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ARTICLES

The Legal Bounds of Physician Conduct Hastening Death

NORMAN L. CANTOR[†] AND GEORGE C. THOMAS III^{††}

For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.¹

The law prohibits, as murder, the intentional shortening of a patient's life, regardless of the motive of the doctor or the age, medical condition, or wishes of the patient . . . It remains as much murder intentionally to shorten the life of an aged, terminally ill cancer patient who pleads for death as it is to kill a young person in the prime of life who strenuously objects to death.

Herman Michelle is a hypothetical 68 year-old male afflicted with terminal lung cancer and experiencing severe physical and emotional distress. Living with this degenerative condition has become so dismal that he prefers death. The pain in Herman's chest region is sometimes excruciating. Lung weakness prompts an

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1. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 310-11 (1990) (Brennan, J., dissenting).

2. John Keown, *The Legal Revolution: From Sanctity of Life to Quality of Life and Autonomy*, 14 J. CONTEMP. HEALTH L. & POL'Y 253, 264-65 (1998).

uncomfortable shortness of breath often accompanied by a choking sensation. Nausea is frequent. Moreover, Herman previously witnessed the protracted dying process of two loved ones afflicted with lung cancer. He therefore has enormous anxiety about his prospective deterioration—fear of increased pain, helplessness, and indignity. A psychiatric consult has determined that while Herman is sad and distressed, he is mentally competent to make his own medical decisions.

Herman is suffering grievously and faces a two to three month process of further deterioration ending in death. While Herman has received first-rate palliative care, including an array of pharmacological interventions, and while he has been informed about available support services, his fatigue, discomfort, and anxiety remain acute. In such a situation, a dying medical patient like Herman might contemplate diverse ways of accelerating death.

Consider the following lethal courses of action that might tempt Herman. As Herman has little appetite and ingesting food prompts pain and nausea, Herman might refuse further mouth feeding and also decline artificial nutrition and hydration. Death would follow within 10 to 14 days. (We call this voluntary stopping of eating and drinking—VSED). Alternatively, Herman might seek administration of increased dosages of opioids or other pain relievers. He might do so with the hope and expectation that the increased dosages would not only relieve pain, but might also depress his respiratory function and prompt his death earlier than would otherwise be the case. (This course we call use of risky analgesics). Or Herman might determine that his suffering is so acute and unbearable that analgesic relief is inadequate; he might then seek administration of sedatives that would render him somnolent or unconscious all of the time. If he simultaneously instructed his care providers not to initiate artificial nutrition or hydration during his unconsciousness, his death within days would be assured. Alternatively, Herman might ask for a supply of barbiturates or opioid analgesics so large that their ingestion would prompt his immediate death—i.e., physician-assisted suicide. If disinclined to ingest such poisonous substances, he might ask a physician to administer a fatal injection of sodium chloride or barbiturates—i.e., active euthanasia. Finally, once Herman becomes ventilator dependent because of his

thoracic deficiencies, he might refuse the ventilator or order its discontinuance in order to precipitate his death. Perhaps at that stage medical personnel would offer Herman sedatives that would ease the panic and discomfort accompanying ventilator withdrawal, but might also pose some risk of further accelerating death.

Which of these modes of hastening death are lawful so that medical personnel may cooperate with Herman's efforts to die? The answers in some instances are easy. Herman's rejection of life-sustaining medical intervention (the ventilator) is clearly his prerogative.³ Conversely, except in Oregon, American medical personnel are forbidden to supply a substance that they know the patient will use for suicide. In all jurisdictions, health care providers are also banned from themselves injecting a lethal poisonous substance, even with the patient's consent. The legality of other means that Herman might seek to employ—cessation of eating and drinking, risky analgesics, and terminal sedation—is more puzzling and complex. This article will focus primarily on those means of hastening death.

The main objective here is to delineate which measures physicians may take to facilitate the death of a dying patient. Medical management of the dying process has been a reality at least since the 1950s when medical science developed the tools to extend life beyond a point that some patients would wish to live.⁴ Since the *Quinlan*⁵ case in 1976, courts and legislatures have struggled to fix the precise legal bounds of such medical management.

Controversy over the appropriate bounds of medical management of the dying process has flared within the last several years. Proponents of assisted suicide and of active euthanasia have contended that given the scope of permissible practices (withdrawal of life support and some uses of risky analgesics), refusal to permit assisted suicide is arbitrary. A typical comment:

3. See *infra* notes 12-14 and accompanying text.

4. See generally ROBERT VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* (2d ed. 1989); ROBERT F. WEIR, *ABATING TREATMENT WITH CRITICALLY ILL PATIENTS* (1989); NORMAN L. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* (1987).

5. See *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

We have created ethical and legal distinctions that allow some suffering patients this choice [death rather than continued suffering], but arbitrarily exclude others whose suffering may be even more extreme and intractable. From the perspective of many suffering patients and their families, some of these distinctions have little meaning and are often not helpful.⁶

The Supreme Court in the recent assisted suicide cases heard claims that punishment of assistance to suicide is so arbitrary (in light of licit means of assisting dying) as to be unconstitutional.⁷ While the Supreme Court ruled that continued punishment of assistance to suicide withstands federal constitutional challenge, the Court by no means ended debate about the precise legal bounds of diverse techniques for facilitating death or about the soundness of current legal distinctions.

This article examines remaining questions about the legal bounds of practices such as VSED, use of risky analgesics, and terminal sedation. Clinicians deserve clarification of the scope of currently permissible practices so that they can conform their behavior to law.⁸ Defining the scope of permissible practices is also important to the ongoing debate, now shifting from the Supreme Court to state legislatures and courts⁹ about possible tensions between forbidden and permitted practices surrounding the dying process. For even if the existing distinctions

6. Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 694 (1994) [hereinafter Quill et al., *Risk Taking*]; see also J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. PALLIATIVE CARE 21, 26 (1996) (noting "little practical significance" in distinctions between withdrawal of treatment, use of risky analgesics, euthanasia, and physician-assisted suicide); Timothy E. Quill et al., *Palliative Options of Last Resort*, 278 JAMA 2099 (1997) [hereinafter Quill et al., *Palliative Options*]; John A. Robertson, *Respect for Life in Bioethical Dilemmas—The Case of Physician-Assisted Suicide*, 45 CLEV. ST. L. REV. 329 (1997); LANCE K. STELL, *PHYSICIAN ASSISTED SUICIDE* 225, 242 (Margaret P. Battin et al., eds., 1998).

7. See *Washington v. Glucksberg*, 521 U.S. 702, 775-77 (1997) (Souter, J., concurring); *id.* at 748-49 (Stevens, J., concurring and noting a "significant tension" between traditional prohibitions on physicians and emerging practices).

8. See Howard Brody, *Physician Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, 82 MINN. L. REV. 939, 962 (1998) (explaining that gray areas of end-of-life practice remain).

9. See, e.g., Ezekiel J. Emanuel, *The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy*, 82 MINN. L. REV. 983 (1998).

withstand federal constitutional scrutiny, questions remain whether, as a matter of public policy, current boundaries are sensible and sufficiently accommodate the social drive for death with dignity.

Our conclusion is not that the ineluctable logic of accepted practices dictates legalization of suicide assistance and active euthanasia. As we will show, the differential legal treatment of various modes of hastening death is logically tenable and defensible. Nonetheless, we suspect that some distinctions in legal treatment of modes of hastening death, to be examined below, are so fragile as to be ultimately swept aside by the momentum of people's yearning for death with a modicum of dignity,¹⁰ a death void of a protracted period of severe debilitation, indignity, or suffering. In our view, some of the theoretical distinctions within the current legal framework are so subtle or so debatable that they cannot ultimately prevail in the face of public pressures to secure death with dignity. Moreover, the theoretical consistency of the framework governing current end-of-life practices (to the extent consistency exists) is not the only issue. Other grounds to support current distinctions in legal treatment of modes of hastening death include supposed differences in the risk of abuse of patients and adverse impact on medical mores from certain modes of hastening death.¹¹ Those apprehensions must also be analyzed in order to finalize public policy.

I. WITHDRAWAL OF LIFE SUPPORT

Among Herman's contemplated modes of hastening his death, withdrawal of a ventilator sustaining his existence would be the most certainly protected. Once Herman's lung function deteriorates to the point where he is ventilator dependent, he would unquestionably be entitled to direct discontinuance of such life support (and medical personnel would be entitled to implement his wishes) even though the

10. Some commentators would vigorously disagree. Yale Kamisar, for example, argues that current distinctions among means of hastening death represent "an historical and pragmatic compromise" worth preserving in the interests of protecting the vulnerable and promoting sanctity of life principles. *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 757-58 (1995). For reasons to be explained in the text, our assessment is that current distinctions are too ephemeral to prevail.

11. See *infra* Part V.

disconnection would result in his prompt demise. Since 1976, when *Quinlan* was decided, the courts have uniformly upheld the prerogative of a competent person facing a potentially fatal disease to decide whether to initiate and to maintain life-sustaining medical intervention.¹² That prerogative has sometimes been grounded in the common law, especially the tort law notion of informed consent as a prerequisite to medical treatment, and sometimes in constitutional liberty. In 1991, in dictum in *Cruzan*,¹³ the United States Supreme Court "strongly suggested" that liberty under the 14th Amendment to the federal constitution encompasses a right to refuse unwanted medical intervention.¹⁴ Thus, Herman's decision to withdraw a ventilator would not only be recognized in every state but would also likely be anchored in the federal Constitution.

A physician's disconnection of the ventilator apparatus would be an action that hastens Herman's death in the sense that he would die significantly sooner than if he remained on the ventilator. Indeed, if the disconnection took place counter to Herman's instructions it would be a criminal homicide.¹⁵ And if, as posited at the outset, Herman really wanted to die when he sought removal of the ventilator, there is a temptation to characterize the physician's conduct in disconnecting the ventilator as euthanasia or assistance to suicide.

Some commentators have asserted that a patient rejecting life support while intending to die is really committing suicide.¹⁶ According to one definition: "A suicide

12. See WEIR, *supra* note 4, at 73-87; see also CANTOR, *supra* note 4, at 2-16.

13. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 278-79 (1990).

14. Chief Justice Rehnquist acknowledged in 1997 that his *Cruzan* opinion had "strongly suggested" the existence of this federal constitutional right. *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997). In *Cruzan* itself, Justice O'Connor's concurring opinion had declared that forced medical intervention would offend a person's constitutional "freedom to determine the course of her own treatment." 497 U.S. at 288-89.

15. See STELL, *supra* note 6, at 245; Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 *FORDHAM. URB. L.J.* 817, 846-48 (1997); David Orentlicher, *The Legalization of Physician-Assisted Suicide: A Very Modest Revolution*, 38 *B.C. L. REV.* 443, 447-48 (1997).

