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Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice

Howard Brody*

When the U.S. Supreme Court agreed to hear appeals from the rulings of the Second and Ninth Circuit Courts of Appeals[1] on whether laws prohibiting physician-assisted suicide (PAS) were constitutional, it opened the way for a legal debate over two relatively arcane ethical concepts. The *moral equivalence hypothesis* holds that if allowing a patient to die by forgoing life-sustaining medical treatment is moral (or immoral), then PAS or active euthanasia must be moral (or immoral) to the same degree. The *principle of double effect* holds that it is moral to administer high-dose narcotics to dying patients, even though there may be some risk of hastening death, whereas it is not moral to administer an overdose of such drugs deliberately to cause death.

These two ethical constructs can be debated in detail and at length, and the protracted discussion would be of great interest in a graduate seminar on ethical theory; however, it would probably put the average physician or attorney promptly to sleep. Nonetheless, the two ethical constructs have, in an implicit rule-of-thumb fashion, helped to guide routine medical practice for some time. Most physicians have conducted their practices as if the moral equivalence hypothesis were false and the principle of double effect were true.

It was therefore striking when the two federal appellate courts recognized a constitutional liberty interest in PAS on

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1. *See* Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, 117 S. Ct. 2258 (1997); Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

grounds that strongly suggested the moral equivalence hypothesis is true and the principle of double effect amounts to hypocritical rationalization. Admittedly, the average physician does not dissect the detailed reasoning in court decisions and modify her clinical practice accordingly. But it is at least noteworthy, if not actually worrisome, when such a radical disconnect appears between the reasoning of federal judges and of practicing physicians on a highly controversial matter of medical practice.

This Article will summarize the recent history of the two ethical constructs and identify the role they played in the two appellate court rulings. It will then assess the final rulings of the Supreme Court and discuss their possible implications for clinical practice in the future. Although the Article will allude to what ethics scholars and the courts have said about these issues, its principal focus will be upon the ethical "rules of thumb" under which physicians operate in everyday practice. In many ways, the quality of care that patients receive depends more on these crude and under-analyzed rules of thumb than on more elegant and logically consistent theories of ethical and legal behavior.[2]

THE MORAL EQUIVALENCE HYPOTHESIS

A defining moment of sorts occurred in the emerging field of bioethics in 1975 when a philosopher, James Rachels, published a paper on the moral equivalence hypothesis in the *New England Journal of Medicine*.[3] It was quite a new development at the time for a philosopher to presume to instruct physicians on medical ethics, especially when the philosopher was declaring that a widely accepted ethical principle was in fact fatally flawed and when the medical editor of a major journal was granting him the forum to do so. Despite the revolutionary nature of the

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2. In the discussion that follows, I will scrutinize the recent court opinions to determine the adequacy with which they deal with the ethical constructs. I agree that the courts are not trying to "get the ethics right" but rather are interpreting the law. (I am grateful to Susan Wolf for calling my attention to this point.) Nonetheless, the criticisms might be helpful for two reasons: first, if the opinions lack logical coherence, they might be flawed in their legal, as well as ethical, reasoning; second, the message physicians receive from the courts regarding the optimal "rules of thumb" for everyday practice will depend not purely on the law but also on the perceived "fit" between the legal opinions and the widely accepted ethical dictates.

3. James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975).

article, subsequent letters to the editor showed that the average practitioner remained unswayed by the philosophical arguments.[4]

Rachels took direct aim at the American Medical Association's (AMA's) ethical stance that physicians could withdraw or withhold life-prolonging medical therapy, but could never ethically participate in mercy killing.[5] Expressing relative indifference to the question of whether active euthanasia was ethical or unethical, Rachels zeroed in on the conceptual dilemma: Is it consistent to have one ethical judgment about allowing a patient to die and a different ethical judgment about active killing? Rachels agreed that most cases of active killing were indeed morally wrong, while many cases of allowing to die were morally defensible, but that left open the question of whether these different moral judgments arose *because of* what Rachels called the "bare difference" between killing and allowing to die, or for other reasons unique to the individual cases or categories of cases involved.

Rachels proposed to resolve this dilemma through a sort of ethical experiment. He constructed a hypothetical case in which the only difference between two actions was the "bare difference" between killing and allowing to die; all other morally compelling features, such as consequences, motives, and intentions, were held constant. He called this hypothetical case the case of Smith and Jones. Supposedly, Smith and Jones each stand to gain an inheritance at the death of a nephew; each sneaks in while the nephew is taking a bath, fully intending to hold the child's head underwater until he drowns. Smith does exactly that, but Jones happens to enter the bathroom just as the child slips, hits his head on the edge of the tub, and falls unconscious with his face submerged. Jones could easily save the child's life by reaching in and lifting his head above water, but instead he stands and watches as the child drowns.

Rachels wondered whether any reader would judge Smith and Jones *differently,* based on the distinction that one actively

4. *See* Letters, *Euthanasia,* 292 NEW ENG. J. MED. 863, 863-66 (1975).

5. *See* Rachels, *supra* note 3, at 79. It is worth noting that the "right to die" debate through the 1970s and 1980s was about allowing to die versus active euthanasia; PAS did not really enter into the discussion until the late 1980s. *See, e.g.,* Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look,* 320 NEW ENG. J. MED. 844, 847-48 (1989).

killed the nephew while the other "merely" allowed him to die. No one offered a justification for doing anything other than condemning both Smith and Jones to an equal degree. This, to Rachels, proved his point. If we judge the case of killing to be morally worse than the case of letting die, it must be due to some difference in the motives, intentions, or consequences of the act, not any general or principled difference between the two actions per se.

Other philosophers and ethicists have been debating Rachels's conclusions in the twenty-three years since the article's publication, and no single consensus position has emerged.[6] I would, however, defend as the best conclusion a critique of Rachels's basic method. What led Rachels to assume that he could answer the general question of whether forgoing treatment and active euthanasia were morally equivalent merely by devising a pair of hypothetical cases, especially cases that had nothing to do with medical practice? Rachels explained that he could do so to the extent that ethical rules and principles are universally applicable, and are thus largely independent of the real-life context of the individual case.[7] If one begins to challenge this view of ethical reasoning, as has occurred with increasing frequency in the last twenty years,[8] then one is less convinced by Rachels's logic.

