuming such a train of justification can be sustained, how are we to understand Justice Breyer’s “right to die with dignity”? Why would it encompass a right to PAS or euthanasia? Justice Breyer contends that this “right to die with dignity” has at its core three components: “personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering.”¹⁴ Many people—including many opponents of PAS and euthanasia—agree that individuals should have personal control over the manner of their death and should have the power to avoid unnecessary physical suffering. What makes Justice Breyer’s perspective capable of justifying PAS or euthanasia is the requirement of “professional medical assistance.”¹⁵ Without this criterion of medical assistance, Justice Breyer would be endorsing a right to suicide, not a narrow right to PAS or euthanasia.

Importantly, Justice Breyer’s view implies that there is not a distinction between PAS and euthanasia for purposes of justification.¹⁶ If a person has a right to control the manner of death with professional medical assistance, then this reasoning must include not only having a physician write a prescription but also having the physician inject life-ending drugs.

More significantly, however, Justice Breyer’s opinion begs the questions of why this “right to death with dignity” requires “professional medical assistance.” After all, one hardly needs professional medical help to die or to commit suicide. With over 31,000 people successfully committing suicide each year in the United States, suicide ranks as the nation’s ninth leading cause

12. *Id.* at 2311 (Breyer, J., concurring).

13. *Id.*

14. *Id.*

15. *Id.*

16. Below, I will argue that the distinction between physician-assisted suicide and euthanasia is a practical impossibility. See *infra* Part III.C.

of death.¹⁷ This constitutes approximately 1.4% of the 2.3 million deaths that occur in the United States every year.¹⁸

By implication, therefore, we can conclude that, in Justice Breyer's view, professional medical assistance is necessary to add the element of *dignity* to death. No doubt many people will find this position somewhat ironic: In an era when many commentators call for the *demedicalization* of death—the goal of allowing death to happen at home, away from doctors and their high-tech apparatus—precisely to ensure “death with dignity,” one of the nation's most prominent jurists has endorsed *increased medicalization* of the dying process as the means by which to achieve dignity. This irony suggests we should think through Justice Breyer's analysis a bit more carefully.

It is difficult to conceive of why Justice Breyer would believe that “death with dignity” necessitates professional medical assistance. In his very short opinion, Justice Breyer never explains or justifies the claim. Justice Souter may have more clearly elaborated Justice Breyer's meaning when he drew an analogy between abortion and PAS without professional medical assistance:

It is, indeed, in the abortion cases that the most telling recognitions of the importance of bodily integrity and the concomitant tradition of medical assistance have occurred The analogies between the abortion cases and [PAS] are several Without physician assistance in abortion, the woman's right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, the patient's right will often be confined to crude methods of causing death, most shocking and painful to the decedent's survivors.¹⁹

Importantly, Justice Souter does not argue that without professional medical assistance there is no effective or real right to death with dignity. He argues only that intentional death without medical assistance might be “crude” and “shocking.”

But there are serious problems with this argument. The first concerns the respective harms that arise from the lack of professional medical assistance. In the case of abortion, the harm that can arise from lack of professional medical assistance is physical injury, even death—what Souter appropriately calls “self-mutilation.”²⁰ In the case of PAS, the harm is aesthetic—what Justice Souter calls “crude” and “shocking.”²¹ Notice that

17. See Anderson et al., *supra* note 7, at tbl.7.

18. See *id.*

19. *Glucksberg*, 117 S. Ct. at 2288.

20. *Id.*

21. *Id.*

one set of harms is physical, encompassing damage to the body and even existence, while the other set of harms is aesthetic, denoting damage to sensibilities and taste. The standard of physical harm is objective and widely agreed upon. Even if one believes that there are objective aesthetic standards, however, there is much greater difficulty in defining them in the public sphere. This distinction displays itself in many other areas of social practice where we permit exercise of rights when they cause aesthetic offense but not physical harm. For example, many people find some instances in which people exercise the right to free speech or to assembly—such as Nazi marches,²² burning the American flag,²³ *Hustler* magazine²⁴—crude and shocking. Yet while we strongly protect the exercise of rights that use crude and shocking methods,²⁵ we prevent the exercise of these very same rights when they might lead to serious physical harms, even harms to the speaker or actor.²⁶

Furthermore, the analogy between surgical abortion and PAS is seriously flawed and should not be used to justify the same kinds of protections. As Table 1 makes clear, these are very different actions that occur in different places and require different skills.

TABLE 1. COMPARING SURGICAL ABORTION AND PAS

SURGICAL ABORTION	PAS
Surgical procedure	Medical procedure
Performed in a hospital or special clinic	Performed in a patient's home
Requires sterile conditions	Does not require sterile conditions
Implements not readily available to patients or "on the street"	Medications readily available, either over the counter or already in patient's possession
A "botched job" results in physical harm or death	A "botched job" results in life

22. See, e.g., *Collin v. Smith*, 578 F.2d 1197 (7th Cir. 1978).

23. See, e.g., *Texas v. Johnson*, 491 U.S. 397 (1989).

24. See, e.g., *Hustler Magazine v. Falwell*, 485 U.S. 46 (1988).

25. See *Cohen v. California*, 403 U.S. 15, 25 (1971) ("[I]t is often true that one man's vulgarity is another's lyric.")

26. See *Brandenburg v. Ohio*, 395 U.S. 444, 447 (1969) (holding that free speech principles prevent a state from proscribing the advocacy of violence or lawlessness except where such incitement is intended to produce such effect and is likely to do so).

A closer analogy to PAS would be medical abortion. With the availability of medical abortions utilizing RU 486 or other medications, the necessity of professional medical assistance for abortions significantly decreases or even disappears. Indeed, the fact that with medications abortion can be done outside the hospital, in the privacy of a woman's home, is why anti-abortion advocates are fighting so strenuously the production and distribution of RU 486 in the United States.²⁷ And yet even in this case it is important to note that the medications for medical abortion—RU 486, methotrexate, or colchine—are not available over the counter. Nor are these medications readily available to women who might need abortion to protect their lives. Conversely, terminally ill patients typically do have prescriptions for medications, like narcotics and sleeping pills, that can be used to commit suicide.

Finally, an empirical claim buried in Justice Souter's argument needs examination. Is it actually the case that suicide methods without professional medical assistance are crude and will shock the decedent's relatives? Would the lack of professional medical assistance prevent dying patients from ending their own lives in a painless manner?

A glimpse at a well-known practitioner of assisted suicide and euthanasia begins to answer these questions. After the confiscation of his "suicide machine," Jack Kevorkian has been using carbon monoxide inhalation to carry out PAS and euthanasia.²⁸ This method of suicide is available to anyone with a car or who purchases a carbon monoxide canister. It requires neither specialized information nor professional medical assistance. Neither does it utilize Dr. Kevorkian's medical training as a pathologist. This method does not seem to inhibit people from seeking out Kevorkian's services or leave relatives of the deceased shocked. Indeed, the relatives are sufficiently satisfied that they praise Kevorkian in courts.