16. This was Justice Scalia's argument in his concurring opinion in *Cruzan*. See 497 U.S. at 296-97; see also STELL, *supra* note 6, at 6; ROBERT N. WENNBURG, *TERMINAL CHOICES: EUTHANASIA, SUICIDE, AND THE RIGHT TO DIE* 19-

is a death one brings on oneself by doing or omitting something with the specific intent that one will die as a result, and where there is reason for one to believe that what one does . . . is substantially certain to produce that result."¹⁷ Such a sweeping definition of suicide would encompass Herman whose intention in discontinuing the ventilator is to die.¹⁸ A physician disconnecting the ventilator would then ostensibly be implicated in Herman's suicidal course of conduct.¹⁹ If one accepts this broad definition of suicide as including rejection of life support, and if rejection of life support is constitutionally protected, the argument follows that at least one form of physician-assisted suicide (rejection of life support) had already been recognized as a patient's prerogative well before 1997.²⁰ A position that essentially equates rejection of treatment with suicide would have enormous implications for the recent claim that physician-assisted suicide is a constitutionally protected liberty. For example, the Second Circuit Court of Appeals in 1996 contended that medical withdrawal of life support at the request of a competent patient is "nothing more nor less than assisted suicide."²¹ That conclusion led to the Second Circuit's determination (overturned by the Supreme Court) that New York's ban on assistance to suicide was an arbitrary denial of equal protection of the laws. New York had previously acknowledged a patient's

23 (1989).

17. STELL, *supra* note 6, at 231.

18. Not every patient who seeks discontinuance of life support intends to die. A particular patient might find a form of life support (e.g., a respirator) to be intolerable and might hope for survival without the hated device. But some patients, like Herman, prefer death over their gravely debilitated condition.

19. Technically, as the physician and not the patient is performing the ultimate death-causing act (withdrawal of the ventilator), the physician's conduct would constitute active euthanasia rather than assistance to suicide. See Yale Kamisar, *"The Right to Die": On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481, 486 n.27 (1996). Another perspective is that the physician's role constitutes an intentional killing, but is justified. See ALLEN BUCHANAN, *INTENDING DEATH: THE STRUCTURE OF THE PROBLEM AND PROPOSED SOLUTIONS*, IN *INTENDING DEATH* 30 (Beauchamp ed. 1996). Alan Meisel has commented: "Doctors have been permitted . . . to kill terminally ill patients for at least two decades." Meisel, *supra* note 15, at 857.

20. "Physicians already have the tacitly recognized liberty to provide suicide assistance by ordering stopped life-sustaining medical treatment." STELL, *supra* note 6, at 245.

21. *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996), *quoted in Vacco v. Quill*, 521 U.S. 793, 798 (1997).

right to reject life-sustaining medical intervention.²²

Is the physician's affirmative conduct hastening Herman's death (disconnecting the ventilator) basically a form of physician assistance to suicide? Certainly, the many courts that between 1976 and 1997 upheld a patient's right to reject life-sustaining medical intervention believed that rejection of treatment was legally distinguishable from suicide. The New Jersey Supreme Court's 1976 *Quinlan* opinion commented: "We would see . . . a real distinction between the self-infliction of deadly harm [suicide] and a self-determination against artificial life support . . . in the face of irreversible, painful and certain imminent death." State legislatures between 1976 and 1997 concurred in this assessment. The "natural death" and "living will" statutes enacted in that period uniformly provided that the withdrawal of life support pursuant to a patient's instructions was not to be equated with suicide or assistance to suicide.²³ Courts subsequent to *Quinlan* elaborated on the instinctive line drawn initially by the New Jersey Supreme Court. These courts did not focus on the presence of immediate and certain death as suggested by the above *Quinlan* quote. Rather, subsequent cases suggested two possible distinctions between suicide and rejection of life-sustaining medical intervention—that rejection of treatment, in contrast to suicide, does not involve either a self-initiated lethal action or a specific intent by the patient to bring about death.²⁴

The absence of a self-initiated cause of death, wholly apart from the specific intent (which we discuss below),²⁵ provides a foundation for the distinction sought to be drawn by the courts and legislatures. Powerful sympathy with a medical patient's plight (afflicted by a fatal disease) helps explain the tendency to differentiate rejection of life support from more typical modes of self-destruction, such as

22. See *Fosmire v. Nicoleau*, 551 N.E.2d 77, 80-81 (N.Y. 1990).

23. For a list of such statutes, see *Choice in Dying, Refusal of Treatment Legislation: A State by State Compilation of Enacted and Model Statutes* (1996).

24. See, e.g., *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 22-26 (Cal. 1984); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1986).

25. See *infra* note 41 (explaining why the specific intent element does not adequately differentiate rejection of life support from suicide).

shooting oneself.²⁶ When a person has a fatal natural affliction and medicine proposes to intervene via bodily invasions, the patient's interest in determining how and if to combat the affliction is self-evident. Sympathy with the stricken patient's delicate decision regarding how much to suffer from the affliction, how much to struggle in response, how much bodily invasion to undergo, how much debilitation and indignity to tolerate, accounts for the universal willingness to give competent patients a choice to decline life-sustaining medical intervention. Because bodily integrity is involved, and because nature, not the patient, has initiated the fatal course, there is reluctance to taint rejection of treatment with the moral disapproval usually surrounding suicide. This is true even if the patient's debilitation and distress are so extreme that the patient specifically intends to die at the moment of withholding or withdrawal of life support.²⁷ The legal structure prefers to regard the afflicted patient as acquiescing in a natural dying process, letting nature take its course (as opposed to self-initiated fatal acts such as shooting oneself or ingesting a poison).

Common sense also dictates recognition of a patient's prerogative to resist life-sustaining medical intervention without attribution of suicide or other negative labels. Otherwise, a debilitated cancer patient rejecting chemotherapy, or a kidney disease patient declining further dialysis, would be branded a suicide. The impetus would then exist for medical personnel to extend life support until the patient's last possible breath in order to prevent such a suicide.²⁸ The specter of forced treatment of a resisting dying patient is indeed gruesome. Law takes a sensible course in regarding a patient's shaping of medical response to a fatal affliction as a basic patient prerogative.

26. N. ANN DAVIS, *THE RIGHT TO REFUSE TREATMENT, in INTENDING DEATH* 119 (T. Beauchamp ed., 1996).

27. A number of cases sustain a patient's prerogative to decline medical intervention even if the patient finds further debilitated existence intolerable and therefore intends to die. See *infra* note 75.

28. "If life-sustaining treatment could not be rejected, vast numbers of patients would be 'at the mercy of every technological advance.'" Kamisar, *The Right to Die*, *supra* note 19, at 493 (quoting NEW YORK STATE TASK FORCE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 75 (1994)).

The notion of acquiescing in a natural dying process is clearest when the patient simply declines treatment at the onset of a fatal disease. But even if Herman's order is to disconnect a previously instituted therapy (a ventilator), and even if the detachment precipitates his immediate death, the underlying lung cancer can still be regarded as the proximate cause of death. Withdrawal of the ventilator allows nature (the lung cancer) to take its fatal course by restoring the circumstances prevailing prior to the artificial intervention (the ventilator).²⁹

In theory, it would have been possible to differentiate between withholding of life support (omission) and withdrawal of life support (action). Courts have uniformly rejected such a distinction, preferring to recognize a patient's prerogative to forgo medical intervention (whether by withholding or withdrawing care) based on interests in self-determination and bodily integrity. As the New Jersey Supreme Court commented: "[A]ctive steps to terminate life sustaining interventions may be permitted, indeed required, by the patient's authority to forgo therapy even when such steps lead to death."³⁰ Withdrawal of life support is then regarded as removing a medically placed artificial obstacle to a natural death and treated as the moral and practical equivalent of medical non-intervention.

Nor would it make sense to differentiate between non-initiation and withdrawal of life support for purposes of defining the permissible scope of physician conduct. That is, it would be foolish policy to allow a physician to refrain from starting a life-sustaining procedure (omission), but forbid the withdrawal of the procedure once started. Such a policy would create an unfortunate disincentive to trying treatments that might have some chance of success for fear that, if the treatment failed, the debilitated patient would have to remain tethered indefinitely to a medical apparatus.³¹

29. *But see* *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996) (stating that there is "nothing natural" in causing death by withdrawal of a ventilator or by withdrawal of artificial nutrition and hydration).

30. *In re Conroy*, 486 A.2d 1209, 1234 (N.J. 1986) (quoting PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 72 (1983)).

31. *See* *Kamisar, Against Assisted Suicide-Even a Very Limited Form*, *supra* note 10, at 755-56.

As Alan Meisel observes, deciding whether to attribute liability to a physician for withdrawing life support is not a simple matter of omission versus commission or of “but for” causation.³² Rather, attribution of blame is shaped in part by policy considerations such as patient autonomy and health care providers’ duty to respect that autonomy.³³ Meisel offers as an illustration a physician who withdraws a respirator without patient authorization because the physician wishes to save electricity.³⁴ The physician’s action is homicide and the withdrawal is the proximate cause of death. By contrast, if the physician withdraws the respirator in response to the patient’s request, the physician is fulfilling a legal duty to respect autonomy³⁵ and the underlying disease (a natural dying process) is legally regarded as the proximate cause of death.³⁶ Again, the patient’s prerogative to control medical intervention is the determinative factor.

All this helps to explain how the Supreme Court in 1997 could conclude that New York’s distinction between withdrawal of life support (permitted) and physician assistance to suicide (forbidden) was rational enough to withstand an equal protection challenge. In reaching that conclusion in *Vacco v. Quill*,³⁷ Chief Justice Rehnquist’s majority opinion³⁸ alluded to the causative element—that a stricken patient rejecting life support dies from the underlying disease rather than a self-initiated action³⁹—and to the element of bodily integrity implicated when a patient

32. See Meisel, *supra* note 15, at 840-42, 847-48.

33. See *id.* at 845-48.

34. See *id.* at 846-47.

35. See GEORGE FLETCHER, *RETHINKING CRIMINAL LAW* 609 (1978) (noting that treating removal of life support as equivalent to withholding of treatment is confined to a “limited set of cases” where unavoidable death is imminent). We regard the patient’s prerogative to control medical intervention as the key element, whether death is imminent or not.

36. The roles of patient prerogative and physician duty are prominent whether the physician’s conduct is omission or commission. A physician would be criminally culpable for omission of treatment (withholding the respirator) if the patient had wanted the life-extending treatment and could benefit from it.

37. 521 U.S. 793 (1997).

38. Although the Rehnquist opinion is labeled a majority opinion, the fifth vote was provided by Justice O’Connor, who expressed distinctive views in her concurring opinion. See *infra* notes 141-43 and accompanying text.