Perhaps the most thorough rebuttal of Rachels was suggested by Paul Menzel.[9] Menzel argued that in some medical contexts, there might be a major moral difference between killing and allowing to die; in other medical contexts, the difference might be less or even nonexistent. In the end, he disagreed with both Rachels and the AMA. He disagreed with Rachels by saying that only after exploring in detail the actual case circum-

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6. For representative replies to Rachels, see Martin Benjamin, *Death, Where Is Thy Cause?*, HASTINGS CENTER REP., June 1976, at 15; K.D. Clouser, *Allowing or Causing: Another Look*, 87 ANNALS INTERNAL MED. 622 (1977); Jean Davies, *Raping and Making Love Are Different Concepts: So are Killing and Voluntary Euthansasia*, 14 J. MED. ETHICS 148 (1988); Raymond J. Devettere, *The Imprecise Language of Euthanasia and Causing Death*, 1 J. CLINICAL ETHICS 268 (1990); Jeff McMahan, *Killing, Letting Die, and Withdrawing Aid*, 103 ETHICS 250 (1993); Richard L. Trammel, *The Presumption Against Taking Life*, 3 J. MED. & PHIL. 53 (1978).

7. *See* JAMES RACHELS, THE ELEMENTS OF MORAL PHILOSOPHY 139-151 (1986).

8. *See, e.g.*, ANTI-THEORY IN ETHICS AND MORAL CONSERVATISM (Stanley G. Clark & Evan Simpson eds., 1989).

9. *See* Paul T. Menzel, *Are Killing and Letting Die Morally Different in Medical Contexts?*, 4 J. MED. PHIL. 269 (1979).

stances could one judge whether allowing to die and killing might be morally equivalent. And he disagreed with the AMA by noting that in at least some medical contexts, if allowing to die was acceptable, then the logic of the circumstances would dictate that active euthanasia would be acceptable as well. It is precisely the set of cases where Menzel saw the moral difference between killing and allowing to die approaching zero that we now view as the "best candidate" for permitting PAS: a competent, suffering, terminally ill patient who has exhausted all other means for symptom relief.

I have tried to extend Menzel's general line of argument to show that the killing/letting die distinction fails to do the moral "work" that many expect of it.[10] One might argue that killing is wrong and allowing to die by forgoing treatment is acceptable because in killing, one directly intends and causes death, which is not true of allowing to die. I have tried to show through medical case examples that the degree to which one intends and causes death varies along a spectrum; there is no bright line that separates allowing to die and killing. For example, there are a few cases, admittedly atypical, in which a patient has suicidal impulses for what most would consider irrational reasons, but also happens to be dependent upon medical life support. If such a patient refuses ongoing life support and dies as a consequence, is that PAS or "merely" forgoing life-sustaining therapy? Certainly the patient, if minimally competent, has a legal right to refuse the treatment, even in jurisdictions where PAS is illegal.

A succinct summary of the validity of the moral equivalence hypothesis was provided a decade ago by Raanan Gillon.[11] He distinguished two arguments: that there is a necessary moral *equivalence* between killing and letting die, and that there is no necessary moral *difference* between killing and letting die. Both, he states, are false; there are a few circumstances in which letting a patient die would be morally equivalent to killing the patient, but there are many more cases in which, due to the specific circumstances, the two acts would be quite morally distinct. The problem, he suggests, is that many seem to conclude from the fact that there is no nec-

10. *See* Howard Brody, *Causing, Intending, and Assisting Death*, 4 J. CLINICAL ETHICS 112 (1993).

11. *See* Raanan Gillon, *Euthanasia, Withholding Life-Prolonging Treatment, and Moral Differences Between Killing and Letting Die*, 14 J. MED. ETHICS 115 (1988).

essary moral difference that killing and allowing to die must necessarily be morally equivalent. For Gillon, Rachels's thought experiment may have successfully proven that in at least one circumstance there is no necessary moral difference, but it certainly failed to show that there is necessary moral equivalence.

Of late, even staunch defenders of PAS and active euthanasia either have avoided using the moral equivalence hypothesis, or else appeared aware of its difficulties. For example, Dan Brock, in one of the most cogent philosophical defenses of a right to PAS and euthanasia,[12] was careful not to employ the moral equivalence hypothesis in its pure form. He argued not that PAS and forgoing treatment are equivalent moral acts, but rather that *the same reasons* that justify forgoing treatment, such as appeals to patient autonomy and a desire to relieve suffering, are the reasons that can be given in defense of PAS.

Against this backdrop, it seemed somewhat odd when in 1992 a note appeared in the *Harvard Law Review* accepting the moral equivalence hypothesis more or less uncritically as a basis for declaring a fundamental right to PAS.[13] In retrospect, this note indeed presaged the two appellate court rulings of 1996, but when the argument first appeared in print it seemed hardly likely to play in Peoria.

Opinion polls give a crude measure of where practicing physicians stand in this debate. A reasonable summary of polling data from the past decade indicates that while as many as ninety percent of physicians support forgoing life-sustaining treatment as an ethical option, only about half endorse PAS or active euthanasia.[14] It is not clear whether the physicians endorsing PAS do so *because* they believe the moral equivalence hypothesis, or whether some or all of them believe that the act is morally acceptable for other reasons, even though the moral equivalence hypothesis is incorrect. My own suspicion is that

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12. *See* Dan W. Brock, *Voluntary Active Euthansasia*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 10.

13. Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2040 (1992).

14. *See* Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying? The Public Perspective*, 267 JAMA 2658 (1992); Jerald G. Bachman et al., *Assisted Suicide and Euthanasia in Michigan*, 331 NEW. ENG. J. MED. 812 (1994) (letter to editor); Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89, 90 (1994).

most practitioners basically agree with the multitude of state supreme court rulings that followed in the wake of the Karen Quinlan case in New Jersey.[15] In virtually all those rulings, the courts stated that in permitting the withdrawal of life-sustaining treatment, they did not intend to permit either suicide or homicide. In other words, I believe that substantially fewer physicians would be willing to endorse forgoing life-sustaining treatment if they were firmly convinced that that act were the moral equivalent of PAS or active euthanasia.[16]

THE PRINCIPLE OF DOUBLE EFFECT

If practitioners generally remain unpersuaded by the moral equivalence hypothesis, they seem traditionally wedded to the principle of double effect, even if few of them could give a detailed explanation of what that principle means.