Even beyond the Kevorkian example, Souter's assumption about the aesthetic unpleasantness of unassisted suicide seems

27. On February 3, 1998, newspapers reported that a letter mailed to the news agency Reuters claimed responsibility for the recent bombing of an abortion clinic in Birmingham, Ala. The letter threatened future bombings would be directed at the manufacturers and distributors of RU 486. See "Army of God" Claims It Bombed Clinic, WASH. POST, Feb. 3, 1998, at A5.

28. Of the 33 suicides assisted by Dr. Kevorkian between 1990 and 1996, nearly all of those died by inhaling carbon monoxide. See Jim Irwin, *Kevorkian Aids 33rd Suicide, Takes Body to Hospital*, NEWS & OBSERVER (Raleigh, N.C.), July 11, 1996, at A7, available in 1996 WL 2887430.

wrong. Although most current, successful suicides are violent²⁹—occurring by gunshot or jumping off bridges—others are painless, certainly as painless as a prescription for narcotics, barbiturates, or muscle relaxants. Moreover, dying patients do not live with empty medicine cabinets. Almost all dying patients—and certainly those dying of cancer and AIDS—have more than enough narcotics and sleeping pills to end their own lives. Physicians typically provide prescriptions for a thirty-day supply of such drugs, so that their terminally ill patients do not constantly have to visit the pharmacy or return to the office for a new prescription.

When prescribed narcotics, sleeping pills, carbon monoxide inhalation, or even Tylenol are mentioned as effective methods of suicide, there are typically two responses. One is that people just do not know about this. The problem with this response is that in the United States there are tens of thousands of suicide attempts each year by these very methods. This strongly suggests that these suicide techniques are not secrets successfully kept hidden by the medical establishment.³⁰

The second response is one of squeamishness: "Suffocation by carbon monoxide is awful"; "Tylenol-induced liver failure is a horrible way to go." This reaction is likely the "shock" referred to by Justice Souter. Such responses suggest, however, another reason that professional medical assistance is believed to be necessary to a death with dignity, a reason that has nothing to do with the crudity of the method. 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. By requiring professional medical assistance, inten-

29. In the United States, "violent" cannot be deemed the same as "crude" and "shocking." Furthermore, it is unclear whether dignity demands medical assistance just because suicide is carried out in a violent way.

30. Indeed, the social barrier to discovering such information may provide a good test of how much a person really desires to end his or her life, one analogous to Oregon's requirement that patients ask for PAS more than once and wait at least fifteen days after the request for the receipt of the prescription. See OR. REV. STAT. § 127.850 (1996).

tionally ending one's life is no longer condemned but permitted. Instead, the doctor's active participation signifies social validation. This reassures the patient and family. The physician does not so much deploy "less crude" techniques—in many cases the doctor is prescribing the very same pills the patient could use on his or her own—as sanction the action. Life-ending prescription or injection by the doctor is a social blessing, the secular version of last rites. Having the doctor perform the life-ending act renders the action itself, not the technique, less crude, shocking, isolating.³¹

Social acceptance is essential to "dignity" because dignity is a social construct. Dignity involves the gaze of others; it requires public acceptance and affirmation of one's actions. This dynamic reveals, however, an important contradiction in the views of PAS and euthanasia advocates. These advocates claim that their goal is a neutral right that does not condemn or praise PAS or euthanasia. They assert that they want people to live their own lives by their own lights, make "those grave judgments for themselves, free from the imposition of any religious or philosophical orthodoxy by court or legislature."³² However, the necessity of professional medical assistance in realizing this vision—not for any methodological expertise but for its imprimatur of dignity—suggests that the grave judgments inherent in PAS and euthanasia are not merely, or even dominantly, individual but very much require social approval. The necessity of society's approval, however, transfers the proper fulcrum of the debate from rights to policy. The logic of Justice Breyer's proposed exception, therefore, inevitably leads one to the conclusion that the legislature, not the Court, is the proper forum for the debate about PAS and euthanasia.

C. THE SOUTER PERSPECTIVE—DEFERENCE TO THE STATES

Adopting a Frankfortian posture, Justice Souter argued in his concurrence that the Court should not displace the experi-

31. It is worth noting that there is no active campaign to have euthanasia performed or suicide assisted by non-physicians. The idea of technically competent and proficient non-physician specialists in ending life—thanatologists—has never generated any support. If the above argument is correct, this is because patients want the social blessing that can only be conferred by socially-respected professionals and not by just a good "death mechanic." There is no interest in having the life-ending actions performed without the social prestige offered by the medical profession.

32. Ronald Dworkin et al., *Assisted Suicide: The Philosopher's Brief*, N.Y. REV. BOOKS, Mar. 27, 1997, at 41, 43.

mentation of various state legislatures by recognizing a right to PAS. The Court, he suggested, might reconsider and ratify such a right once it has become socially accepted, after state experimentation and evolution of social values:

One must bear in mind that the nature of the right claimed, if recognized as one constitutionally required, would differ in no essential way from other constitutional rights guaranteed by enumeration or derived from some more definite textual source than "due process." An unenumerated right should not therefore be recognized, with the effect of displacing the legislative ordering of things, without the assurance that its recognition would prove as durable as the recognition of those other rights differently derived. To recognize a right of lesser promise would simply create a constitutional regime too uncertain to bring with it the expectation of finality that is one of this Court's central obligations in making constitutional decision. . . . While I do not decide for all time that respondents' claim should not be recognized, I acknowledge the legislative institutional competence as the better one to deal with that claim at this time.³³

In Justice Souter's view, the Supreme Court should not declare the existence of such unenumerated rights, but rather should ratify a social process that creates and accepts these rights. This perspective properly shifts the discussion away from abstract, first-person arguments of principle and toward third-person interest-balancing and the empirical assessment of the utility of protections and regulations.

III. THE POLICY QUESTION OF LEGALIZING PHYSICIAN-ASSISTED SUICIDE OR EUTHANASIA

A. INDIVIDUAL CHOICE VS. SOCIAL PRACTICE

Consideration of PAS or euthanasia as a matter of policy rather than right requires a shift of perspectives, from the moral to the political. In any individual case that might be raised in the media or in the courts, proponents and opponents of PAS and euthanasia might agree on the wisdom of administering life-ending drugs. Once the debate moves to the state legislatures, however, the issue is not the appropriateness of PAS or euthanasia in a particular case but rather its appropriateness as a matter of social policy. Citing the wishes of a suffering individual, or even a few thousand suffering individuals, or expressing what one would personally want if placed in certain terrible circumstances, no longer becomes dispositive. The real issue is

33. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2293 (1997).

whether it is prudent to have a general rule that potentially makes PAS or euthanasia available to almost all terminally ill patients. Therefore, we need to consider not just particular cases but the impact on the care for terminally ill patients generally. And we need to be sure that we are making these assessments accurately.

The current debate is being conducted via myths. The two most important are the myth of pain and the myth of separation. These myths frame policy considerations for a nonexistent world.