39. See *Vacco*, 521 U.S. at 801.

resists unwanted treatment.⁴⁰ These elements were deemed sufficiently rational to support the customary legal and medical differentiation between withdrawal of life support and assistance to suicide.⁴¹

That such a differentiation is sufficiently rational to withstand constitutional challenge does not, of course, mean that it is necessarily sound or sensible as a matter of public policy. We will discuss later Herman's request for a prescription of a lethal dose of barbiturates, i.e., his possible resort to physician-assisted suicide. That later discussion will address whether continued prohibition of physician assistance to suicide reflects sound public policy. For the

40. See *id.* at 807. Bodily integrity is more respected when it involves resistance to invasions (including medical treatment) than introduction of substances into the body (such as addictive substances, poisons, or bullets). See *id.*

41. Chief Justice Rehnquist also tried to use specific intent of the actors (patient and physician) as a factor differentiating treatment withdrawal from assistance to suicide. His basic contention was that a physician withdrawing treatment may only intend to respect a patient's choice while a physician providing a lethal poison must necessarily intend that the patient die. See *id.* at 801-02. Reliance on specific intent as a major distinguishing factor in this context is shaky. As many commentators have noted, a dying patient rejecting life support may well intend to bring about death as a form of relief. See STELL, *supra* note 6, at 234-35; Meisel, *supra* note 15, at 837; Quill et al., *Palliative Options*, *supra* note 6, at 2102. Even if a patient does not exactly wish to die, if the patient's main object is relief from suffering and that object can be attained only by death, then the mindset accompanying rejection of further treatment (in order to hasten death) is quite close to the specific intent of any suicide who finds existence unbearably painful or meaningless. Justice Stevens in *Vacco* noted that there is often "little distinction . . . [in] intent" among people performing various end-of-life practices. 521 U.S. at 750 (Stevens, J., concurring) On the irrelevance of a physician's specific intent in this context, see Ann Alpers, *Criminal Act or Palliative Care? Prosecutions Involving the Care of the Dying*, 26 J.L. MED. & ETHICS 308, 316 (1998); Elizabeth J. Latimer, *Ethical Decision-Making in the Care of the Dying*, 6 J. PAIN & SYMPTOM MGMT. 329, 334 (1991); David Orentlicher, *The Supreme Court and Terminal Sedation*, 24 HASTINGS CONST. L.Q. 947, 957-59 (1997). In theory, law might have demanded that a patient rejecting life support not have a specific intent to die. Under such a regime, a patient could reject treatment because of its burdensome side effects, but could not reject treatment because life had become so dismal that death was preferable. See Keown, *supra* note 2, at 266-67; see also Daniel Sulmasy, *Killing and Allowing to Die: Another Look*, 26 J.L. MED. & ETHICS 55, 60 (1998) (drawing a moral distinction between removal of life support because of the burdens of machinery and removal with an intent to bring about death). However, law has never drawn such a line. A patient rejecting life support may be motivated by a conviction that current or prospective existence is so dismal that death is preferable. See McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

moment, one mode of hastening death—withdrawal of life-sustaining medical intervention—has been established as a legitimate form of self-determination available to Herman Michelle.

II. CESSATION OF EATING AND DRINKING

In one scenario, Herman decides to stop eating and drinking and to reject all forms of artificial nutrition and hydration proffered. His hope is to die within 14 days as opposed to the two to three month period projected with continued nutrition. He does not expect any pain and suffering associated with this process of death by dehydration, as he expects his health care providers to furnish palliative care. This means mouth care to avoid dryness and cracking of lips and perhaps benzodiazepine sedatives to ease any pain or emotional upset (possibly suffering connected with his underlying cancer condition) until the point when he will slip into a coma from which he will never emerge.⁴² Herman sees this dehydration course as offering a gentle passage at a significantly earlier juncture than if he were to continue to accept nutrition and hydration.

Notice that no natural pathology or disease process obstructs Herman's normal processes of ingestion and digestion. This is not an instance when illness necessitates artificial means of nutrition and hydration (ANH). Were that the case, Herman would clearly be entitled to reject ANH. For ANH has uniformly been treated by the courts as a form of medical intervention which competent patients

42. See JOANNE LYNN & JACQUELINE GLOVER, *ETHICAL DECISION-MAKING, in ENTERAL NUTRITION*, IN *ENTERAL AND TUBE FEEDING* 580 (Rombeau & Caldwell eds., 2d ed. 1990); James Bernat, et al., *Patient Refusal of Hydration and Nutrition*, 153 *ARCHIVES INTERNAL MED.* 2723, 2727 (1993) (describing the palliative measures that will eliminate suffering during the process of dying from dehydration); Robert M. McCann, et al., *Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition*, 272 *JAMA* 1263, 1265-66 (1994); Candace Jans Meares, *Terminal Dehydration: A Review*, 11 *AM. J. HOSPICE & PALLIATIVE CARE* 10, 11 (1994). Death by dehydration is not always a tranquil process. Some patients manifest symptoms of discomfort. See Robin Fainsinger & Eduardo Bruera, *The Management of Dehydration in Terminally Ill Patients*, *J. PALLIATIVE CARE* 55, 55 (1994). This means that the impact of dehydration has to be monitored and assessed on a case by case basis. See KILLIAN DUNPLY ET AL., *REHYDRATION IN PALLIATIVE AND TERMINAL CARE*, *PALLIATIVE MEDICINE* 221, 225 (1995).

are entitled to refuse.⁴³ Nor is Herman simply following the common tendency of patients imminently dying to lose interest in eating and drinking. With an unavoidable death approaching within days, patients often decline food without experiencing hunger awareness or suffering beyond that prompted by the underlying disease process. At that stage, physicians frequently acquiesce in this patient predilection and refrain from parenteral nutrition.⁴⁴ Herman, by contrast, is making a deliberate decision to hasten his demise in order to shorten what has become for him an anguishing dying process.

Herman's VSED constitutes what some commentators herald as a simple and effective way for terminally ill or chronically suffering patients to control the timing of their own death.⁴⁵ One advocate of this technique for managing death argues:

We learn about how to avoid eating and drinking things we don't want by the time we are two years old. Yet, somehow as adults we have a tendency to forget that we have this power. Simply by clenching our teeth and turning our heads, we can sabotage the best efforts of any 'feeder.' . . . [H]umans who have lived out their lives should be allowed to 'withdraw' when they feel that their time has come.⁴⁶

Even Ann Landers endorses VSED as a means of timing one's death.⁴⁷ For most people, VSED and death by dehydration may seem like a cumbersome way to die. But

43. See *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1141 (Cal. Dist. Ct. App. 1986); *In re Requena*, 213 N.J. Super. 475, 485-86 (N.J. Super. Ct. Ch. Div.) *aff'd*, 213 N.J. Super. 443 (N.J. Super. Ct. App. Div. 1986) (*per curiam*); *In re Rodas*, No. 86PR139 (Colo. Dist. Ct. Mesa Co. Jan 22, 1997, *as modified*, April 3, 1997) (Buss, J.); *Thor v. Superior Court*, 855 P.2d 375, 384 (Cal. 1993); see also Alan Meisel, *Barriers to Forgoing Nutrition and Hydration in Nursing Homes*, 21 AM. J.L. & MED. 335, 352-55, 367 (1995).

44. See Paul Rousseau, *Hospice and Palliative Care*, DISEASE A MONTH 788, 829-30 (1995) [hereinafter Rousseau, *Hospice*]; Louise Printz, *Terminal Dehydration, a Compassionate Treatment*, 152 ARCHIVES INTERNAL MED. 697, 700 (1992); McCann, *supra* note 42, at 1266; Meares, *supra* note 42, at 10.

45. See Bernat, *supra* note 42, at 2723, 2725; Quill et al., *Palliative Options*, *supra* note 6, at 2100; Lori Montgomery, *Starving is Legal Suicide Method*, DETROIT FREE PRESS, Nov. 20, 1996, at 1A.

46. William Bartholome, posting to the MCW Bioethics Forum, Oct. 1, 1996 (on file with author).

47. See Ann Landers, *Death With Dignity Hard to Find in Hospital Bed*, STAR-LEDGER ARCHIVE, July 10, 1998, at 42.

for a person like Herman, otherwise locked into a prolonged and dismal dying process, VSED may seem like an expeditious path to relief.

What is the legal status of Herman's conduct and of the medical personnel who are asked to cooperate with his effort to hasten death? Is Herman committing suicide? If so, are physicians under a legal and moral obligation to try and frustrate his effort by forced administration of artificial nutrition and hydration? Would personnel cooperating with Herman be guilty of aiding and abetting suicide if they furnish palliative measures such as mouth care or sedatives? Or is Herman invoking a right to self-determination and/or bodily integrity when he stops eating and drinking and insists that no intravenous or other artificial nutrition be instituted?

Herman's conduct has many earmarks of suicide. His determination to stop eating (and his accompanying resistance to ANH) is an unnatural self-destructive course prompted by despair over dismal conditions of existence. Most philosophers concede that suicide can be accomplished by passive means, such as a refusal to eat, as well as by active means such as shooting or stabbing.⁴⁸ The conduct at issue is different in one important sense from rejection of life-sustaining medical intervention by a dying patient even where that rejection is undertaken with the specific intent to bring about death. When a fatally stricken patient rejects medical treatment, the natural affliction can be regarded as the cause of death—a cause not initiated by the patient.⁴⁹ When VSED brings about death, the patient has introduced the fatal cause, dehydration, so the conduct has an element of suicide absent when the patient merely rejects treatment.⁵⁰

48. See WENNBERG, *supra* note 16, at 33-34 (branding as a suicide anyone who "intentionally creates a pre-emptive fatal condition . . ."); Terence M. O'Keefe, *Suicide and Self-Starvation*, in *SUICIDE: RIGHT OR WRONG?* 117, 123 (John Donnelly, ed. 1990).

49. We previously described how a patient acquiesces in a natural dying process even when physicians remove a previously installed block to death such as a respirator or artificial nutrition and hydration.

50. See K. Danner Clouser, *Allowing or Causing: Another Look*, 87 *ANNALS INTERNAL MED.* 622, 624 (1977) (noting a difference "in principle" between refusal of treatment and rejection of normal support for life, such as food). *But see* Bernat, *supra* note 42, at 2725 (asserting that it is "irrelevant" whether a competent patient invoking VSED is causing a "natural" death).

This intuition that VSED is a form of suicide draws support from a few judicial sources. Justice Scalia took that position in his concurring opinion in *Cruzan*.⁵¹ In several cases involving hunger striking prisoners whose object was to fast until death, the courts indicated that the prisoners' conduct constituted suicide.⁵² Suicide was deemed to be implicated because the prisoner "set the death-producing agent [dehydration] in motion [by resisting food] with the specific intent of causing his own death."⁵³ The saga of Elizabeth Bouvia also supports this notion that a person capable of eating who rejects nutrition may be committing suicide. Ms. Bouvia was a 28 year-old quadriplegic, suffering from severe cerebral palsy, who sought to reject both hand feeding and ANH. When the California court understood her to be rejecting food even though she was capable of normal eating, her conduct was regarded as attempted suicide and the court refused to insulate her conduct from medical intervention. When her condition deteriorated so that her physical affliction prevented normal eating, the court upheld her right to reject ANH.⁵⁴

Denominating VSED as a form of suicide does not resolve its legal status. Attempting suicide, while once a felony, is no longer a criminal act.⁵⁵ This leaves room for the law to tolerate at least some forms of suicide, including VSED. Some medical commentators assert that VSED is both widely accepted by palliative care physicians and "probably legal."⁵⁶ The legality assertion is made with little or no reference to legal authority. These commentators simply regard VSED as an extension of the acknowledged

51. "Starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned." *Cruzan v. Director, Missouri Dep't Health*, 497 U.S. 261, 296-97 (1990).