The principle has a venerable tradition in ethics, particularly within the Roman Catholic tradition, quite apart from its medical applications. One may find a variety of statements of its precise content;[17] for our purposes, the following account will suffice:

1. I perform action A.
2. By performing A, I intend to accomplish outcome X.
3. A and X themselves are morally praiseworthy, or at least morally neutral.
4. By doing A, I know that I will also accomplish, or risk accomplishing, outcome Y.
5. I do not intend Y.

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15. *See* Robert F. Weir & Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients: Ethical Standards and Legal Liability for Physicians After* Cruzan, 264 JAMA 1846 (1990).

16. I have not addressed in this section another possible variant of the moral equivalence hypothesis—that PAS is morally equivalent to active euthanasia, regardless of whether either or both are morally equivalent to forgoing treatment. This point has been occasionally debated in the medical-ethical literature. *See, e.g.*, Glenn C. Graber & Jennifer Chassman, *Assisted Suicide Is Not Voluntary Active Euthanasia, But It's Awfully Close*, 41 J. AM. GERIATRIC SOC'Y. 88 (1993); David T. Watts & Timothy Howell, *Assisted Suicide Is Not Voluntary Active Euthanasia*, 40 J. AM. GERIATRIC SOC'Y 1043 (1992). For what I am arguing in this article, one may assume that I regard these two acts as morally equivalent, although I have argued for a somewhat different view elsewhere. *See* Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 NEW ENG. J. MED. 1384 (1992).

17. *See, e.g.*, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 206-211 (4th ed. 1994); Jorge L.A. Garcia, *Double Effect*, *in* 2 ENCYCLOPEDIA OF BIOETHICS 636, 636-641 (1995).

6. There is no alternative action to accomplish X that would not risk causing Y in the process.

The principle of double effect states that even if Y is morally bad, it may be acceptable to do A in order to accomplish X. The essence of the principle is that it is acceptable to do A if Y is a *foreseen but unintended consequence* of an otherwise justifiable act.

The principle of double effect is used by many ethicists, particularly within religious traditions, to analyze a wide variety of acts, both medical and nonmedical. Whether abortion is justifiable to save the life of a mother is just one example. Indeed, in some ways, something akin to the principle of double effect is central to medical practice; without it, surgery, for example, would be ethically unacceptable.

There is one complexity of double effect that is not important for present purposes. The point of distinguishing the *action* A from the *outcomes* X and Y is to make it clear that A causes X and Y, but that Y does not cause X. The classical Roman Catholic account lays special stress on this point because that ethical tradition strongly opposes doing an evil act, even if it might produce a good outcome as a consequence. Otherwise stated, if the "evil" outcome Y *directly* caused the "good" result X, then the action A would be immoral regardless.[18] For the ethicist who is not wedded to this religious tradition, however, applying this rule often seems to lead to disingenuous hairsplitting. For instance, if it is evil to cause a patient's death but good to relieve suffering, and a suffering patient is being kept alive on a ventilator, then it would not be moral to discontinue the ventilator to relieve the suffering because causing the patient to die, the evil outcome, would directly cause the good outcome. If the purpose of removing the ventilator is to remove the burden that mechanical ventilation places on the patient's body and death is a "foreseen but unintended" consequence, however, then the action might be ethically acceptable. Such fine distinctions might be beneficial within a system that opposes consequentialist ethical reasoning[19] and yet wants to allow for consequences making a moral

18. *See* Garcia, *supra* note 17, at 637.

19. Consequentialist ethical reasoning states that an action is good or bad depending on whether the consequences that follow from it are good or bad, or on the net balance is good and bad when all the consequences are considered. A nonconsequentialist approach views certain actions, such as causing death, as intrinsically wrong, regardless of the consequences they may produce.

difference, but they are not necessary for the present discussion.

The application of double effect of interest here is the justification for using high doses of narcotic medication in treating the pain of terminal illness. In the formula,

A = prescribing or administering high doses of narcotics,
X = relieving pain, and
Y = the risk of hastening death because of respiratory depression due to the medication.

To show the value, as well as the potential precision, of the principle of double effect, consider a recent commentary by two experts in palliative care, Andrew Billings and Susan Block.[20] They argue for expanding the debate over PAS and euthanasia within palliative care circles because, despite the field's widespread rejection of those practices, some commonly accepted palliative care activities are essentially indistinguishable from euthanasia. One practice they consider to be "slow euthanasia" is increasing the rate of a morphine drip in a terminally ill and often unconscious patient with the unspoken intention of hastening death, either for the patient's benefit or for the relief of those standing by and watching the patient's suffering. This probably occurs more frequently in general hospital practice than in hospice programs, but Billings and Block claim that it is commonplace nonetheless.

With respect to terminal analgesia, it is important to note that there is an unexamined empirical assumption in the statement of double effect. It is assumed that the risk of respiratory depression is substantial when one uses narcotics in needed doses in this setting. This was indeed thought to be the case for many years, as part of the general phobia of opioid drugs within the medical and nursing fields. More recent experience within palliative care has shown that respiratory depression, although theoretically possible and occasionally encountered, very seldom is of practical concern when physicians exercise care in adjusting dosages and observing patients for responses to medication.[21] In practice, the dosage level at which one can achieve pain relief and the level at which respi-

20. *See* J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, J. PALLIATIVE CARE, Winter 1996, at 21.

21. *See* Howard Brody et al., *Withdrawing Intensive Life-Sustaining Treatment—Recommendations for Compassionate Clinical Management*, 336 NEW ENG. J. MED. 652, 652-53 (1997).

ratory depression might occur are much farther apart than traditionally has been appreciated.