B. THE MYTH OF PAIN

*We are using a working-model which fails to fit the facts that we really wish to talk about*³⁴

*A picture held us captive. And we could not get outside it*³⁵

The policy debate over the legalization of PAS and euthanasia has been distorted. It employs the wrong working model, thereby preventing proper deliberation.³⁶ The debate about PAS or euthanasia is dominated by the picture of a terminally ill person forced to suffer horribly without relief. This is the picture that comes to mind any time the words *physician-assisted suicide* or *euthanasia* are mentioned. It is also the scenario invoked by advocates when they seek public approval for these techniques.³⁷ The trouble is that the picture fails to fit the facts.

One of the most vivid invocations of this picture to justify PAS and euthanasia occurred in the Ninth Circuit's ruling in *Compassion in Dying v. Washington*:

Americans are living longer, and when they finally succumb to illness, lingering longer, either in great pain or in a stuporous, semi-comatose condition that results from the infusion of vast amounts of pain killing medications. Despite the marvels of technology, Americans frequently die with less dignity than they did in the days when ravaging diseases typically ended their lives quickly. AIDS, which often subjects its victims to a horrifying and drawn-out demise, has also contributed to the

34. STANLEY CAVELL, *MUST WE MEAN WHAT WE SAY?* 97 (1969).

35. LUDWIG WITTGENSTEIN, *PHILOSOPHICAL INVESTIGATIONS* 115 (1968).

36. See CAVELL, *supra* note 34, at 97.

37. Another case that comes to mind is that of a patient with Lou Gehrig's disease confined to a wheel chair. The general problem with invoking patients with this disease to justify physician-assisted suicide or euthanasia is that the disease is progressive and the patient is usually already on a respirator. Death can be had by terminating life-sustaining interventions—the respirator—without the need for physician-assisted suicide or euthanasia.

growing number of terminally ill patients who die protracted and painful deaths.³⁸

The polling data indicate a similar public perception. The only way to elicit significant public support for PAS or euthanasia is by asking either a very general, hypothetical question or one specific to a patient in pain. One standard polling question has been asked since the late 1940s, and its response has been frequently cited by legalization advocates as demonstrating public support for PAS of 60-70%: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life if the patient and his or her family request it?"³⁹ The only other type of question about PAS or euthanasia that elicits similar public approval asks some variation of this question: "If a terminally ill person who is conscious and suffering a great deal of pain asks his or her doctor to administer lethal drugs or injections that would end the person's life?"⁴⁰ This suggests that when asked in an abstract or hypothetical way about PAS or euthanasia the "picture" that comes into people's minds is the patient in pain. This interpretation is supported by the fact that public support for PAS or euthanasia drops dramatically when the scenario is not one of a patient in pain, but of a bedridden patient, a patient worried about burdening the family, or a patient who just finds waiting for death purposeless.⁴¹

38. *Compassion in Dying v. Washington*, 79 F.3d 790, 812 (9th Cir. 1996) (en banc), *rev'd sub nom. Washington v. Glucksberg*, 117 S. Ct. 2258 (1997). It is one of the ironies of this appellate court decision that it presents contradictory views about the role of medical technology in the physician-assisted suicide or euthanasia debate. On the one hand, technology is a cause of the interest in physician-assisted suicide or euthanasia because it keeps us alive and changes the demography of the dying to more chronic illnesses. On the other hand, the court argued that interest in physician-assisted suicide or euthanasia is ancient, going back at least 2,500 years, well before the advent of any medical technology, and that medical technology in many cases can reduce pain that causes interest in euthanasia. How can advances in medical technology "cause" interest in physician-assisted suicide or euthanasia and yet there be interest before the advent of that very technology? Further, with the effectiveness of technology in reducing pain, interest in physician-assisted suicide or euthanasia should be obviated. See generally Ezekiel J. Emanuel, *The History of Euthanasia Debates in the United States and Britain*, 121 ANNALS INTERNAL MED. 793 (1994).

39. Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying? The Public Perspective*, 267 JAMA 2658, 2659 (1992) (reporting data derived from surveys conducted by various polling organizations).

40. *Id.* at 2660.

41. See Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 LANCET 1805, 1805 (1996).

When the Supreme Court Justices discussed PAS and euthanasia they invoked the same picture of patients in pain. In their mind, this image of excruciating pain is the quintessential and standard case in which people request PAS or euthanasia. Justice O'Connor considered circumstances in which patients in pain might be denied palliative care as constitutive of those in which there might exist a right to PAS.⁴² Justice Breyer argued that a right that encompassed PAS could exist when "the law's impact upon serious and otherwise unavoidable physical pain [accompanying death] would be more directly at issue."⁴³ Justice Stevens discussed "avoiding intolerable pain and the indignity of living one's final days incapacitated and in agony" as central to considerations in favor of PAS.⁴⁴ These comments occurred in the course of the Justices' exploration of when PAS would be justified, but they constitute more than just the cases in which they think these interventions would be acceptable. Citing these circumstances of "intolerable pain" and "unavoidable physical pain" reveals that these are precisely the instances in which the Justices imagine requests for PAS or euthanasia would arise. Like everyone else, the Justices believe that intolerable pain is the paradigm for requests of PAS, making it the standard for the consideration of sufficient justification.

The picture of a patient writhing in pain and begging for PAS or euthanasia is, however, largely a myth. All the available evidence indicates that there is virtually no causal connection between pain and interest in PAS or euthanasia. Using intolerable pain as the framework in which to think about PAS or euthanasia, distorts the assessment of their benefits and harms. There are two sources of data on the reasons patients have for requesting PAS or euthanasia: (1) interviews with physicians who have received requests for and have performed PAS or euthanasia, and (2) interviews with patients who might be interested in PAS or euthanasia. The four studies of physicians who have performed PAS or euthanasia, summarized in Table 2, show that pain is given as any part of patients' reason for requesting PAS or euthanasia in about one third of the cases and is given as the sole reason in only 5-11% of the cases.

42. See *Washington v. Glucksberg*, 117 S. Ct. 2303 (1997) (O'Connor, J., concurring).

43. *Id.* at 2312 (Breyer, J., concurring).

44. *Id.* at 2307 (Stevens, J., concurring).

TABLE 2. PAIN AS A FACTOR IN REQUESTING PAS OR EUTHANASIA (PHYSICIAN STUDIES)

	1990 DUTCH ⁴⁵	1994 DUTCH NURSING- HOME ⁴⁶	1996 DUTCH ⁴⁷	1996 WASH. STATE ⁴⁸
Pain is any part of the justification	46%	29%	32%	35%
Pain is the sole or main justification	5.3%	11%	0%	NA

Additional data come from three studies examining the reasons for interest among patients who might be candidates for PAS or euthanasia. In the first study, among 378 HIV-infected patients (90% of whom qualified for an AIDS diagnosis), 55% had considered PAS; experiencing frequent or persistent pain was not a predictor for having considered PAS.⁴⁹ In a second study, 27.3% of cancer patients had serious thoughts about PAS or euthanasia and 11.9% had serious discussions about PAS or euthanasia.⁵⁰ Again, experiencing pain was not a predictor for thoughts or discussions about PAS or euthanasia. Indeed, cancer patients experiencing pain were (1) more likely to find PAS or euthanasia unacceptable, (2) more likely to state that discussion of PAS or euthanasia with the physician would not increase trust, and (3) more likely to change physicians if their physician mentioned that he or she had provided PAS or

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

46. See M.T. Muller et al., *Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?*, 42 AM. J. GERIATRICS SOC'Y 624 (1994).