52. See *Laurie v. Senecal*, 666 A.2d 806, 809 (R.I. 1995); *In re Caulk*, 480 A.2d 93, 97 (N.H. 1984); *Von Holden v. Chapman*, 450 N.Y.S. 2d 623, 627 (N.Y. App. Div. 1982).

53. *Caulk*, 480 A.2d at 97.

54. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 299 (Cal. Dist. Ct. App. 1986). For a more detailed discussion of the *Bouvia* episode, see CANTOR, *supra* note 4, at 28-30.

55. See *Washington v. Glucksberg*, 521 U.S. 702, 712-14 (1997) (sketching of the history of legal treatment of suicide and explanation, by Chief Justice Rehnquist, that, while suicide is no longer punished by criminal law, public policy disfavors suicide).

56. Quill et al., *Palliative Options*, *supra* note 6, at 2103; see also Bernat, *supra* note 42, at 2726; Montgomery, *supra* note 45, at 1A.

right to reject life-sustaining medical intervention, invoking the same self-determination and bodily integrity interests recognized in that context.⁵⁷ That analysis is too simplistic. VSED indeed involves self-determination and resistance to bodily invasion. But the commentators ignore the element of self-initiated cause of death accompanying VSED that is absent when a fatally stricken patient rejects ANH or other life support. The conclusion that Herman's conduct is lawful might be correct, but it needs further explication.

The cases concerning hunger-striking prisoners offer mixed signals. Two American cases uphold the prerogative of a competent prisoner to refuse to eat or accept ANH even if that course of conduct will bring about the prisoner's death. In *Zant v. Prevatte*,⁵⁸ the Georgia Supreme Court in 1982, without mentioning suicide, simply declared that a prisoner has a constitutional right to "refuse to allow intrusions on his person, even though [the intrusions are] calculated to preserve his life."⁵⁹ A Florida intermediate appellate court in 1996 relied on the Florida constitution to protect a prisoner's hunger strike.⁶⁰ However, that court circumvented the suicide issue in a manner not available to Herman Michelle and other terminally ill patients. The Florida case ruled that because the hunger striker was protesting government conduct and sought changes in government behavior, he did not intend to die. According to the court, "the purpose of the hunger strike was to bring about change, not death."⁶¹ It is a nice question whether a hunger striker seeking to pressure government to make

57. See Howard Brody, *Physician Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, 82 MINN. L. REV. 939, 960 (1998); see also Quill, et al., *Palliative Options*, *supra* note 6, at 2100.

58. 286 S.E.2d 715 (Ga. 1982).

59. *Id.* at 717. A British case also upholds the prerogative of a hunger striker to resist "any form of physical molestation" including forced feeding. See *Secretary of State for the Home Dep't v. Robb*, 1 All E.R. 677, 680 (Fam. 1995) (declaring without analysis that resisting nutrition is not a form of suicide).

60. See *Singletary v. Costello*, 665 So.2d at 1109 (Fla. Dist. Ct. App. 1996); see also *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993).

61. Ironically, the fact that the prisoner was seeking to extract a concession should have been a reason for the court to intervene. For a person cannot be allowed to coerce administrative officials by means of a threat to self-destruct. See *In re Sanchez*, 577 F. Supp. 7, 9 (S.D.N.Y. 1983). But see *Zant v. Prevatte*, 286 S.E.2d 715, 717 (Ga. 1982) (holding that a hunger strike even though the prisoner was seeking to extract concessions from prison officials).

concessions has a suicidal intent.⁶² However that issue is resolved it cannot help Herman Michelle because he has made clear his explicit intent to die.

The bulk of the cases involving hunger strikers acknowledge the relevance of suicide and hold that a prisoner has no constitutional right to resist life-preserving nutrition.⁶³ A New York intermediate appellate court's comment is typical:

[I]t is self-evident that the right to privacy does not include the right to commit suicide.... To characterize a person's self-destructive acts [hunger striking] as entitled to Constitutional protection would be ludicrous. On the contrary, the State has a duty to protect the health and welfare of those persons in its custody.⁶⁴

Yet these cases allowing forced feeding of hunger strikers are not really determinative of the matter of dying medical patients. For one thing, the cases often rely on a government interest in maintaining internal order and discipline within a correctional institution⁶⁵—an interest that has no application to people like Herman Michelle. Moreover, the cases sometimes involve prisoners seeking to extract concessions via the coercive impact of a threat to hunger strike until death.⁶⁶ That coercive element alone could warrant overriding the prisoner's effort and, again,

62. For an interesting discussion of this issue, see O'Keefe, *supra* note 48, at 125-31. O'Keefe argues that a political hunger striker is engaged in "instrumental self-killing," intending to put pressure on government and hoping that government will yield and that the striker will not have to die. *Id.* at 127. O'Keefe is willing to treat such instrumental self-killing as lacking an overriding intent to die and therefore outside the bounds of suicide. *See id.* at 131. An alternative perspective, though, is that the prisoner knows that no concession will be forthcoming and that he will have to die; then, his protest is just a motive for his self-destructive act and does not alter his intent to die.

63. *See In re Grand Jury Subpoena John Doe*, 150 F.3d 170, 172 (2d Cir. 1998); *Martinez v. Turner*, 977 F.2d 421, 423 (8th Cir. 1992); *Sanchez*, 577 F. Supp. at 8-9; *In re Caulk*, 480 A.2d 93, 97 (N.H. 1984); *Commonwealth v. Kallinger*, 580 A.2d 887, 893 (Pa. Commw. Ct. 1990); *Laurie v. Senecal*, 666 A.2d 806, 808 (R.I. 1995).

64. *Von Holden v. Chapman*, 450 N.Y.S.2d 623, 625 (App. Div. 1982); *see also Laurie*, 666 A.2d at 808-09 (holding that the state has a right and a duty to intervene and protect patients).

65. *See In re Caulk*, 480 A.2d at 96; *Laurie*, 666 A.2d at 809.

66. *See Sanchez*, 577 F. Supp. at 9. *But see Zant*, 286 S.E.2d at 717 (upholding a hunger striker's prerogative despite the striker's attempt to exact concessions).

that element is absent in the case of a dying medical patient invoking VSED.

Authority on point, cases specifically addressing a competent, terminally ill person invoking VSED despite being physically capable of eating, is sparse. We are aware of only a few cases, all of them in lower courts. Two such opinions, both in New York and both unpublished, relate to requests from nursing homes for authorization to give ANH to elderly, debilitated patients resisting all forms of nutrition.⁶⁷ Both cases involved chronically ill women in their mid-eighties who decided to die via VSED. In both cases, a judge refused to intervene despite the nursing home's invocation of a New York statute authorizing prevention of suicide. In one instance, the opinion declared a right of an adult to determine what can be done to his or her own body and cited cases involving refusal of life-sustaining medical intervention.⁶⁸ The court did not attach significance to the patient's self-destructive course and did not mention New York precedent allowing forced feeding of a hunger-striking prisoner. In the *Bouvia* case, mentioned earlier, a lower court judge ordered medical intervention for a 28 year-old quadriplegic when it was thought that the patient was seeking to die by refusing to eat.⁶⁹

The dearth of judicial authority concerning VSED prevents easy resort to precedent to establish the legal status of the practice. Nonetheless, we project that judicial non-intervention is likely to continue in instances of suicidal VSED by competent, dying medical patients.⁷⁰ A major factor impelling non-intervention is revulsion at the prospect of restraining for extended periods people who are competent and determined to resist nutrition. Long term feeding of a resisting patient requires physical or chemical

67. See *In re Brooks* (N.Y. Sup. Ct. 1987) (unpublished decision, on file with the *Buffalo Law Review*); see also Rebecca Dresser, *When Patients Resist Feeding*, 33 J. AM. GERIAT. SOC'Y 790, 793 (1985); *A.B. v. C.*, 477 N.Y.S.2d 281, 284 (Sup. Ct. 1984) (describing in dictum the petition of a severely incapacitated person whose petition was dismissed as being prematurely filed).

68. See *Brooks* (N.Y. Sup. Ct. 1987) (unpublished decision on file with the *Buffalo Law Review*).

69. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 299 (Cal. Ct. App. 1986).

70. See Dresser, *supra* note 67, at 793 (predicting that courts will allow patients to reject nutrition where an "underlying physical condition will soon produce death").

restraints⁷¹—restraints so demeaning and inhumane that courts will likely be unwilling to order them, especially where the patient is enmeshed in an inexorable dying process.⁷² Several judicial sources have noted the distasteful specter of forcible restraint of a competent patient.⁷³ The likelihood is that solicitude for the competent patient's dignity will impel courts to refrain from interfering when nutrition is declined by fatigued, dying patients.

While judicial reluctance to order forced feeding has been overcome in some instances of hunger-striking prisoners, the approach to dying patients has been, and will likely continue to be, different. The explanation probably lies in judicial intuition about the moral status of suicide in the context of a fatally stricken patient. Moral condemnation of suicide is grounded in part on disapproval of the hopelessness reflected in a suicide choice.⁷⁴ The spurned lover or ruined businessperson who chooses suicide is repudiating the possibility of improved circumstances over time. Especially where a young person opts for suicide, that denial of the possibility of change is seen as imprudent and immoral. By contrast, where a person has been stricken by a fatal condition, the potential for improved circumstances is limited. In such an instance, people (and judges are, after all, people) sympathize with the pessimism and resignation reflected by the patient who chooses to acquiesce in the fatal course that the affliction brings. That sympathy is certainly visible in the cases involving rejection of life support by competent patients whose condition is so

71. See Bernard Lo & Laurie Dornbrand, *Guiding the Hand that Feeds*, 311 N. ENG. J. MED. 402, 403 (1984).

72.

Consider the force and violence entailed in compelling a resistant patient to ingest food or fluids. Restraint is necessary first to emplace a feeding tube or catheter; four-quadrant physical restraints must then be employed to prevent the resistant patient from dislodging the tubes. The patient is thus immobilized and forced to use a bed pan (or is accompanied to the toilet by a monitor). The physical and psychosocial consequences are so repulsive and inhumane as to preclude physical intervention in the face of a competent patient's self-starvation.

Norman L. Cantor, *Two Opinions in Search of a Justice: The Constitution and Physician-Assisted Suicide*, 28 RUTGERS L.J. 435, 447-48 (1997).

73. See *Cruzan v. Director, Missouri Dep't Health*, 497 U.S. 261, 287-92 (1990) (O'Connor, J., concurring); *In re Hier*, 464 N.E.2d 959, 964 (Mass. App. Ct. 1984).