Consequently, two things are likely to happen in general hospital settings where the physicians and nurses are relatively unskilled in palliative care. First, if a patient is in pain, staff will increase the rate of the morphine drip, and sometime thereafter the patient will die. Staff will wrongly believe that the drip hastened the patient's death, when in fact the patient would have died at approximately the same time in any event.[22] Second, staff who indeed wish the patient to die more quickly may accomplish this by increasing the morphine drip rate. To accomplish their end, however, they will have to raise the dosage level much higher than is necessary for analgesia, and in the process they will have to ignore fairly clear clinical signs that pain has already been adequately relieved and that breathing is becoming shallower and less frequent.

There is thus a clear practical difference in most cases between appropriately managing a morphine drip for terminal pain relief and mismanaging a morphine drip as a form of surreptitious euthanasia, real or imagined. The ethical difference, as our formula has already made clear, is equally distinct. If one *intends* to hasten death, one is no longer employing the principle of double effect, and one can no longer seek shelter under its moral umbrella.

Are we then sliding down a sort of "slippery slope" from the legitimate employment of the principle of double effect in terminal care to permitting "slow euthanasia"? After all, we know that euthanasia and PAS occur surreptitiously despite their illegal status.[23] But there is no reason to regard terminal analgesia under the principle of double effect as any more "slippery" than other practices. We can draw fairly clear distinctions, both conceptually and practically, between use and abuse of this principle. If abuse occurs on a widespread basis in general hospitals, the blame lies not with the principle but with the level of ignorance of palliative care techniques, a matter to which I will return in greater detail below.

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22. *See* William C. Wilson et al., *Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Critically Ill Patients*, 267 JAMA 949, 952-53 (1992).

23. *See* Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 921 (1996).

Despite its venerable tradition among practitioners, the principle of double effect is not without critics. In a textbook intended for clinicians, for instance, Bernard Lo argues alongside Tom Beauchamp and James Childress that double effect can easily become a form of rationalization:

> People are held accountable for consequences they should have foreseen, not merely those consequences that they intended.... The doctrine of double effect also leads to the implausible conclusion that physicians are more justified in administering large doses of narcotics if they can put out of mind the possibility that death may be hastened.[24]

I would suggest, however, that the potential for abusing the principle does not necessarily lead to the conclusion that the principle itself is without merit.

To summarize the previous sections, then, most medical practitioners in the United States believe they have a general ethical roadmap for end-of-life care:

1. it is permissible to forgo life-sustaining medical therapy at the informed request of a competent patient, or at the request of the surrogate for an incompetent patient; and
2. it is permissible to provide effective analgesia for pain in terminal illness, even if the dosages required approach levels that might hasten death; but
3. it is not permissible to perform PAS or active euthanasia.[25]

If asked why the first is permissible while the third is not, the physician would likely base her conclusion on a rejection of the moral equivalence hypothesis. If asked why the second is permissible and the third is not, she would likely allude to the principle of double effect. If challenged, it is true that the physician would probably be unable to discuss the nuances of either ethical argument; a substantial minority of physicians are perhaps even prepared to argue that the third is outmoded and should be re-evaluated. In general, however, physicians have long assumed that the federal courts were on their side as they followed these general rules of conduct.

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24. BERNARD LO, RESOLVING ETHICAL DILEMMAS: A GUIDE FOR CLINICIANS 143 (1995).

25. While a narrow majority of physicians support PAS and its legalization, they do not appear to hold this position because they see it as congruent with the "received" medical ethic. Rather, they argue that the received medical ethic needs to be revised and extended.

THE NINTH CIRCUIT

Against this background, the ruling of the Ninth Circuit Court of Appeals seemed to toss conventional medical wisdom into a cocked hat.

The court began by redefining the basic question it was to address. The issue was not, according to the court, whether there is a "constitutional right to *aid* in killing oneself," as the original three-judge panel had phrased it, but rather "whether there is a liberty interest in determining the time and manner of one's death."[26] This reformulation tended already to beg the question, and to tip the scales in favor of accepting the moral equivalence hypothesis. If the moral equivalence hypothesis is indeed correct, and forgoing treatment is an morally acceptable act, then *both* PAS and forgoing life-sustaining treatment would be morally acceptable ways of determining the time and manner of one's death.

The court explained that it preferred this broader reformulation because it was not sure that "suicide" was the correct label for the sort of action involved in the case:

> [A] competent adult has a liberty interest in refusing to be connected to a respirator or in being disconnected from one, even if he is terminally ill and cannot live without mechanical assistance. The law does not classify the death of a patient that results from the granting of his wish to decline or discontinue treatment as "suicide." Nor does the law label the acts of those who help the patient carry out that wish . . . as assistance in suicide.[27]

The court therefore hinted that it had already judged that the action described in the case was morally equivalent to PAS, and if calling PAS "suicide" implies a moral stigma, then the same moral stigma ought to apply to forgoing treatment. Conversely, if forgoing treatment is not morally stigmatized, then PAS should not be either.

The court argued that the *Cruzan*[28] ruling of the Supreme Court presaged such an expanded liberty interest. The Supreme Court must have recognized that removing Nancy Cruzan's feeding tube would "lead inexorably to her death,"[29] so if there was some liberty interest in having this tube withdrawn, it

26. Compassion in Dying v. Washington, 79 F.3d 790, 801 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, 117 S. Ct. 2258 (1997) (emphasis added).

27. *Id.* at 802.

28. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

29. *Compassion in Dying*, 79 F.3d at 816.

must have been a "liberty interest in hastening one's own death."[30] In fact, the court explicitly stated that "it was the discontinuance of the provision of food and water, not Cruzan's accident almost eight years earlier, that caused her death."[31] As a further salvo in defense of moral equivalence, the court noted that the same abuses many fear from legalizing PAS, such as exerting pressure on vulnerable patients to die prematurely, could arise just as easily from the lax use of advance directives.