47. See GERRIT VAN DER WAL & PAUL J. VAN DER MAAS, EUTHANASIE EN ANDERE MEDISCHE BESLISSINGEN ROND HET LEVENSEINDE—DE PRAKTIJK EN DE MELDINGSPROCEDURE (1996); Paul J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 NEW ENG. J. MED. 1699 (1996).

48. See Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996).

49. See William Breitbart et al., *Interest in Physician-Assisted Suicide among Ambulatory HIV-Infected Patients*, 153 AM. J. PSYCHIATRY 238, 238 (1996).

50. See Emanuel et al., *supra* note 41, at 1808.

euthanasia.⁵¹ In the third study, this one of 988 patients with terminal cancer, heart disease, lung disease and other terminal conditions, 10.5% had thought about ending their life with PAS or euthanasia and 3.7% had discussed PAS or euthanasia with someone.⁵² Again, terminally ill patients experiencing severe or moderate pain were not more likely than patients not experiencing significant pain to have considered or discussed PAS or euthanasia.

These results suggest that two dominant factors unrelated to pain motivate patients to desire PAS or euthanasia: (1) depression and (2) caregiving needs that place burdens on the patients' loved ones. According to the studies of physicians represented in Table 3, the leading reasons for PAS or euthanasia are concern about being a burden, loss of dignity, and depression.

TABLE 3. REASONS FOR PAS OR EUTHANASIA (PHYSICIAN STUDIES)

	1990 DUTCH ⁵³	1994 DUTCH NURSING HOME ⁵⁴	1996 DUTCH ⁵⁵	1996 WASH. STATE ⁵⁶
Depression	NA ⁵⁷	NA	NA	55%
Being a burden	33%	28%	NA	75%
Loss of dignity	57%	NA	56%	72%

Similarly, in the studies involving interviews with AIDS and oncology patients, depression and the burden of high caregiving needs consistently show up as the most important factors determining patient interest in PAS or euthanasia, as is illustrated in Table 4.

51. *See id.* at 1808-09.

52. *See* D. Fairclough et al., *Interest in Euthanasia and Physician-Assisted Suicide Among Terminally Ill Oncology Patients: Results from Commonwealth-Cummings Project*, J. CLINICAL ONCOLOGY (forthcoming 1998).

53. *See* van der Maas et al., *supra* note 45.

54. *See* Muller et al., *supra* note 46.

55. *See* VAN DER WAL & VAN DER MAAS, *supra* note 47; van der Maas et al., *supra* note 47.

56. *See* Back et al., *supra* note 48.

57. NA means that these options were either not asked or not reported in these studies. The Dutch did not include this as a response category.

TABLE 4. FACTORS PREDICTING PATIENT INTEREST IN PAS AND EUTHANASIA (PATIENT STUDIES)

	AIDS PATIENTS IN N.Y. ⁵⁸	CANCER PATIENTS IN NEW ENG. ⁵⁹	TERMINALLY ILL PATIENTS IN U.S. ⁶⁰
Statistically significant factors predicting patient interest in PAS or euthanasia	1) Depression 2) Hopelessness 3) Fewer social supports 4) Being a burden	1) Depression 2) Poor physical functioning	1) Depression 2) High caregiving needs 3) Longer illnesses

Every study conducted suggests, then, that the conventional portrait of the person who is interested in PAS or euthanasia is inaccurate. This of course does not mean that there are no individual terminally ill patients suffering intolerable pain who do in fact want PAS or euthanasia to relieve their misery. However, these data indicate that this patient is not the norm. The debate over the wisdom of PAS or euthanasia should turn on the rule rather than the exception. If tough cases make bad law, then surely we need the proper case for discussing the prudence of legalizing PAS or euthanasia. And the proper, paradigmatic case of a terminally ill patient who desires PAS or euthanasia is the depressed person who requires a great deal of care from his or her family.

If the working model were appropriately altered, relevant actors would suddenly be much less inclined to consider PAS or euthanasia acceptable. There are few people who would be willing to justify PAS or euthanasia based on its benefit for depressed terminally ill patients or those needing a great deal of care. Indeed, the polling data show that Americans are much less inclined to consider PAS or euthanasia acceptable for patients who want it because they worry about being a burden.⁶¹ Only about a quarter of Americans support PAS or euthanasia for patients who want it because they do not want to be a burden on their family.⁶²

58. See Breitbart et al., *supra* note 49.

59. See Emanuel et al., *supra* note 41.

60. See Fairclough et al., *supra* note 53.

61. See Emanuel et al., *supra* note 41, at 1807.

62. See *id.*

C. THE MYTH OF SEPARATION

The debate in the United States surrounding legalization focused initially on both PAS and euthanasia. Nonetheless, many proponents of PAS and euthanasia interpreted the defeat of the Washington and California referenda in the early 1990s as a repudiation of euthanasia alone. Some have argued on principle that PAS is preferable to and distinct from euthanasia because it provides the added safeguard of requiring the patient to take the medications. Others seem to advocate legalizing PAS as a strategic move because public opposition is less. This theory may presume that once the public becomes accustomed to the practice of PAS, the public is likely to become less resistant to the legalization of euthanasia. Whatever the motive, the public debate is now couched in terms of legalizing PAS alone.⁶³

The separation between PAS and euthanasia is conceptually tenable. As I have suggested in critiquing Justice Breyer's view, however, the separation in justification seems problematic.⁶⁴ If the justifications for PAS are personal control over the manner of one's own death, professional medical assistance, and the avoidance of unnecessary suffering, then these justifications should hold equally for euthanasia. Furthermore, there is the problem of patients who are so debilitated that they cannot end their own lives even with medications. For these people PAS would not realize any of the advantages claimed by advocates. The justification for PAS for those who are physically capable of ending their own lives should encompass euthanasia for those who physically cannot end their own lives.

Most importantly from a policy perspective, the separation of PAS and euthanasia is impossible to operationalize. One problem is that if physicians do not understand the difference between PAS and euthanasia, then it cannot affect their practices. Data suggest that physicians frequently label actions as PAS when in fact the actions are euthanasia.⁶⁵ Physicians' terminology is influenced by two factors. First, physicians and other medical providers focus on euthanasia because it is the

63. The Oregon experiment exemplifies this trend by permitting only physician-assisted suicide. See OR. REV. STAT. § 127.805 (1996) (providing that a capable adult "may make a written request for medication" to end his or her life).