74. See C.G. PRADO, *THE LAST CHOICE: PREEMPTIVE SUICIDE IN ADVANCED AGE* 53-55 (1990).

dismal that they prefer death, rather than life-sustaining medical intervention.⁷⁵ That sympathy probably extends to the suffering, dying patient who chooses to hasten death by VSED. Customary moral condemnation toward suicide should dissipate in such a circumstance just as it did in the few lower court cases regarding nursing home patients.⁷⁶

As noted, sympathy for the plight of the terminally ill patient is reflected in the cases recognizing a patient's prerogative to decline life-sustaining medical intervention even where the patient's intention is to bring about death.⁷⁷ Some courts have even suggested that the government interest in the preservation of human life weakens as a person's life trajectory nears its unavoidable end. That notion surfaced as early as *Quinlan's* comment that the state interest weakens as "the prognosis dims."⁷⁸ Some later opinions subscribe to the idea that the state's interest lessens when "the issue is not whether, but when, for how long and at what cost to the individual . . . life may be briefly extended."⁷⁹ Indeed, when the Ninth Circuit ruled in 1996 that Washington's ban on assisted suicide was unconstitutional as applied to terminally ill patients, Judge Reinhardt's opinion asserted that the state interest in preserving life is diminished in the context of a terminally ill patient.⁸⁰

This notion that the state interest in preservation of life weakens as death nears seems wrong. Criminal law protects the fatally afflicted person just as vigorously as the healthy person. People have been convicted of homicide for murdering patients who would have died within days

75. See *Bouvia*, 225 Cal. Rptr. 297; *In re Farrell*, 529 A.2d 404, 406-07 (N.J. 1987); *In Re McAfee*, 385 S.E.2d 651, 651 (Ga. 1989); *McKay v. Bergstedt*, 801 P.2d 617, 620 (Nev. 1990); *Thor v. Superior Court*, 855 P.2d 375, 379 (Cal. 1993).

76. Not everyone is willing to relax moral antipathy toward suicide via VSED just because the patient is nearing unavoidable death. See Keown, *supra* note 2, at 263 (branding suicidal refusal to accept nutrition as "patently immoral"). Some people regard suicide as intrinsically immoral because it interferes with God's dominion over life and death. See O'Keefe, *supra* note 48, at 120-23.

77. See generally *supra* note 75 and accompanying text.

78. *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976).

79. *Browning v. Herbert*, 568 So.2d 4, 14 (Fla. 1990) (quoting *Satz v. Perlmutter*, 362 So.2d 160, 162 (Fla. Dist. Ct. App. 1978)).

80. See *Washington v. Glucksberg*, 79 F.3d 790, 817 (9th Cir. 1996).

anyway.⁸¹ The above judicial expressions about a diminished state interest in the lives of inexorably dying patients really reflect sympathy for the plight of the fatally afflicted patient who must determine how to respond to impending death. Those judges were striving to maximize the self-determination of the stricken patient and they erroneously deemed the state's interest to be diminished in that context. It is not that the state interest in preservation of life is weak, but that the individual interest in shaping the dying process in the face of unavoidable death is so strong.⁸² The same kind of sympathy with the dying patient's plight is likely to impel courts to protect people like Herman Michelle in their decision to stop eating and drinking.

There is another distinction between VSED and typical modes of suicide. The VSED patient is ceasing the natural flow of nutritive substances into her body. Although stopping this flow is unnatural, the decision to eat and drink is normally within the complete control of humans. Deciding to cease an act that is within our control seems dissimilar from suicide which, at least in its paradigmatic form, requires the person to perform an affirmative act ending life. To be sure, the distinction between act and omission is usually a thin one. Bringing about a consequence by failing to act usually creates moral responsibility for the consequence; allowing a child to drown when the actor could easily and safely save the child makes the actor morally responsible for the child's death just as if the actor had drowned the child.⁸³ Yet there is a lingering intuition that failing to act is somehow not quite as culpable. The actor who lets the child drown somehow seems less culpable (even if only slightly so) than the actor

81. See, e.g., *Edinburgh v. State*, 896 P.2d 1176, 1178 (Okla. Crim. App. 1995).

82. "[T]he state's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life." *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985). Even when the U.S. Supreme Court rejected the constitutional challenge to state laws banning assistance to suicide, several Justices expressed strong sympathy with a competent patient's prerogative to avoid suffering. Those expressions are discussed *infra* notes 139-41 and accompanying text.

83. The point in the text is to compare the morality of VSED with that of suicide. But omissions can be criminal as well as immoral. The example of a parent failing to save a child is an example of a criminal omission.

who drowns the child. The act-omission distinction might, therefore, distinguish VSED from typical modes of suicide by reinforcing the inclination to call VSED part of the patient's self-determination.

Even if the cessation of eating is regarded as a suicidal act, there may be room to exculpate the medical cooperation that Herman Michelle is seeking. Attempting suicide is not a crime but some states have a statutory crime of aiding and abetting suicide. The issue then becomes whether the medical role in VSED—providing a clean bed, wetting the lips, offering skin care (turning the patient to avoid bed sores), and providing light sedation in the face of agitation or anxiety—constitutes aiding and abetting suicide.

Our legal analysis of palliative assistance to VSED starts with the common law approach to aiding and abetting. Aiding and abetting was not a separate crime at common law. Rather, the aider and abettor derived liability from the principal and was deemed as culpable as the principal. Someone who facilitated the principal's crime would be held responsible for that crime—so the getaway driver would be guilty of the crime of robbery committed by his partners who robbed the bank. Notice, as this example makes clear, that aiding and abetting need not be an indispensable or even a "but for" cause of the principal crime; presumably, if the getaway driver had refused to participate in the crime, the robbers would have found another driver. Nor need aid actually be given. "It is sufficient encouragement that the accomplice [the one who aids and abets] is standing by at the scene of the crime ready to give some aid if needed"⁸⁴ To avoid dispersing criminal liability too broadly to peripheral players, however, the common law required a uniquely high threshold of mens rea to hold an aider and abettor liable for the crime of the principal: "the accomplice must intend that his acts have the effect of assisting or encouraging another [to perpetrate a crime]."⁸⁵

This stringent mens rea requirement for accomplice liability would apply to a charge of aiding and abetting the common law felony of suicide. The typical example of assisting suicide—providing the means of suicide by

84. WAYNE R. LAFAYE & AUSTIN W. SCOTT, JR., *CRIMINAL LAW* 577 (2d ed. 1986).

85. *Id.* at 580.

supplying a poison to be ingested—is illustrative of these common law principles. Writing a prescription for the poison could be aiding and abetting even if the suicide would have been able to procure the poison from another source or would have found another means to commit suicide. But it would not be aiding and abetting under common law unless the physician intended his act to encourage the patient to take his own life. Presumably, most physicians do not intend the patient to kill himself but merely intend to allow that option. For example, a prescribing physician may well hope to reassure a terminal patient that relief is available if suffering ultimately becomes extreme—with the interim hope and expectation that the reassured patient will persevere longer, rather than use a poison.⁸⁶ In such a scenario, the physician intends to facilitate the patient's choice but does not intend to encourage suicide.⁸⁷

Today, committing suicide is typically not a crime in the United States. Thus, the classic common law analysis could not produce liability for the aider and abettor of suicide because there is no criminal liability to derive from the principal. It is not, for example, a crime to aid and abet an adult to purchase liquor in a state that permits the sale of liquor. The principal way aiding and abetting suicide can be a crime today, therefore, is if a state legislature explicitly makes that particular conduct a crime.⁸⁸

Many modern statutes do indeed create an independent crime of aiding or soliciting suicide.⁸⁹ For example, the Model Penal Code provides: "A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or attempted suicide, and otherwise of a misdemeanor."⁹⁰ This model statute incorporates a very high mens rea

86. See generally MARILYN WEBB, *THE GOOD DEATH* (1997).

87. George Annas relies on this point in urging that physicians are not criminally responsible for providing prescriptions for potentially lethal drugs that have an immediate palliative justification. See GEORGE J. ANNAS, *SOME CHOICE* 213-14, 220, 232 (1998).

88. The Michigan Supreme Court, however, did rule that assisting suicide could be prosecuted in Michigan as a common-law crime. See *People v. Kevorkian*, 527 N.W.2d 714, 716 (Mich. 1994).

89. See, e.g., IND. CODE ANN. § 35-42-1-2.5 (West 1998); MICH. COMP. LAWS ANN. § 752.1027 (West 1993); MINN. STAT. ANN. § 609.215(3) (West 1998).

90. MODEL PENAL CODE § 210.5 (1) (1962).

requirement of “intent”—here called “purpose”—in a fashion similar to the common law prerequisite for accomplice liability. Under the Model Penal Code, one acts purposely with respect to a result of his conduct if his conscious object is that the result occurs.⁹¹ In the assisting suicide context, the aider would have to have as a conscious object that the patient commits suicide. The Commentary notes: “It seems clear that no lesser culpability should suffice [A] requirement of less than purposeful conduct would run the serious risk of overinclusiveness, perhaps applying, for example, to one who sells readily available goods to another who states that he intends to kill himself.”⁹² The Model Penal Code thus draws a distinction between one who assists *knowing* that the principal will commit the assisted act and one who assists because it is his *purpose* for the principal to commit the assisted act.

Application of this framework exculpates most, if not all, medical personnel who help Herman Michelle implement VSED. Medical personnel furnishing palliative care (primarily mouth and skin care) to the patient invoking VSED are unlikely to have the patient’s death as a conscious object. They are simply meeting basic humanitarian needs. They likely intend to be helpful and to care for the patient. They may want the patient to have VSED as an option. But none of this entails that their conscious object is the patient’s death. Indeed, if the patient decided to stop VSED at any time, the medical personnel would assist in that reversal of VSED just as they are assisting in VSED. Thus, even though VSED may be a suicidal act, provision of palliative assistance should not trigger criminal liability.

There are also policy reasons that support this construction of the law of aiding and abetting. If medical personnel were foreclosed by criminal law from providing a clean bed and elementary mouth care, the patient would be relegated to a home environment where lay people might or might not be available to perform the simple palliative steps sought. Institutions might thus be deterred from

91. See MODEL PENAL CODE § 2.02(2)(a)(i) (1962). See generally Kevin Breer & Cherie Durst, Note, *Recent Developments in Kansas Bioethics Law: The Kansas Prevention of Assisted Suicide Act*, 38 WASHBURN L.J. 557, 567 (1999) (explaining that state statutes often adopt similar mens rea requirement).

92. MODEL PENAL CODE, Commentary to § 210.5 (1962).

providing palliative facilitation of VSED, but patients would not likely be deterred from their fatal course. They would persist either with lay assistance or on their own. In sum, because the palliative measures in issue are so clearly humane, because criminal law doctrine strictly limits the reach of accomplice liability, and because criminalization of the palliative conduct would not foreclose VSED, judicial policy is almost certain to exclude such steps from the bounds of aiding and abetting suicide.⁹³

Our reliance on absence of specific intent to aid suicide in our exculpation of medical personnel facilitating VSED does not contradict our later point that murder ordinarily encompasses both knowing and purposeful conduct. We will later argue that there is no difference of substance between a physician who administers a lethal analgesic dose knowing that it is lethal and a physician who administers a lethal dose with the purpose of killing the patient. The distinction between knowledge and purpose when an actor is the one who causes the harm is of no legal significance.⁹⁴ But the distinction between knowledge and purpose is crucial when the state of mind is not of the principal actor herself but of one who is aiding the principal actor. When someone else causes the harm, the liability of the aider is necessarily derivative and the criminal law requires a purposeful mens rea to limit this derivative liability to those who are without doubt culpable.