The court then addressed the principle of double effect, finding it essentially devoid of value.[32] The fact that "ethical" physicians are prepared to administer high doses of narcotics in terminal pain management was seen by the court as evidence that many terminally ill patients die from drugs rather than their underlying diseases. This could only mean that medical practitioners are already crossing the bridge from letting die to PAS. The opinion concluded that the language of double effect

> may salve the conscience of the AMA, but it does not change the realities of the practice of medicine or the legal consequences that would normally flow from the commission of an act one has reason to believe will likely result in the death of another. In the case of "double effect" we excuse the act or, to put it more accurately, we find the act acceptable, not because the doctors sugarcoat the facts in order to permit society to say that they couldn't really *know* the consequences of their action, but because the act is medically and ethically appropriate even though the result—the patient's death—is both foreseeable and intended.[33]

The court was so dismissive of the very notion of double effect as anything other than moral hypocrisy that it failed to make clear its underlying empirical assumptions. Was the court convinced that many cases of high-dosage narcotic treatment are really cases of what Billings and Block call "slow euthanasia,"[34] and did the court believe that conduct to be morally acceptable? Or did the court believe that the real risk of hastening death, when narcotics are titrated properly toward the goal of adequate pain relief, is extremely high? The

30. *Id.*

31. *Id.* at 820 n.91.

32. *See id.* at 821-22.

33. *Id.* at 823 n.95.

34. *See supra* note 20 and accompanying text (discussing the similarity between terminal pain management and euthanasia).

first assumption is at least questionable[35] and the second is demonstrably incorrect.[36]

If these empirical assumptions arose simply from an ignorance of the present potential of palliative care, then the court gave ample evidence that it shares the level of ignorance of many members of the medical profession today. In fact, one looks in vain through the entire body of this lengthy ruling for any evidence that there is such a thing as *successful* palliative care. For example, the court mentioned the case of an AIDS patient who requested medication to hasten his impending death after enduring four excruciating months "because he did not wish to die in a hospital in a drug-induced stupor,"[37] as if enduring incredible pain or being rendered stuporous are the only choices available to the average terminally ill patient. Another passage that typifies the court's view reads as follows:

> [T]erminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends. Not only is the state's interest in preventing such individuals from hastening their deaths of comparatively little weight, but its insistence on frustrating their wishes seems cruel indeed. As Kent said in *King Lear,* when signs of life were seen in the dying monarch:
>
> > Vex not his ghost: O! let him pass; he hate him
> > That would upon the rack of this tough world
> > Stretch him out longer.[38]

THE SECOND CIRCUIT

The narrower reasoning of the Second Circuit Court of Appeals led it to espouse the moral equivalence hypothesis, without addressing the principle of double effect.

The Second Circuit differed from the Ninth in its reluctance to find a new fundamental right to assisted suicide, because it could not be described as "deeply rooted" in the nation's history.[39] Nor was the court "'inclined to take a more expansive view of . . . authority to discover new fundamental rights imbedded in the Due Process Clause.'"[40] Ultimately, however,

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35. *See supra* notes 20-23 and accompanying text (describing "slow euthanasia").

36. *See supra* notes 17-18 and accompanying text.

37. *Compassion in Dying*, 79 F.3d at 834.

38. *Id.* at 821 (citations omitted).

39. Quill v. Vacco, 80 F.3d 716, 724 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

40. *Id.* (quoting Bowers v. Hardwick, 478 U.S. 186, 194 (1986)).

the court found grounds to overturn the New York statute prohibiting PAS in the Equal Protection Clause of the Fourteenth Amendment. This reasoning required the court to adopt the moral equivalence hypothesis (or at least its legal cousin), because if PAS and forgoing treatment were significantly different ethical actions, it would not violate the Equal Protection clause to permit terminally ill patients to do the latter but not the former. As the court stated:

> New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.[41]

In this case it again appeared that the framing of the "factual" circumstances begged the moral question. The issues in the case were precisely whether two terminally ill patients, one connected to life-support equipment and the other not, are indeed "similarly situated," and whether "hastening death" is indeed the proper moral description of the act of forgoing life-sustaining therapy.[42]

In defense of the moral equivalence hypothesis, the court turned to an ironic source: Justice Scalia's concurring opinion in *Cruzan*. Scalia argued that the action-inaction distinction is irrelevant because "the cause of death in both cases [PAS and forgoing treatment] is the suicide's conscious decision to 'pu[t] an end to his own existence.'"[43] Rather than advocating PAS, however, Scalia's intent in *Cruzan* was to invoke the moral equivalence hypothesis to argue that since PAS is illegal, forgoing therapy should be as well.[44] The Second Circuit used his

41. *Id.* at 729.

42. The court assumed, reasonably in my view, that a patient near death who is not attached to life support, but who is suffering enough to contemplate PAS, probably received some form of life-prolonging medical care during an earlier stage of illness to allow the illness to reach such an advanced stage. Thus, the court laid the groundwork for rejecting the idea that forgoing life-sustaining treatment, unlike PAS, *merely* allows the "natural" course of the illness to unfold. The court suggested, along with several philosophers who filed amicus briefs with the Supreme Court, that there is no longer such a thing as the natural course of illness. *See id; infra* note 45 and accompanying text; *see also* Ronald Dworkin et al., *Assisted Suicide: The Philosopher's Brief*, N.Y. REV. BOOKS, Mar. 27, 1997, at 41, 42.

43. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 296-297 (1990) (Scalia, J., concurring) (quoting 4 WILLIAM BLACKSTONE, COMMENTARIES *189).

44. Hence his use of the loaded term "suicide" to describe both categories

words to argue the opposite conclusion, namely that since forgoing treatment is recognized as a basic right, the Equal Protection Clause requires that PAS be afforded similar protection in sufficiently similar circumstances. According to the court,

> there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes . . . , a patient hastens his death by means that are not natural in any sense.[45]

Practitioners, therefore, "do not fulfill the role of 'killer' by prescribing drugs to hasten death any more than they do by disconnecting life-support systems."[46]

While the Second Circuit's opinion did not have the same dismissive and occasionally contemptuous tone as the Ninth Circuit's, it amounted to an equally severe assault on conventional medical thinking. The court told physicians, in effect, that just as Moliere's character had been speaking prose all his life but never realized it, doctors had been assisting suicide throughout their careers without realizing it. In essence, the court said that in asking physicians to assist in suicides now, it was merely asking them to do something legally and morally indistinguishable from what they had always done. If that notion seemed radical, it merely illustrated how obtuse the court believed doctors had been in the past. Oddly, neither court seemed to recognize the collision that was certain to occur between their lines of reasoning and accepted medical wisdom on ethical care at the end of life. Had physicians actually accepted the reasoning of the federal courts of appeals, they would not merely have agreed to add PAS to their medical armamentarium; they would have been forced to radically rethink virtually every aspect of providing and forgoing care for dying patients.