64. See *supra* Part II.B.

65. See Ezekiel J. Emanuel et al., *The Practice of Euthanasia and Physician-Assisted Suicide Among Oncologists: Adherence to Safeguards and Effects on Physicians* (submitted 1998).

action they feel most implicated in and uncomfortable about.⁶⁶ From the public debate they understand euthanasia as a situation in which the “physician injects into the patient life-ending drugs.”⁶⁷ They then classify as PAS all actions that are intended to end the patient’s life but do not involve the physician injecting the medication. Consequently, when physicians write an order for a hospital or hospice nurse to inject the patient with life-ending drugs, they do not view this as euthanasia but as PAS because the physician is not actually doing the injecting. Yet, by commonly accepted definitions, such action constitutes euthanasia.⁶⁸ It might be thought that through proper education physicians could better learn the difference between euthanasia and PAS. But it is difficult to imagine more effective educational initiatives than all the media coverage of the PAS and euthanasia controversy and the concomitant medical conferences and rounds on the topic.

There is however a second—and more important—reason why it will be hard to permit PAS but prohibit euthanasia: failures. Today, most suicide attempts fail. Failures will likely continue even when there is professional medical assistance. The most effective oral drug cocktail with which to end a life is not known, and many physicians report feeling uncertain about what to prescribe.⁶⁹ Furthermore, even with appropriate drugs and instructions from the physician, patients may fail to execute the instructions correctly. One survey of oncologists who have acknowledged participating in euthanasia or PAS suggests that as many as 20% of PAS incidents fail to end the patient’s life.⁷⁰

Any appropriate policy would have to consider how to handle these PAS failures. In the Netherlands, euthanasia is viewed as a necessary “back-up” to PAS. The Dutch ethos is for the physician to be in close proximity to the patient performing PAS—if the drugs fail to end the patient’s life, the physician should then provide euthanasia. For the Dutch, euthanasia is viewed as a necessary “back-up” to PAS. This may be why in the Netherlands euthanasia occurs almost six times more frequently than PAS.⁷¹

66. See Emanuel et al., *supra* note 41, at 1807 (describing medical professionals’ greater comfort with physician-assisted suicide).

67. See Emanuel, *supra* note 3, at 1891.

68. See *id.*

69. See Melinda A. Lee et al., *Legalizing Assisted Suicide: Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 313 (1996).

70. See Emanuel et al., *supra* note 65.

71. See van der Maas et al., *supra* note 47.

It seems highly unlikely that a state will prosecute physicians who commit euthanasia thinking they were performing PAS, or who commit euthanasia because they were remedying a PAS failure. Practically speaking, then, there will be no distinction between PAS and euthanasia. We should therefore stop the charade of arguing only about legalizing PAS. While PAS and euthanasia are conceptually distinct, from a social policy perspective this distinction cannot be sustained. The real choice is to legalize both PAS and euthanasia, or to legalize neither.

IV. WHAT ARE THE BENEFITS OF LEGALIZING PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA?

Anyone honestly examining the issue will acknowledge that there are both benefits and harms from legalizing PAS and euthanasia or keeping them illegal. Because of the illegality of PAS and euthanasia, some terminally ill patients who want to end their lives suffer needlessly.⁷² Some other people would find reassurance just from having the option of PAS and euthanasia available, even if they never actually used the procedures. Legalization would certainly benefit these people. Against these benefits one must weigh the harms. Legalization would inevitably result in abuses: patients coerced into ending their lives; patients given PAS or euthanasia without having received all palliative care interventions; patients ending their lives for economic reasons; nonconsenting patients having their lives ended. Dan Brock, a strong advocate for PAS and euthanasia, forthrightly acknowledges that whatever safeguards are implemented, they would "substantially reduce, . . . not . . . eliminate, the potential for abuse."⁷³ The real question, then, is whether the acknowledged benefits of legalization outweigh its acknowledged risks.

While there has been significant debate about the potential harms from legalizing PAS and euthanasia, there has been almost none about the extent of likely benefits. It is as if the benefits of legalization are somehow "obvious" and do not need

72. Although it should be mentioned that even in the current situation in which physician-assisted suicide and euthanasia are illegal, some patients receive these interventions and have their lives ended. We do not know the number, but we do know that about 15% of oncologists have acknowledged performing physician-assisted suicide or euthanasia. See Ezekiel et al., *supra* note 41; Back et al., *supra* note 48.

73. Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 10, 20.

delineation or quantification, while at the same time the potential harms need to be extensively assessed. But what are the likely benefits? Are they really so substantial?

Proponents typically identify three main benefits to legalization: (1) ensuring the integrity of autonomy; (2) reducing needless pain; and (3) providing reassurance to terminally ill patients.⁷⁴ Opponents counter with four main dangers: (1) a reduction in the moral integrity of medical care; (2) a reduction in commitment to quality end-of-life care; (3) coercive pressure on patients to utilize PAS or euthanasia; and (4) expansion of practice to intentionally ending the lives of patients for whom PAS is not justified, such as patients who have not been provided optimal palliative care, depressed patients, or mentally incompetent patients.⁷⁵

Some of these benefits and harms are, no doubt, difficult to evaluate. For instance, few would challenge the proposition that autonomy is a fundamental American value⁷⁶ and that preserving the integrity of our social values should be an objective of our social policies. However, the exact link between valuing autonomy and legalizing PAS or euthanasia is subject to interpretive disagreement. So, too, is the connection between legalizing assisted suicide and the integrity of the medical profession. These interpretive disagreements are unlikely to be resolved within our democratic system. This realistic assessment should not be construed to denigrate or dismiss the importance of further deliberation about these issues. Further debate can clarify the areas of agreement, narrow interpretive difference, and reveal some of the practical implications of the different interpretations.

The relevant considerations for legalization are more expansive, however, than the potential effects on autonomy and medical professionalism. It is worth examining these factors both to clarify existing policy choices and to identify interpretive gaps in order to define the data needed by legislatures to make fully informed policy choices. Though some benefits and harms can be empirically assessed, deficiencies in the available data

74. See *Should Physicians Aid Their Patients in Dying? The Public Perspective*, 267 JAMA 2658, 2659 (1992); Brock, *supra* note 73, at 14; Emanuel, *supra* note 3.

75. See Emanuel, *supra* note 3; David C. Thomasma, *When Physicians Choose to Participate in the Death of Their Patients: Ethics and Physician-Assisted Suicide*, 24 J.L. MED. & ETHICS 183, 193 (1996).

76. See Rogers M. Smith, *The Constitution and Autonomy*, 60 TEX. L. REV. 175, 175 (1982) (charting the rise of autonomy as a fundamental value).

render any assessment of the benefits from legalizing PAS or euthanasia little more than guesswork. Nonetheless, by relying on knowledge of practices in the Netherlands, current practices, and projections about the effect of removing legal barriers, we can make useful educated guesses about likely actual practices.