Several states have statutes that encourage the prevention of suicide by justifying the use of force to prevent a suicide attempt. Alabama's statute, adopted from the Proposed Federal Criminal Code and similar to several other state statutes,⁹⁵ can serve as an example:

A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use reasonable physical force upon that person to the extent that he reasonably believes it necessary to thwart the result.⁹⁶

93. The administration of sedatives that render the self-starving patient unconscious or semi-conscious presents a harder question regarding the aiding and abetting of suicide. That issue is addressed in the context of terminal sedation. See generally *infra* notes 231-35 and accompanying text.

94. See generally *infra* notes 122, 149-53 and accompanying text.

95. N.Y. PENAL LAW § 35.10 (McKinney 1997); TEX. PENAL CODE ANN. § 9.34, 9.61-9.63 (1994); MODEL PENAL CODE § 3.07, 3.08 (1962).

96. ALA. CODE § 13A-3-24(4) (1975).

Does this statute conflict with our conclusion that physicians and nurses can assist Herman Michelle in his VSED? At least in states like Alabama, can a care provider ignore the policy in favor of preventing suicides so clearly expressed in the above statute? The answer is that we defend VSED only in the limited circumstance where the patient is terminally ill, has no personally acceptable chance for improved circumstances, and has voluntarily chosen VSED. In this circumstance, the statutory policy in favor of intervening in a suicide attempt seems inapplicable. We doubt that the Alabama legislature's intent was to frustrate a considered choice of VSED motivated by a stricken patient's determination that death is preferable to further existence and further medical intervention. The legislative commentary notes: "The purpose of this section is to delineate certain circumstances where an actor . . . may apply reasonable physical force against a person *in order to protect or promote the welfare of that person . . .*"⁹⁷ Given the policy statement's focus on promoting the welfare of the person attempting suicide, and given the permissive nature of the statute (a person "*may* use reasonable force"), it seems unlikely that the state legislature intended by the general statutory language to foreclose a fatally afflicted patient's VSED option.

To summarize, some courts would view VSED not as a suicide but as an exercise of bodily integrity, in effect giving the patient the right to VSED.⁹⁸ In those jurisdictions, a court would not only refuse to authorize medical interventions but would order removal of ANH initiated by health care providers over a patient's objections. Other courts, while not explicitly recognizing VSED as a right, would recognize pragmatic reasons not to intervene—primarily, distaste toward putting a patient in restraints to keep her from pulling out the I.V. that is keeping her alive—when a patient seeks VSED and the care-providing institution either does not oppose the request or seeks court authorization to initiate ANH against the patient's will. The hardest case in such a jurisdiction, we believe, would be if a health care provider forces nutrition and hydration

97. Commentary to ALA. CODE § 13A-3-24 (emphasis added) (justifying statute that contains the justification of the use of force in preventing suicide).

98. That would certainly be the case where courts have already endorsed a prisoner's prerogative to hunger strike. See *generally supra* notes 58-60, 67-69.

on a competent patient who has initiated VSED. Though there are no cases of which we are aware, we project that if a health care provider initiates ANH over a competent patient's objections, at least some courts would likely view this unconsented bodily invasion as a common law battery and would uphold the patient's autonomy.

III. USING RISKY ANALGESICS⁹⁹

In one scenario, Herman Michelle, finding himself in the throes of unbearable physical and emotional suffering, asks that his health care providers administer opioid analgesics, probably in the form of an intravenous morphine drip. Such provision of pain relief is an integral part of medical responsibility to furnish palliative care to a dying patient.¹⁰⁰ Many sources contend that opioid analgesics are safe—that patients build considerable tolerance to the substances and that any hazard of hastening death is exaggerated.¹⁰¹ However, depending on dosage, there may well be a risk of causing some respiratory depression and hastening death in some measure.¹⁰² Herman, given the depth of his emotional suffering, is hoping that the analgesics will indeed do more than mitigate pain and that they will accelerate his dying process.

In this section, we discuss the criminal law principles that sometimes justify administration of risky analgesics. Our analysis rejects the conventional wisdom that the

99. The term "analgesics" is employed here as a shorthand for the variety of substances, including opioids and barbiturates, that may be used to ease patients' pain and suffering during a dying process.

100. See, e.g., AMA OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, OPINIONS 2.18 AND 2.20 (1998–1999); Nathan I. Cherny et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. PALLIATIVE CARE 71, 72 (1994); *State v. Naramore*, 965 P.2d 211, 213 (Kan. Ct. App. 1998).

101. See Deborah C. Hinnant, *Do Opioids Hasten Death?* 95 AM. J. NURSING 61, 61 (1995); NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 39, 162 (1994) [hereinafter NYSTF REPORT]; Howard Brody, *CID v. Washington, Promoting Dangerous Myths in Terminal Care*, II BIO LAW S154, S156 (1996); Marcia Angell, *The Quality of Mercy*, 306 N. ENG. J. MED. 98, 99 (1982).

102. See Cherny et al., *supra* note 100, at 337; Frank J. Brescia, *Killing The Known Dying: Notes of a Death Watcher*, 65 J. PAIN & SYMPTOM MGMT. 337, 338 (1991); Thomas A. Cavanaugh, *The Ethics of Death-Hastening or Death-Causing Palliative Analgesic Administration to the Terminally Ill*, 12 J. PAIN & SYMPTOM MGMT. 248 (1996).

physician's specific intent to relieve pain always serves as an exculpation from any responsibility for death. In its place, we develop a more nuanced framework for responsibility based on the potential risk and reward of particular analgesic uses in the context of the individual patient's situation. This framework is grounded in principles of recklessness that allow justification for some risk taking. Our risk/reward framework not only rejects the simplistic specific intention solution to physician liability but also provides the criminal law answer to any situation in which risky analgesics are contemplated. The framework confirms the legality of using risky analgesics as commonly done within a palliative regimen. However, a risk/reward framework makes it highly unlikely that a physician could justify a dose of analgesics that is *known* to be lethal, despite comments by a few Supreme Court justices and hints in a few professional standards suggesting that such conduct might be licit.

When a terminal patient is given risky analgesics, causation is always an issue. It is very difficult to establish that analgesics hastened a dying process when critical natural pathologies were already afflicting the debilitated, terminally ill patient.¹⁰³ In the rare instances when health care providers have been accused of criminal behavior in using analgesics, the prosecutions or attempted prosecutions have usually foundered on the difficulty of showing that the substances in fact hastened death.¹⁰⁴ Even

103. Brief of Choice in Dying, *amicus curiae*, at 11, *Vacco v. Quill*, 521 U.S. 793 (1997) (No. 95-1858). See generally Phebe Saunders Haugen, *Pain Relief for the Dying: The Unwelcome Intervention of the Criminal Law*, 23 WM. MITCHELL L. REV. 325, 354-56 (1997) (discussing cases wherein defendants were acquitted because the prosecution was unable to prove causation).

104. See Brian Bergman, *The Final Hours: Does a Doctor Have a Right to End a Patient's Life?*, MACLEAN'S, Mar. 9, 1998, at 46 (discussing case wherein Judge ruled there was insufficient evidence to try a respirologist for the murder of one of her patients); Donald G. Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 127, 128 n.4 (1990); Maureen Cushing, *Causes of Death: Drug or Disease?*, 83 AM. J. NURSING 943, 944 (1983); see also *Regina v. Cox*, 12 BMLR 38 (1992), LEXIS (discussing a British doctor who administered potassium chloride to a dying patient and was prosecuted for attempted murder, not murder, because of the difficulty of showing causation). But see *State v. Naramore*, 965 P. 2d 211 (Kan. Ct. App. 1998) (reversing conviction of physician on grounds that evidence did not support jury's finding that defendant had requisite mens rea); Haugen, *supra* note 103, at 354-56 (describing instances wherein defendants have been acquitted in jury trials although they admit to having administered what might

if the chances of prosecution are negligible, however, health care providers should understand the legal bounds of risky pain relief. Understanding those bounds will help determine whether the law is sensibly and consistently treating end-of-life medical practices.

Assume that in response to Herman's request, a physician sets up a morphine drip dispensing 2 milligrams per hour into Herman's body. Assume also that Herman dies 3 days later (rather than the projected 2 to 3 months later) and that the morphine can be established as either a sole or contributing cause of death. Has Herman's physician acted in the finest tradition of palliative medicine or should she be facing a criminal homicide charge?

Notice that this scenario is significantly different from the previous scenario involving withdrawal of a ventilator. In the present scenario, lung cancer has not simply been allowed to follow its natural lethal course. The physician has introduced a lethal agent (morphine) that hastened death, and it has been black-letter criminal law for centuries that the acceleration of death is homicide. Notice also a difference from the scenario involving VSED. There, Herman merely invoked bodily integrity and refused all forms of nutrition. He asked that medical personnel then take modest steps to ease his self-initiated dying process. Here, Herman enlisted active medical participation in the death-hastening conduct (the morphine drip).

Many sources would assert that Herman's physician, acting with the object of easing Herman's unbearable pain, engaged in sound medical practice by setting up the morphine drip. Yet that conduct significantly hastened Herman's death. Usually, killing a patient, even a grievously suffering patient who requests death as a form of relief, is criminal homicide. Glanville Williams, an eminent authority on criminal law, comments on euthanasia (mercy killing) as a form of criminal homicide: "Neither the consent of the patient, nor the extremity of his suffering, nor the imminence of death by natural causes . . . is a defense."¹⁰⁵

otherwise be lethal doses of analgesics); Francis A. Molenda, *Active Euthanasia: Can It Be Justified?*, 24 TULSA L.J. 165, 187 (1988); Richard H. Nicholson, *A Quick and Painless Death*, 23 HASTINGS CENT. REP. 5 (1993) (reporting the conviction of a rheumatologist for criminal homicide based on administration of chemical substances to dying patients). See generally Alpers, *supra* note 41, at 311-15 (summarizing outcomes of criminal investigations during the 1990's).

105. GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 319

American jurisprudence generally subscribes to this principle; neither relief of suffering nor the victim's request justifies a killing.¹⁰⁶ If relief of a patient's suffering is not a sufficient justification for a killing, how can Herman's physician be exonerated for the fatal morphine drip?

Some sources contend that there is no significant difference between euthanasia and the physician's use of risky analgesics prompting death. Indeed, a common argument of proponents of legalizing active euthanasia is that euthanasia has already been tacitly accepted in the guise of risky pain relief.¹⁰⁷ For reasons to be explained, we do not equate euthanasia with risky pain relief, and we find a plausible basis for distinguishing the two. Before that explanation, however, we address and repudiate the common rationale used to distinguish the legality of risky pain relief from the illegality of euthanasia—the asserted distinction between intent to relieve suffering and intent to kill.