THE SUPREME COURT

In reversing the two appellate court rulings and denying the existence of a constitutionally protected right to physician-assisted suicide, the Supreme Court principally employed a historical argument. The Court agreed with the Second Circuit that the Due Process Clause protects only those fundamental

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of patients.

45. Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996).

46. *Id.* at 730.

rights and liberties "'deeply rooted in this Nation's history and tradition.'"[47] Because the historical record is squarely opposed to any recognition of a right to suicide or suicide assistance, the Court believed that it could not find any such basic liberty interest. According to the Court, the task of balancing the liberty interests of individual citizens with the traditionally recognized state interest in preventing suicide is best left to the legislature; it would be inappropriate for the judicial branch to intervene to elevate individual interests at the expense of the state's concerns.

The Court's mode of argument thus diverged for the two appeals. With respect to the Ninth Circuit's holding, which established a basic right to PAS, the Court did not feel compelled to directly address either the moral equivalence hypothesis or the principle of double effect. It believed that it was sufficient to invoke the historical record on laws opposing suicide and suicide assistance.[48] The Court simply noted in passing that the Ninth Circuit had misunderstood *Cruzan:*

> The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.[49]

In other words, the Court felt that given the disconnect between the moral equivalence hypothesis and the legal tradition, all it needed to do in its ruling was invoke history and *assert* (without substantive argument) that PAS and forgoing treatment were morally distinct acts. The principle of double effect could simply be ignored.

By contrast, when it discussed the Second Circuit's decision, the Court had no such "out" because the Second Circuit had not found a fundamental right to PAS in the Constitution. Instead, it had to address the moral equivalence hypothesis in a more direct way:

> Unlike the court of appeals, we think the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational.[50]

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47. Washington v. Glucksberg, 117 S. Ct. 2258, 2268 (1997) (quoting Moore v. East Cleveland, 431 U.S. 494, 500 (1977)).

48. *See id.* at 2268-69.

49. *Id.* at 2270.

50. Vacco v. Quill, 117 S. Ct. 2293, 2298 (1997).

Unfortunately, from an academic standpoint, the Court then proceeded to rehash rather stale arguments in favor of moral nonequivalence: the physician in PAS must intend the patient's death, while the physician withdrawing treatment may merely intend that the patient be freed from unwanted medical interventions; in PAS the physician kills the patient, while in withholding treatment the patient dies of the underlying disease. This was indeed an argument against the moral equivalence hypothesis that more closely comports with the prevailing sentiment in the medical community, but it was conducted as if the bioethical debate of the last two decades never occurred. In a paper for a graduate seminar in bioethics, it would have been lucky to earn a C-minus.[51]

The concurring opinions by individual justices attempted to shed more light on the underlying issues. Justice O'Connor stated:

> [T]here is no need to address the question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering that they may experience in the last days of their lives. There is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths.[52]

Here, O'Connor seems to be addressing the principle of double effect as a legal construct, permitting even such pallia-

51. It may be indicative of the quality of the reasoning that the Court, in its majority opinion, cites only sources widely viewed as opposed to PAS, with no mention of any sources that are either neutral or in sympathy. Apparently Lawrence Gostin agrees with my "C-minus" grade, stating,

> The Supreme Court in *Vacco* found the distinction between assisted suicide and withdrawal of life-sustaining treatment to be "important, logical, rational, and well-established." Yet, its reasons for differentiating between the two practices fly in the face of a body of philosophic literature examining questions of causation and intention in medicine.

Lawrence O. Gostin, *Deciding Life and Death in the Courtroom*, 278 JAMA 1523, 1527 (1997) (footnote omitted).

Gostin, in turn, sees a better reason to distinguish between PAS and forgoing treatment in the distinction between negative and positive duties, arguing that a right to forgo treatment places only a negative duty upon the physician (not to interfere with the patient) while a right to PAS would create a positive duty to perform various affirmative acts leading to death. But this in turn seems too simple, since most managements of "withdrawal of treatment" actually entail a mix of doings and omissions on the part of the medical staff. It may be argued that withdrawing life-sustaining treatment, in order to be done compassionately, requires a number of associated medical "doings." *See* Brody et al., *supra* note 21.

52. *Glucksberg*, 117 S. Ct. at 2303 (O'Connor, J., concurring).

tive measures as terminal sedation and barbiturate coma that undeniably shorten life. It is not clear from this passage, however, whether she was swayed by the reasoning of the Ninth Circuit and believed that shortening life was a *frequent* consequence of routine palliative care. Nor is there any hint that she is aware that in practice, quality palliative care may be difficult to obtain, even absent constitutional barriers. The assumption appears to be that the ready availability of palliative care is itself an argument against creating or recognizing any legal right to PAS.

Justice Stevens, in the "concurring" opinion that most closely resembles a dissent from the majority's reasoning, exhibited a greater understanding of the issues underlying the principle of double effect. He stated, "Encouraging the development and ensuring the availability of adequate pain treatment is of utmost importance; palliative care, however, cannot alleviate all pain and suffering."[53] Thus, unlike Justice O'Connor, Stevens explicitly recognized both that there may be problems with obtaining access to palliative care, and that palliative care by itself is not a definitive argument against allowing PAS. Stevens went on to address both the potential strengths and weaknesses of the moral equivalence hypothesis:

> [B]ecause physicians are already involved in making decisions that hasten the death of terminally ill patients—through termination of life support, withholding of medical treatment, and terminal sedation—there is in fact significant tension between the traditional view of the physician's role and the actual practice in a growing number of cases .... I agree that the distinction between permitting death to ensue from an underlying fatal disease and causing it to occur by the administration of medication or other means provides a constitutionally sufficient basis for the State's classification. Unlike the Court, however, I am not persuaded that in all cases there will in fact be a significant difference between the intent of the physicians, the patients or the families in the two situations.[54]

Here, at long last, one finds legal language consistent with what I take to be the best philosophical analyses of the moral equivalence hypothesis. Instead of the uncritical embracing of

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53. *Id.* at 2308 (Stevens, J., concurring).