A. HOW MANY TERMINALLY ILL PATIENTS MIGHT BENEFIT FROM LEGALIZING PAS OR EUTHANASIA?

To understand who might benefit from using PAS or euthanasia, we need to understand the epidemiology of death. In the United States, just over 2.32 million people die each year.⁷⁷ Two thirds of these people are over sixty-five years of age, and about 0.5% are under eighteen years of age.⁷⁸ Not all deaths are preceded by a "dying process." That is, many deaths have no "prodrome" in which the person is recognized to be dying and could choose to have PAS or euthanasia. Deaths from sudden heart attacks, strokes, ruptures of aortic aneurysms, certain viral infections, motor vehicle and other accidents, and violent crimes are sudden events without an identifiable preceding "dying process." While there are no firm data on how many deaths are acute and how many have a "dying process," I estimate that approximately half of all deaths in the United States occur among adults who have a preceding dying process. This accounts for about one million deaths per year.⁷⁹ Not all of these dying adults are mentally competent and capable of requesting PAS or euthanasia. We have no good data on what proportion of people

77. This is the latest number projected for 1997. A measurement several years old puts the number at just over 2.27 million. See U.S. NAT'L CENTER FOR HEALTH STATISTICS, 1993 VITAL STATISTICS OF THE UNITED STATES 96 tbl.131 (1993).

78. See *id.* at 95 tbl.130.

79. This calculation is obviously a very rough estimate. It is based on the idea that there are (1) slightly under 50,000 deaths among those under 18 years of age; (2) 70,000 deaths from accidents among those over 18 years of age; (3) 30,000 suicides; and (4) 15,000 deaths by homicide. In addition, there are 150,000 strokes, most of which are acute, and 82,000 cases of acute pneumonia and influenza distinct from emphysema. In addition, there are 750,000 deaths from heart disease. A crude guess is that about half are sudden death either from myocardial infarction or arrhythmia. Conversely, we can estimate the number of deaths with prodrome or recognizable dying process. In this case, there are approximately 525,000 deaths from cancer; 100,000 deaths from emphysema; 375,000 deaths from cardiac disease such as congestive heart failure; 37,000 deaths from AIDS; and about 15,000 deaths from liver disease, such as cirrhosis. Some of the 50,000 or so deaths from diabetes are acute from insulin overdoses, diabetic ketoacidosis, or acute infections. This accounts for just over one million deaths per year. See *id.* at 96 tbl.131.

who die are mentally competent within the last six months of their lives. But because dementia increases with age and death occurs disproportionately among those over sixty-five, a significant proportion of those who experience a dying process are likely to be incompetent and unable to request PAS or euthanasia for themselves. To take the high side, however, we can estimate that there are about one million people over eighteen years of age who are mentally competent and have a recognizable "dying process."

The question of what proportion of these one million Americans who die each year could benefit from PAS or euthanasia if legalized is problematic because it requires settling on the precise circumstances in which people would find providing PAS or euthanasia beneficial. The scenario in which PAS and euthanasia are most widely—although not universally—viewed as justified is when the dying person suffers from unremitting physical pain.⁸⁰ This circumstance receives the strongest public support and is the one cited by the Supreme Court Justices as being most persuasive.⁸¹ Beyond this core circumstance, the "benefits" of using PAS become much more controversial and, correlatively, public support dramatically declines.⁸²

There are two ways to estimate the percentage of the one million patients who experience a "dying process" who also have such unremitting pain that PAS or euthanasia might be a justifiable option. First, current data suggest that in the months before death approximately 80% of patients have little or no pain

80. The fact that pain is an expandable notion presents a problem with using pain as the justifiable circumstance for physician-assisted suicide or euthanasia. Soon every adverse condition will be reclassified as pain. The phrase "pain and suffering" shows this tendency. The phrase suggests that pain and suffering are interchangeable, as if every kind of suffering constitutes pain, or that pain and suffering necessarily occur together, which is not always the case since it is possible to have either one without the other. See TIMOTHY E. QUILL, *A MIDWIFE THROUGH THE DYING PROCESS: STORIES OF HEALING AND HARD CHOICES AT THE END OF LIFE* (1996).

Once, when I was teaching a class and presenting the data on how depression motivates patients to desire physician-assisted suicide or euthanasia, a physician argued (without a sense of irony) that patients with depression had "mental pain" that made physician-assisted suicide and euthanasia justifiable in their circumstances. Justice Breyer may have specifically emphasized "unavoidable physical pain (accompanying death)" to preclude this augmentation of claims about pain. See *Washington v. Glucksberg*, 117 S. Ct. 2302, 2312 (1997) (Breyer, J., concurring).

81. See *infra* Part III.B.

82. See *infra* Part III.B.

and about 20% of dying patients experience significant pain.⁸³ These data are used to suggest that physicians undertreat pain. It is frequently argued that with optimal pain management, only about 5% of dying patients will have intractable, unremitting pain.⁸⁴ Using this figure, 50,000 dying patients per year (5% of one million patients experiencing a dying process) would have such unremitting pain that PAS or euthanasia might be viewed as a tangible benefit.

The experience of significant, unremitting pain does not necessarily correspond, however, to an interest in PAS or euthanasia. Recent data from cancer patients suggest that slightly over 10% of terminally ill patients with significant pain have an interest in PAS or euthanasia and that only about 4% have discussed PAS or euthanasia.⁸⁵ Data from HIV patients in New York suggest that 53% of HIV patients with significant pain have considered PAS.⁸⁶ This means that among terminally ill patients with unremitting pain we might estimate that between 5,000 and 25,000 might be interested in ending their lives through PAS or euthanasia.⁸⁷

A second method of estimating the number of terminally ill patients for whom PAS or euthanasia might be a justifiable option is to extrapolate from data from the Netherlands. In the

83. See The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)*, 274 JAMA 1591, 1595 (1995). This study also reported that in the last three days of life about 55% of patients experience significant pain. See *id.* However, this finding is based on reports of the patient's relatives, which frequently are inaccurate.

84. See WORLD HEALTH ORGANIZATION, *CANCER PAIN RELIEF AND PALLIATIVE CARE* (1990); Kathleen M. Foley, *The Treatment of Cancer Pain*, 313 NEW ENG. J. MED. 84, 85 (1985).

85. Fairclough et al., *supra* note 52.

86. Breitbart et al., *supra* note 49, at 240.

87. These numbers are calculated by the following method: among the 50,000 people who die each year with unremitting pain despite optimal treatment, between 10% and 50% might desire physician-assisted suicide or euthanasia. However, the proportion of patients in pain who want physician-assisted suicide or euthanasia is likely to be on the low side. Patients dying of AIDS—which generates the higher number—tend to be younger and less religious, two factors that significantly increase interest in physician-assisted suicide or euthanasia. See *id.* Yet, according to the Dutch data, 80% of patients receiving euthanasia or physician-assisted suicide are cancer patients; AIDS patients are a very small proportion—less than 10%—of the patients who receive euthanasia or physician-assisted suicide in the Netherlands.