The popular wisdom is that analgesics that risk accelerating death are lawful so long as the physician's primary intent is to reduce suffering rather than to cause death.¹⁰⁸ In *Vacco v. Quill*, Chief Justice Rehnquist's majority opinion noted: "It is widely recognized that the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death if the medication is intended to alleviate pain and severe discomfort, not to cause death."¹⁰⁹ The premise behind this assertion is that, for criminal law purposes, causing death as an unintended side effect (of providing pain relief) is different from intentionally causing death. This rationale attempts to transfer the double effect

(1957).

106. See *Turner v. State*, 108 S.W. 1139, 1141 (Tenn. 1908); *Edinburgh v. State*, 896 P.2d 1176, 1180 (Okla. Crim. App. 1995); *Griffith v. State*, 548 So.2d 244, 247 (Fla. Dist. Ct. App. 1989).

107. See Stephen A. Newman, *Euthanasia: Orchestrating the Last Syllable of Time*, 53 U. PITT. L. REV. 153, 175 (1991).

108. See Haugen, *supra* note 103, at 351; Keown, *supra* note 2, at 258; Miriam K. Feldman, *Pain Control in Dying Patients, How Much is Too Much?*, 73 MINN. MED. 19, 21 (1990); Casswell, *supra* note 104, at 129; Cornelius J. van der Poel, *Ethical Aspects in Palliative Care*, AM. J. HOSPICE & PALLIATIVE CARE 49, 54-55 (1996).

109. 521 U.S. 793, 808 n.11 (1997) (quoting the NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE IN THE MEDICAL CONTEXT* 108, 163 (1994)).

principle of moral philosophy to the criminal law context.¹¹⁰ The effort is neither logically convincing nor consistent with prevailing criminal law doctrine.

Using the palliative care provider's specific intent as the main determinant of culpability is highly problematic in the context of end-of-life palliative care. For starters, specific intent is largely indeterminable in this context. Patients like Herman Michelle are gravely debilitated and suffering grievously to the point where they may well be desirous of death. In this situation, even the provider who administers an only slightly risky analgesic dosage¹¹¹ may harbor an intent to put the patient out of his misery by accelerating death.¹¹² On the other hand, even a physician who knows that an analgesic dosage necessary to relieve suffering will precipitate death might still have a primary object of relieving suffering. Also, as Alan Meisel points out, a provider might possess more than one intent, including both relief of suffering and causation of death.¹¹³ The elusiveness of specific intent in this context is thus patent. The 1983 President's Commission for the Study of Ethical Problems in Medicine noted that the spectrum of possible purposes behind administration of risky analgesics entails "substantial potential for unclear or contested determinations."¹¹⁴ Accordingly, the Commission concluded that the theoretical distinction between intending death

110. See generally Cavanaugh, *supra* note 102, at 248; Stephen R. Latham, *Acquinas and Morphine: Notes on Double Effect at the End of Life*, 1 DEPAUL J. HEALTH CARE LAW 625 (1997); Patrick F. Norris, *Palliative Care and Killing: Understanding Ethical Distinctions*, 13 BIOETHICS FORUM 25 (1997) (discussing the moral philosophy underlying the double effect principle).

111. A physician might intend to cause death but use an only slightly risky dosage in order to avoid detection.

112. See Timothy Quill, *The Ambiguity of Clinical Intentions*, 329 N. ENG. J. MED. 1039 (1993). Even staunch defenders of the double effect principle in the palliative care context concede the possibility that the palliative care provider might intend to cause death. See Robert Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 NEW ENG. J. MED. 1678, 1680 (1992); Cavanaugh, *supra* note 102, at 252; Norris, *supra* note 110, at 27. One such defender observes: "The pain-medicating physician would then be a euthanist in disguise." Latham, *supra* note 110, at 643. See Paul J. van der Mass, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 THE LANCET 669, 672 (1991).

113. See Meisel, *supra* note 15, at 835.

114. *Deciding to Forego Life-Sustaining Treatment*, in PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MED. AND BIOMED. AND BEHAVIORAL RESEARCH 78 (1983) [hereinafter PRESIDENT'S COMMISSION].

and merely foreseeing death as a consequence “does not help.”¹¹⁵

Given the indeterminability of specific intent in this context, hinging culpability on such intent (where the impetus is strong to hasten a patient’s torturous dying process) encourages a hypocritical practice. The palliative care provider either strains to keep his or her mind off what may be the real objective of hastening death or later simply asserts that his or her mind was so tuned. Some commentators contend that providers commonly give large, dangerous dosages of analgesics with the intent not just to mitigate suffering but to bring about a quicker death.¹¹⁶ If challenged, the provider will assert that the primary intention was to relieve suffering. The provider’s protestation that he or she is only intending to ease suffering is then seen as a “fig leaf” for euthanasia¹¹⁷ or, as one physician puts it, euthanasia “hidden by the cosmetics of professional tradition and language.”¹¹⁸ The temptation of self-deception and deception of others is indeed powerful where a physician strongly desires to relieve a patient’s extreme and persistent suffering and that result is attainable by hastening death (via analgesics) while claiming an inherently unknowable mental state (viz., stating an intention merely to relieve suffering).¹¹⁹ In

115. *Id.* at 81-82, (exposing an alternative approach to risky analgesics based on the justifiability of pain relief practices as determined in part by professional norms). That approach parallels the approach presented in this article.

116. See Marcia Angel, *No One Trusts the Dying*, THE WASHINGTON POST, July 7, 1997, at A19; Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. TIMES, Nov. 1, 1994, at A27. The actual incidence of such physician conduct is unknown, but, anecdotal reports of such conduct are readily available. See, e.g., Ronald E. Cranford, *Going Out in Style, the American Way*, 17 L. MED. & HEALTH CARE 208 (1989); Mark Austen, *Doctor Admits Killing 50 People*, SUNDAY TIMES (LONDON), July 20, 1997 (discussing doctor’s admission of having helped at least 50 people to hasten their death); Sebastien Berger, *We Helped 200 People to Die, Say Doctors*, DAILY TELEGRAPH (U.K.), July 21, 1997, at 1 (discussing physicians’ admission to having administered overdoses of diamorphine to help 200 patients die).

117. Truog et al., *supra* note 112, at 1680; Brief for Coalition of Hospice Professionals, *amicus curiae*, at 14, *Washington v. Glucksberg*, 521 U.S. 702 (1997) (No. 96-110).

118. Preston, *supra* note 116.

119. See DAVIS, *supra* note 26, at 118 (describing a similar impetus for physicians to shape their descriptions of their own state of mind in the context of withdrawal of life support).

addition, specific intent does not trigger criminal liability in end-of-life practices.¹²⁰ For example, in the context of withdrawal of life support, a provider's specific intent to bring about the patient's death would not make criminal the act of fulfilling a competent patient's wishes.¹²¹

Our position is that the legality of using risky analgesics is determined not so much by the specific intent of the provider, but by standard criminal law principles of recklessness and justification. In a previous article, we explained:

The question of criminal liability for risky pain relief normally cannot be resolved by reference to the physician's purpose—i.e., the conscious object or result sought by his or her action. Purpose does not map the criminal law boundary between crimes and non-crimes because a good purpose (a conscious object to achieve a good result) does not necessarily exculpate, and an evil purpose (a conscious object to cause death) is not required to prove criminal homicide. First, as a matter of exculpation, the purpose to relieve pain does not justify euthanasia. . . . The uniform judicial position in the United States that euthanasia is always unjustified homicide reflects a view that pain relief can never outweigh the harm of purposely causing a premature death. Second, as a matter of inculpation, a purpose to kill is not required for homicide. A reckless state of mind is sufficiently culpable to prove murder or manslaughter under the MPC. . . . Thus, actions taken with a conscious disregard of the risk of death can, in some

120. The specific intent element is even more problematic for people who maintain that pain relief must be the only object of the actor, not just the primary intention. In effect, the physician cannot harbor even a secondary intention to bring about the patient's death. See Emanuel, *supra* note 9, at 495-97. Such purity of thought is a difficult concept both in theory and practice. See Haugen, *supra* note 103, at 351 n. 182.

121. *But see* Daniel Sulmasy, *Killing and Allowing to Die: Another Look*, 26 J.L., MED. & ETHICS 55, 59-60 (1998) (arguing that a physician is acting unethically or improperly if the physician's specific intent at the moment of withdrawing life support is to end the patient's life). However, as a legal matter, the physician is implementing the patient's right to have treatment withdrawn. Indeed, to refuse the competent patient's request for withdrawal would entail a legal battery. Because continued medical intervention against a competent patient's will would constitute a battery, an attending physician has a duty to remove the unwanted intervention. The physician's intent in discharging that legal duty is irrelevant. See Latimer, *supra* note 41, at 334. Not surprisingly, cases addressing the legality of withdrawal of life support tend not to discuss the physician's state of mind. See *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. App. 2 Dist. 1986); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989); *In re Farrell*, 529 A.2d 404 (N.J. 1987); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990).

circumstances, result in liability for homicide . . . [I]f recklessness is otherwise established, proof that the actor's primary object was to relieve pain would not justify the reckless conduct in issue.¹²²

Under a recklessness framework, the issue shifts from the physician's specific intent to whether the risk created by the analgesics is justified. To justify the risk, several conditions must be met.¹²³ The patient must be grievously suffering because relief from unendurable pain furnishes the benefit that justifies risking death.¹²⁴ The patient must make an informed request and the analgesic dosage used must be the safest means of relieving the patient's suffering. This effectively means that dosage must start with a level thought to be safe and must be escalated only as necessary. The requirement of using only the dosage necessary for effective pain relief stems from the notion that conduct risking human life must be genuinely necessary in order to be justified in law.¹²⁵ Medical professional norms also help shape the legal determination of justifiable conduct, and good palliative care practice demands careful analgesic administration. Most medical authorities indicate that as a prerequisite to risky analgesics there should be no less harmful pain relief method available and the dosage should be titrated upward on an as needed basis.¹²⁶ Study commission reports¹²⁷ and a

122. Norman L. Cantor & George C. Thomas III, *Pain Relief, Acceleration of Death, and Criminal Law*, 6 KENNEDY INST. ETHICS J. 107, 110-11 (1996).

123. For a detailed analysis of the concept of recklessness under Section 202(2)(c) of the Model Penal Code, see *id.* at 111-13.

124. See Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms, Guidelines for Evaluation and Treatment*, 10 J. PALLIATIVE CARE 31, 36 (1994).

125. See Margaret A. Somerville, *Pain and Suffering at Interfaces of Medicine and Law*, 36 U. TORONTO L.J. 286, 309 (1986) (arguing that when risky pain relief treatment is "the only reasonably effective means available to relieve the pain," it may be characterized as necessary and defensible).