54. *Id.* at 2309-10 (Stevens, J., concurring) (citation and footnotes omitted). I will leave to legal analysts the discussion of how wide a door the concurring opinions generally left open for future constitutional challenges to anti-PAS laws, based on the facts of specific cases. The possibility of such future cases is of great interest legally and ethically, but would, I contend, have little impact on clinical practice today. I appreciate Kathryn L. Tucker calling my attention to the importance of this aspect of the decision.

the hypothesis by the courts of appeals, or the equally uncritical rejection of the hypothesis by the majority, Justice Stevens offered a nuanced appreciation that whether or not there is a significant difference in causality, intent, and other morally important features between a case of PAS and a case of forgoing treatment will depend in the final analysis on the facts of the particular cases.

IMPLICATIONS FOR CLINICAL PRACTICE

If some physicians choose to defend PAS and active euthanasia and call for changes in the law to permit and regulate these practices, then it is important that they rely on the best possible justifications for this view.[55] Defenders of assisted death should not expect to make their case "on the cheap"; in other words, they must do more than simply cite a similar but legally distinct medical practice and argue that if that practice is allowed, PAS should be as well. They should look PAS squarely in the eye, with all its advantages and disadvantages, and argue cogently and forthrightly that the practice should be permitted.

Because the debate over PAS seems destined not to be resolved in the foreseeable future, however, physicians of all persuasions must agree in the meantime how to improve the care of the dying right now. In the face of compelling evidence that the status quo is far below optimal, if not actually scandalous,[56] there is no excuse for debating bioethics rather than focusing on the practical steps needed to improve the current quality of terminal care. The Second and Ninth Circuit opinions were a setback to that clinical goal; the Supreme Court at least wiped the slate clean, but without substituting any superior view.[57]

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55. *See* Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119 (1994).

56. *See generally* COMMITTEE ON CARE AT THE END OF LIFE, INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE (Marilyn J. Field & Christine K. Cassel eds., 1997); Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592 (1994); 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 (1995).

57. But compare the view of Robert Burt, who argues that the decision amounts to finding "a constitutional right to palliative care." Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234 (1997). Nor is this to say that the Supreme Court opinions had no value even to physicians who might favor

Clinicians must believe, to some degree, in a form of the principle of double effect in order to provide optimal symptom relief at the end of life.[58] This is so because all physicians ought to be equally committed to palliative goals. Roughly a third of physicians, however, are strongly opposed to PAS or euthanasia on moral grounds. At least that third of physicians must be reassured that if they use the most effective palliative techniques, no one will accuse them of violating their own moral codes and deliberately causing death. A serious assault on the logic of the principle of double effect could do major violence to the (already reluctant and ill-informed) commitment of most physicians to the goals of palliative care and hospice.

It would, of course, be desirable for this general endorsement of double effect to be combined with a sophisticated understanding of the bioethical debate about that principle and its potential abuses. This would prevent physicians from mistakenly concluding that surreptitious or "slow" euthanasia can be carried out under the moral cover of that principle.[59] However, to ask the average physician to attend so carefully and consistently to the rather academic discourse of philosophical bioethicists on this point may be a counsel of perfection.

PAS. The Court upheld the permissibility of forgoing life-sustaining treatment, of high-dose pain relief in terminal care, and even of terminal sedation. It encouraged ongoing debate over the issues and state-by-state experimentation with legislation; and indicated that it might hear specific future cases. *But cf. supra* text accompanying note 51 (asserting that the Supreme Court's reasoning was biased against PAS in that the Court relied solely on sources that opposed PAS). For these observations I am indebted to Timothy Quill, one of the appellants in the Second Circuit case. *See generally* Timothy Quill, Address at Michigan State Medical Society Bioethics Conference (Sept. 27, 1997).

58. I am indebted to Franklin G. Miller for the reminder that "some form" of the principle of double effect need not be a form that rejects consequentialist arguments and demands adherence to absolute moral principles; and if so, the new "form" of the principle is so far away from the traditional roots of that mode of moral reasoning to be no longer recognizable as "double effect." One then simply argues that it is all right to administer high-dose painkillers because of the ratio of benefit to burden (i.e., good consequences to bad consequences); the good intentions of the physician; patient consent; and the lack of better alternatives.

59. I say this with the belief that either euthanasia and PAS should not be performed, or they should be performed openly and regulated appropriately. *See* Miller et al., *supra* note 55; Franklin G. Miller et al., *Can Physician-Assisted Suicide Be Regulated Effectively?*, 24 J.L. MED. ETHICS 225 (1996). If the majority of physicians and patients agree that PAS and euthanasia are moral acts, but the law continues to deny permission and guidance, then many would argue that sub rosa practices such as "slow euthanasia" become the best available safety value under those suboptimal circumstances.

For a similar reason, it is highly desirable that a rough practical distinction be maintained between both the ethics and the law of forgoing therapy and of PAS or euthanasia. This is necessary if the one-third of physicians strongly opposed to PAS are to accept the rights of patients and their surrogates to refuse life-prolonging care.[60] Perhaps more important, however, is the need to ensure that the current legal protections patients enjoy in making these decisions not be dissipated or reversed. Susan Wolf was probably the first to call attention to the relatively flimsy basis of the present "consensus" in favor of the right to refuse treatment. Her warning that the moral equivalence hypothesis could as easily be used to eliminate the rights of patients to refuse treatment as to support PAS remains pertinent today, despite the Supreme Court rulings in *Cruzan* and the present two cases.[61]

The political power and will of those who would impose their religiously grounded right-to-life perspective upon society through force of law do not seem to have diminished. If, for instance, while PAS remains illegal, there are widespread calls for refusal of nutrition and hydration as the quickest and most painless way to hasten one's death,[62] then there are likely to be efforts made to reverse the legal position that refusing food and water is protected to the same degree as refusing a ventilator. Similarly, if it becomes widely known (or alleged) that palliative care techniques sometimes deliberately hasten death,[63] we can expect new laws to be introduced that would hamstring palliative practice.[64] In at least some states, such laws would

60. Robert A. Burt, analyzing the Supreme Court decisions for the *New England Journal of Medicine* writes, "In the wake of the Second Circuit Court's ruling, some physicians in New York had found new reasons to overrule patients' refusals of life-prolonging treatment and even more reasons to fear the legal consequences of adequately managing symptoms through the use of opioids . . . ." Burt, *supra* note 57, at 1234. However, Burt cites no source for this claim.