Netherlands, 3.4% of all deaths are by PAS or euthanasia.⁸⁸ But 0.7% occur in patients who are not competent when provided euthanasia. An additional 0.3% were not terminally ill, as defined by their physicians' estimate they would have lived longer than six months when given PAS or euthanasia.⁸⁹ Overall then, approximately 2.4% of all dying patients in the Netherlands might receive PAS or euthanasia if the safeguards generally accepted in the United States were applied. However, pain plays some role in motivating the request for PAS or euthanasia in only about a third of these cases.⁹⁰ Thus, using the Dutch data, in only about 0.8% of all deaths is PAS or euthanasia provided for reasons of significant pain. Applying such figures to the 2.32 million deaths in the United States suggests that under 25,000 patients per year would utilize PAS or euthanasia to relieve excruciating pain refractory to optimal treatment.

Remarkably, these two different approaches produce fairly consistent estimates, suggesting that the "benefit" from legalizing PAS or euthanasia for the relief of pain can be reliably estimated to affect between 5,000 and 25,000 terminally ill patients from among the 2.32 million Americans who die each year. Because some PAS or euthanasia occurs despite illegality (although we do not know exactly how much), the "net" benefit of having legalization is likely to be lower.

We have only very limited data on the question of how many patients in the "dying process" might benefit from the reassurance provided by knowing that PAS or euthanasia would be potentially available. In the only study that asked patients and the public about such issues, approximately 40% indicated that their level of trust would increase if they discussed the availability of PAS or euthanasia with their physician.⁹¹ Importantly, an almost equal number indicated that their trust would be reduced by such a discussion.⁹² Interestingly, patients with severe pain and patients whose cancer recurred indicated that such discus-

88. See van der Maas et al., *supra* note 47, at 1701 tbl.1.

89. See *id.* at 1700. According to the agreed-upon safeguards in the Netherlands, patients seeking physician-assisted suicide or euthanasia do not need to be terminally ill. See Gerrit van der Wal et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706, 1706 (1996). The most recent data suggest that as many as 10% of patients receiving physician-assisted suicide or euthanasia would have lived longer than six months.

90. See *supra* Part III.B.

91. See Emanuel et al., *supra* note 41, at 1808.

92. See *id.*

sions would not improve their trust and reassurance.⁹³ While such data are tenuous at best, they do suggest that there is no net "reassurance" benefit from legalizing or permitting PAS or euthanasia.

B. HOW MANY TERMINALLY ILL PATIENTS MIGHT BE HARMED FROM LEGALIZING PAS OR EUTHANASIA?

The major potential harms of legalization for which some empirical data exist are (1) coercive pressure on patients to commit suicide, (2) application of the intervention to patients who have not received all appropriate palliative measures, and (3) application of the intervention to patients incapable of consenting. Some data indicate that financial pressures arising from end-of-life medical care do correlate with preferences by families to withdraw or withhold life-sustaining treatment for patients.⁹⁴ This suggests that the possibility of coercive pressure is real. Nevertheless, there is a shortage of reliable data by which to quantitatively estimate the frequency with which financial and other pressures might induce patients to express an interest in PAS or euthanasia, cause families to desire PAS or euthanasia for their dying relatives, or lead families to pressure patients into receiving PAS or euthanasia. While data on these issues are very difficult to generate, they are very important and should be a priority. Coercive pressure by families on patients to end their lives is hard to detect, and is unlikely to be restrained by currently proposed procedural safeguards.

There is also a concern that patients may receive PAS or euthanasia before exhausting palliative care options. The only data that bear on this are data from the Netherlands, where in at least 9% of cases physicians admitted that euthanasia was provided despite additional palliative interventions that could have been utilized.⁹⁵ Since these data relied on physician admission of undertreatment, they are likely to be low. There are anecdotal reports both in the United States and the Netherlands of cases in which depressed patients were provided PAS or euthanasia either without any treatment or with inadequate treatment. But there are no reliable quantifiable data on this

93. *See id.*

94. *See* Kenneth E. Covinsky et al., *Is Economic Hardship on the Families of the Seriously Ill Associated with Patient and Surrogate Care Preferences?*, 156 ARCHIVES INTERNAL MED. 1737 (1996).

95. *See* Muller et al., *supra* note 46.

point. Nor are there data on how many patients request and receive PAS or euthanasia whose pain, shortness of breath, fatigue, nausea and vomiting, and other symptoms have not been optimally treated.

A final concern is that patients will receive PAS without their consent. In the Netherlands, in 0.7% of all deaths (20% of all PAS and euthanasia cases), a patient who is not competent receives euthanasia.⁹⁶ Just over half of these patients at some time voiced interest in euthanasia, but subsequently became incompetent and could not consent at the moment of injection. In these cases, we do not know whether the patient's interest had persisted or whether the patient had changed his or her mind. Nevertheless, 48% of patients (or 0.35% of all deaths in the Netherlands) had never expressed an interest in euthanasia and yet were given euthanasia when they were mentally incompetent.⁹⁷ Translating this figure to the United States would result in more than 7,000 deaths per year of patients who have not consented. Similarly, data from physicians in the United States who acknowledged participating in PAS or euthanasia indicate that in 15% of these cases, patients' lives were intentionally ended, either by the physician or the family with the physician's assistance, without the participation of the patient in the decision either because the patient was incompetent or was not asked to consent.⁹⁸

In sum, it is difficult to estimate quantitatively how many patients would be at risk of receiving PAS or euthanasia inappropriately in the event of legalization. There are worrisome anecdotes. There are also experiences in the Netherlands suggesting that 7,000 or so people might be given euthanasia in the United States without their consent, that there are likely to be many others who will request and receive PAS or euthanasia despite inadequate palliative care, and there are likely to be that others may be coerced into having their lives ended.

C. THE EFFECTIVENESS OF SAFEGUARDS IN PREVENTING HARMS

It is frequently argued that by legalizing PAS or euthanasia, it would be possible to implement safeguards that would prevent harms and abuses. These claims are unpersuasive for at least three reasons. First, simply because safeguards or guidelines

96. See van der Maas et al., *supra* note 47, at 1704 tbl.4.

97. See *id.*

98. See Emanuel et al., *supra* note 65.

are enacted into law, there is no reason to think adherence will be high, much less absolute. Legal protections may make it possible to prosecute violations but this is far different from increasing adherence to safeguards. The question of whether legalization will ensure adherence—or greater adherence—to safeguards is an empirical question that cannot be assumed. Second, the Dutch experience demonstrates that carefully crafted safeguards, widely endorsed by the medical profession and courts, do not necessarily lead to adherence. No matter how one looks at the data, there are substantial violations of the safeguards in the Netherlands. In 0.7% of all deaths, nonconsenting people are given euthanasia. Disabled neonates are given euthanasia, violating the requirement that euthanasia only be for competent adults. Patients for whom optimal palliative care has not been provided are given euthanasia, violating the requirement that all palliative measures be implemented and the suffering be truly unremitting. One counterargument is that while these cases are violations of the safeguards they are nonetheless morally acceptable. In many cases—especially those in which patients never consented to euthanasia or in which palliative measures went untried—such a claim seems disingenuous. Most importantly, adherence to specified safeguards is likely to be much higher in the Netherlands than in the United States. The Netherlands is geographically small, densely populated, and culturally homogeneous, making it a much easier place than the United States in which to enforce laws. Furthermore, the Netherlands provides universal health coverage, which the United States does not. The Netherlands, then, provides a best-case scenario; the violation of safeguards and resulting harms are likely to be much more frequent in the United States. Finally, while safeguards can minimize abuse, some harms will occur no matter what regulations and safeguards are in place.⁹⁹ Again, the real question is how the benefits of legalizing PAS or euthanasia compare to the likely harms.

D. COMPARING BENEFITS AND HARMS

It is impossible to overemphasize the tenuous nature of our ability to predict what will happen if PAS or euthanasia is legalized. We have some data that suggest that the benefits in terms of relief of unremitting pain and reassurance of legalizing PAS or euthanasia are comparatively small. This is not to dismiss

99. See *supra* note 73 and accompanying text.

the harm caused to 5,000 to 25,000 people who endure needless pain and who might be helped by having their lives ended. But from a social policy perspective this is a small number in both absolute and relative terms. We should not deceive ourselves into thinking that improving the last few days of life of 5,000 to 25,000 patients constitutes a substantial intervention to improve end-of-life care in the United States, where 2.32 million people die each year.

Such benefits must be weighed against the harms of legalization. Regrettably, the data do not permit any quantitative assessment of harms. But we should not confuse this absence of concrete data with the conclusion that there are no serious harms. Indeed, with at least one million people per year facing a dying process, the numbers of those at risk would dwarf the numbers of those helped.

E. HOW, IF LEGALIZED, PAS AND EUTHANASIA MIGHT EXPAND IN SCOPE

None of this even considers what might happen if we were to lower the barrier to ending life and become acclimated to using PAS and euthanasia. Inevitably, if we legalize PAS and euthanasia, they will become more accepted and commonplace. Initially, it was hard for physicians, patients, and American society to refrain from resuscitating every dying patient. Today 85% or more of hospitalized dying patients, and as many as 95% of terminal cancer patients, die without resuscitation. Initially it was hard for physicians, patients, and American society to terminate respirators, dialysis machines, and other life-sustaining technologies. Today, it is reported that as many as 90% of patients dying in intensive care units have life-sustaining treatments withdrawn—an average of four withdrawn per patient.¹⁰⁰ As we become more accustomed to ending life, we also expand the types of patients for whom we are willing to do it. Such expansion would inevitably happen if we were to legalize PAS or euthanasia. This is well illustrated in the Netherlands where between 1990 and 1995, there was an increase in PAS and euthanasia from 2.7% of all deaths to 3.4% of all deaths—a 25% increase in just five years.¹⁰¹

100. See K. Fuber-Langendoen, *A Multi-Institutional Study of Care Given to Patients Dying in Hospitals: Ethical Practices and Implications*, 156 ARCHIVES INTERNAL MED. 2130 (1996).

101. See van der Maas et al., *supra* note 47, at 1701 tbl.1.

Imagine if we legalize PAS or euthanasia. What will happen as the baby boom generation ages? What will happen as the Social Security system gets stressed and teeters on bankruptcy, as the Medicare system becomes insolvent, as the costs of caring for elderly parents increasingly burden families, and as the act of intentionally ending life becomes more routine and accepted? The most likely scenario is that PAS and euthanasia will expand to include incompetent patients, Alzheimer's patients, and patients with strokes and other neurological diseases. Indeed, a leading advocate of assisted suicide has advanced just this scenario:

There is reason to expect that legalization of voluntary active euthanasia might soon be followed by strong pressure to legalize some non-voluntary euthanasia of incompetent patients unable to express their own wishes. Respecting a person's self-determination and recognizing that continued life is not always of value to a person can support not only voluntary active euthanasia, but some non-voluntary euthanasia as well. . . . Recent history here is instructive. In the medical ethics literature, in the courts since *Quinlan*, and in norms of medical practice, that right has been extended to incompetent patients and exercised by a surrogate [often without explicit instructions from the patient]. . . . The very same logic that has extended the right to refuse life-sustaining treatment from a competent patient to the surrogate of an incompetent patient (acting with or without a formal advance directive from the patient) may well extend the scope of active euthanasia.¹⁰²

If we begin legalizing PAS or euthanasia, the real harms are likely to come not today or tomorrow but in the year 2010, when demographic changes, financial pressures, and comfort with the concept of assisted suicide combine to make the intentional ending of a dying patient's life routine.

This is not meant to be a Cassandra-like prediction. It is meant to make us understand that our actions today need to be considered in light of their likely future impact. A sober assessment based on our recent experience with the dying and the added pressures brought about by the aging of the population must be part of our cost-benefit calculus. Our choice about legalizing PAS or euthanasia today is really a choice about the future.

F. THE ETHICAL IMPERATIVE FOR EMPIRICAL ASSESSMENT

Oregon has decided to proceed with a social experiment. Because of the importance of collecting much more empirical data, we must be sure to rigorously assess the consequences of Oregon's trial, no matter how difficult the studies are to conduct.

102. See Brock, *supra* note 73, at 20 (footnote omitted).

If we fail to obtain additional data from Oregon, its social experiment will be a failure because we will have learned nothing from it. The priority list for research includes five areas necessary to make prudent policy decisions:

- (1) Evaluating the clinical care of those who request and receive PAS, and determining what proportion of those who receive PAS have received optimal palliative care and what proportion have not.
- (2) Determining the reasons for requesting and receiving PAS.
- (3) Determining the proportion of patients for whom financial demands and caregiving needs are high and likely to play a role in the request for PAS.
- (4) Determining the proportion of patients for whom families initiated the process of requesting and receiving PAS.
- (5) Determining how many cases of PAS result in failure and what is done after the failure.

CONCLUSION

The Supreme Court has rejected a constitutional right to PAS or euthanasia while recognizing that in a democracy states should be able to debate the merits of legalizing such interventions. As we proceed in this debate, we must transcend the proponent-opponent dichotomy fostered by debating the constitutional question. Opponents need to be honest and recognize that in some cases PAS may be proper. Proponents need to recognize that legalization will benefit few dying patients and that safeguards will not avert abuses and harms. Both sides need to be clear about what legalization would entail. And here we have much to learn. Terminal sedation, requests by dying patients with extreme pain to have their lives ended, and inaccessibility of life-ending medications are the exceptions, not the common occurrence. We need to recognize that much more information is needed to understand—and not just speculate about—the impact, positive and negative, that legalization is likely to produce. At the very least, all of those involved in the debate can agree on the kinds of information we need to make more intelligent policy judgments.