61. Susan M. Wolf, *Holding the Line on Euthanasia*, 19 HASTINGS CENTER REP., Jan.-Feb. 1989, at S13.

62. *See* James L. Bernat et al., *Patient Refusal of Hydration and Nutrition: An Alternative to Physician-Assisted Suicide or Voluntary Active Euthanasia*, 153 ARCHIVES INTERNAL MED. 2723 (1993); David M. Eddy, *A Conversation with My Mother*, 272 JAMA 179 (1994).

63. *See* Billings & Block, *supra* note 20, at 22; David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1236 (1997).

64. Addressing the flip side of this coin, David Orentlicher argues that by rejecting assisted suicide but apparently accepting terminal sedation and barbiturate coma, the Court actually moved in the direction of "embracing

likely pass, and it is not at all clear that they would be reversed upon court challenge, considering the current prevalence of conservative judges in the court system.

Even if the more general right to refuse "extraordinary" medical therapy remains untouched by such laws, they could exert a highly pernicious chilling effect upon physician practices in terminal care, and upon patient perceptions that they retain some control over medical decisions.[65] Ironically, the net result of this scenario is likely to be an increase in surreptitious PAS, despite the fact that those who would champion these changes in social policy will use the fear of a "slippery slope" toward PAS as one of their rallying cries.

While a rule-of-thumb distinction between forgoing treatment and PAS or active euthanasia is highly desirable for purposes of public policy, one would wish that physicians had a deeper understanding of the clinical difficulties in defining these categories. One would like physicians to attain the level of understanding suggested by Justice Stevens, namely that in particular cases of forgoing treatment or administering palliative care, physician intent and the degree of causation of death might be virtually indistinguishable from that in cases of PAS or euthanasia. The public policy distinction works precisely because many cases fit nicely within the general categories, but there are also going to be messy cases which sit on the fences.[66]

A serious policy question with regard to the fence-sitting cases is how health care professionals will explain them to the public. Thus far, the tendency has been for organized medi-

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euthanasia." Orentlicher, *supra* note 63, at 1239.

65. A good case in point is Katherine L. Tucker's article, *Surrogate End of Life Decisionmaking: The Importance of Providing Procedural Due Process, A Case Review*, 72 WASH. L. REV. 859 (1997), which describes a case in which a flawed decision to remove a feeding tube was made by a family-member surrogate (and reversed upon court review). Tucker then notes that Washington case law precedent permits surrogate decisions to withdraw life-prolonging treatment only for two classes of patients: terminally ill and permanently unconscious. She further argues for "prognosis committees" as a necessary procedural safeguard and seems dismissive of hospital ethics committees, as currently constituted, in that function. Legal questions aside, I agree with Tucker that an unfortunate aspect of the "reverse slippery slope" has been the fact that decisions to withdraw treatment may be made too cavalierly because the spotlight of controversy has shifted over to assisted suicide and euthanasia. That said, I think the legal and procedural solutions she proposes would be far too restrictive in actual practice and would have the effect of prolonging the suffering of many incurable patients, though the full consideration of this question is beyond the scope of this Article.

66. *See* Brody, *supra* note 10.

cine, in its public proclamations, to act as if everything fits within the well-defined category limits, treating the messy cases as an inside secret with which we should not burden the public's delicate sensibilities.[67] I believe this strategy is certain to reduce public trust in medicine in the long run, perhaps ultimately restricting the allowable amount of physician discretion in managing terminal care. We must find better ways to make the public and policymakers understand that fence-sitting cases do exist, and that these cases present a multitude of problems.[68]

CONCLUSION

Patients with terminal illnesses will receive the best care when physicians and other health professionals adhere to certain general rules of thumb for ethical practice. For some years, a rough consensus on these rules of thumb had been evolving. The decisions of the Second and Ninth Circuits temporarily undermined that evolving ethical consensus. The Supreme Court provided little thoughtful guidance with regard to those ethical principles, but at least restored the status quo ante by overturning the lower court rulings.

Ethical constructs are not sufficient to assure good clinical practice, however; personal and institutional habits, reimbursement incentives, and many other forces may work to reduce the quality of terminal care. While the status of PAS will probably be debated well into the future, some things are cer-

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67. In this regard, one of the most worrisome features of the Billings and Block controversy is the note by the editor of the palliative care journal that colleagues had appealed to him to suppress publication of the article. *See* David J. Roy, *On the Ethics of Euthanasia Discourse*, J. PALLIATIVE CARE, Winter 1996, at 3 (editorial) (discussing his decision to publish the lead article by J. Andrew Billings and Susan D. Block, *supra* note 20).

68. It is my understanding that there is relatively little established law, either statutory or case law, regarding these "fence-sitting" cases. Because the medical profession has not brought them to public attention, they generally are not addressed by legislators; perhaps surprisingly, few of these cases have been brought to court. In light of the goal of more explicit and open recognition of the problem, however, the Supreme Court's discussion of one fence-sitting category, terminal sedation, is probably a move in the right direction. On this point, see Orentlicher, *supra* note 63. Many physicians probably prefer that the law remain silent on these cases and that they be handled in the future by medical discretion; to some extent, this is probably unavoidable. For a discussion of the inability of law to deal effectively with these difficult cases, see J. Griffiths, *The Regulation of Euthanasia and Related Medical Procedures that Shorten Life in the Netherlands*, 1 MED. LAW INT. 137 (1994).

tain under the law. Patients have an ethical and legal right to determine whether to accept life-prolonging therapy, and they have an ethical (and legal, according to some Supreme Court justices) right to adequate pain relief, especially in cases of terminal illness. There is a pressing need today for both physicians who oppose and physicians who support legalization of PAS to put aside those differences and form alliances for enhanced terminal care, so that all patients are provided these treatment options. It is likely that in doing so, they will substantially reduce the number of patients who feel driven to seek PAS.