126. See, e.g., Nathan I. Cherny & Kathleen Foley, *Nonopioid and Opioid Pharmacotherapy of Cancer Pain*, 10 HEMATOLOGY/ONCOLOGY CLINICS OF NORTH AMERICA 79, 82, 92, 94 (1996); Russell K. Portenoy & Nessa Coyle, *Controversies in the Long-Term Management of Analgesic Therapy in Patients with Advanced Cancer*, 5 J. PAIN & SYMPTOM MGMT. 307, 311 (1990); Brody, *supra* note 8, at 947; William R. Greene & William H. Davis, *Titrated Intravenous Barbiturates in the Control of Symptoms in Patients with Terminal Cancer*, 84 SO. MED. J. 332 (1991); see also Robyn S. Shapiro, *Liability Issues in the Management of Pain*, 9 J. PAIN & SYMPTOM MGMT. 146, 149-50 (1994) (discussing pain control versus euthanasia).

127. See House of Lords Select Committee para. 242 reprinted in JOHN

few state statutes¹²⁸ reinforce the contention that conformity to such sound medical practice is a prerequisite to lawful use of risky analgesics.

Statutes in some states might, at first blush, seem to undercut our insistence that specific intent does not determine the legal limits of pain relief administration. States that have adopted explicit bans on assistance to suicide in the last ten years commonly include a provision clarifying that when a physician supplies pain relief medication that may hasten death, she is not assisting suicide unless the medication is intended to cause death. Indiana law is typical and specifies that its criminal prohibition on assisted suicide does not apply to:

A licensed health care provider who administers, prescribes, or dispenses medication or procedures to relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death.¹²⁹

In large measure, such a statutory provision merely confirms our earlier point—that aiding and abetting culpability is generally confined to people acting with specific intent. Thus, it is unsurprising and unexceptionable that statutes punishing assisting suicide require specific intent. However, the same statutes mention a physician who “administers” pain relief medication that may hasten death. The claim might then arise that these provisions signal a legal immunity, including protection against homicide charges, for any physician who administers lethal

KEOWN, EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 103 (1995); PRESIDENT'S COMMISSION STUDY, *supra* note 114, at 79-81; NYSTF REPORT, *supra* note 101, at 150, 164.

128. See ARIZ. REV. STAT. ANN. § 13-3412.01 (West 1997) (requiring a prescribing physician to meet “professional medical standards”); FLA. STAT. ch. 458.326(3) (1995) (demanding conformity to a level of care of “a reasonably prudent physician”).

129. IND. CODE ANN. § 35-42-1-2.5(a)(1) (Michie 1998); see also IOWA CODE ANN. § 707A.3(1) (West Supp. 1996); KAN. STAT. ANN. § 60-4403(a) (Supp. 1998); KY. REV. STAT. ANN. § 216.304 (Banks-Baldwin 1995); LA. REV. STAT., § 14:32.12 (West 1997); MD. CODE ANN. § 416 (April 1999); MICH. COMP. LAWS ANN. § 752.1027 (West 1994); MINN. STAT. ANN. § 609.215(3) (West Supp. 1994); N.D. CENT. CODE § 12.1-16-06 (1992); OKLA. STAT. ANN. tit. 63, § 3141.4 (West 1998); R.I. GEN. LAWS §11-60-4 (1994); S.D. CODIFIED LAWS § 22-16-37.1 (Michie 1997); TENN. CODE ANN. § 39-13-216 (Supp. 1993); VA. CODE ANN. § 801-622.1 (Michie 1998).

analgesics without the primary intent to cause death.

We strongly doubt that these statutory provisions in fact make primary intent the key to criminal culpability for administration of risky analgesics. The provisions on their face relate to assisting suicide and not homicide. However, it is homicide that is potentially implicated where a substance administered by a health care provider accelerates a patient's death. Moreover, these provisions make no mention of other highly relevant medical practice factors such as the nature of the suffering necessitating pain relief, maximum tolerable risk of death, and graduated dosages. In other words, these statutes do not track the elements of good medical practice that would shape allowable pain relief practice.¹³⁰ Finally, these recent provisions exist in only twelve states and have never been judicially interpreted. We suspect that even in these jurisdictions principles of recklessness shape the bounds of criminal homicide responsibility for analgesics hastening death.

Our suggested recklessness framework conforms to common understandings about the justifiability of risk taking in medical practice. A risky surgery, such as a heart by-pass operation, is justified if it offers a substantial gain in the patient's longevity or quality of life, but reckless if the prospective gain to the patient is modest compared to the accompanying risk of death.¹³¹ Similarly, use of an analgesic carrying some risk of hastening death can be justified if this is the only means of relieving a patient's grievous suffering. As noted, good palliative care practice appears to conform to the principle that a risky analgesic is justifiable only where it is the least dangerous means of accomplishing the pain relief objective.

How is it that euthanasia is unlawful if it is permissible to use risky analgesics in order to relieve grievous

130. See generally ARIZ. REV. STAT. ANN. § 13-3412.01 (West 1997); FLA. STAT. ch. 458.326 (1997) (speaking more generally to permissible pain relief practices without special reference to assisted suicide); VA. CODE ANN. § 54.1-2907.01 (Michie 1998); VA. CODE ANN. § 54.1-3408.1 (Michie 1998). These provisions seem to stress physician good faith and conformity to professional standards of practice.

131. "It is one thing for a doctor to perform neurosurgery to remove a malignant tumor, even though the operation may prove fatal; quite another to perform it merely because the patient has a headache." Keown, *supra* note 2, at 259.

suffering? Frances Kamm asks: if pain relief is a greater good (than preserving life) when analgesics are used, "why may we not intentionally deprive someone of life when . . . that death is the lesser evil?"¹³² Our response is grounded in the recklessness framework that tolerates risk taking while precluding conduct that the actor knows will cause death. In other words, awareness of the certainty of death helps explain the current legal line between euthanasia and use of risky analgesics. As in other areas of medical practice, it is justifiable to take risk in using analgesics in order to mitigate a patient's grievous suffering. However, if a physician knows that a dosage of analgesics will certainly or almost certainly cause death, the act is done knowingly and fits within the prohibition of criminal homicide.¹³³ As an analogy, consider an organ transplant operation from a living donor with the objective of saving an ill patient's life. A surgeon may be authorized to transplant a kidney with the attendant minor risk to the donor, but would be forbidden to transplant a heart because that operation would certainly kill the donor. In short, euthanasia involves conduct that will certainly or almost certainly cause death. Permissible use of risky analgesics involves conduct that carries a risk of death that is less than "practically certain."¹³⁴

132. Frances M. Kamm, *The Doctrine of Double Effect: Reflections on Theoretical and Practice Issues*, 16 J. MED. & PHIL. 571, 579 (1991).

133. See MODEL PENAL CODE § 2.02 (stating that an actor's conduct will be "knowing" if the result [death] is "practically certain"); see also Donald Casswell, *Rejecting Criminal Liability for Life-Shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POLICY 127 (1990). For purposes of the Model Penal Code, as well as the common law, there is no distinction in culpability between acting with the knowledge that one will cause death and acting with the conscious object to cause death. There is little difference between these states of mind. Criminal homicide can also be committed recklessly when the actor consciously disregards a substantial risk of death and that conscious disregard is not justifiable. Of course, in the context of risky pain relief, as we have argued, a substantial risk of death will often be justified as the best way to relieve grievous suffering and thus not be criminally reckless. See generally Cantor & Thomas, *supra* note 122.

134. The Model Penal Code concludes that an actor acts "knowingly" with respect to a result of his conduct when "he is aware that it is practically certain that his conduct will cause such a result." MODEL PENAL CODE § 2.02(2)(b)(ii). Sometimes, to avoid an awkward sentence construction, we use "almost certainly" or "certainly" but in every case we mean to reference the Model Penal Code standard of awareness that death "is practically certain" to occur.

We contend that this distinction between use of risky analgesics and euthanasia—based on risk taking as opposed to awareness of certainty of consequences—is logically tenable.¹³⁵ Within this framework, a physician may legally use an analgesic carrying a substantial risk of death as long as the use of the analgesic is justified—i.e., as long as the pain is unrelenting and unbearable, the dosage is the least dangerous medical treatment that can achieve pain relief, and the risk of death is not too great.

What do we mean by a risk of death that is not “too great”? Fixing a maximum percentage chance of death beyond which the use of risky analgesics cannot be justified is a difficult legal and philosophical problem. Use of a dosage that would be certain or practically certain to cause death constitutes a knowing killing and cannot, we contend, be justified under the prevailing criminal law framework.¹³⁶ On the other hand, use of a dosage that poses only a substantial risk could be justified.

To see the difference between disregard of a substantial risk and awareness that death is practically certain, consider a dosage that creates an 80% probability of death and one that creates a 99% risk of death. Is it possible to distinguish the administration of these dosages, both of

135. Some people might insist that if relief of suffering is a legally sufficient justification for risky pain relief it ought to be a justification for euthanasia as well. See, e.g., WILLIAMS, *supra* note 105, at 322-23; Kamm, *supra* note 132, at 577-81. That is a plausible position as a matter of public policy. See footnotes 250-64, 269-88, and 304-17 and accompanying text for further discussion of public policy *vis à vis* euthanasia and physician-assisted suicide. But that position is not logically compelled. A rational legislator could think that knowing or intentional killing, even for a worthy reason such as pain relief, is more heinous than behavior merely risking death. Phrased differently, a worthy object such as relief of suffering might warrant risk taking even though it would not warrant an intentional or knowing killing (recall the example of a kidney donation as opposed to a heart donation).

Yale Kamisar, a distinguished opponent of active euthanasia, found our analysis of how use of risky analgesics contrasts to euthanasia to be “quite persuasiv[e].” Kamisar, *The Right to Die*, *supra* note 19, at 499-500; see also Howard Brody, *Commentary on Billings & Block’s “Slow Euthanasia,”* 12 J. PALLIATIVE CARE 38, 39 (1996) (endorsing risky analgesics that carry only a “finite risk” of hastening death); Fr. Robert Barry & James E. Maher, *Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles*, 6 ISSUES IN L. & MED. 117, 140 (1990) (differentiating between risking death and causing death).

136. The Model Penal Code permits only narrow and special justifications when the act of killing is knowing or purposeful. Examples include, self-defense, defense of others, or reacting to a natural disaster in a way that saves more lives than are lost.

which create a high probability of death? We believe that a difference in kind exists here. The physician who is not aware that the dosage is practically certain to cause death—the one who gives the 80% dosage—can at least hold out a realistic hope that the analgesic will not kill. Any doctor who is practically certain could not have this realistic hope. As long as a doctor has a realistic hope that the treatment is both life affirming and the best means of providing pain relief, the conduct does not pose the same threat to the sanctity of life principle that underlies much American jurisprudence. We believe that the doctor who says “I created a high probability of death but realistically hoped that the dose would not kill” is less culpable than the doctor who says, “I knew the dose would kill.”

Isolated language from concurring opinions in the recent Supreme Court cases on assisted suicide casts doubt on our risk-based analysis of the legality of hastening death via analgesics. That language suggests that use of analgesics is lawful even if the administering health care provider *knows* that the analgesic will hasten death. By contrast, we argue that analgesic administration is not legally justifiable where death is a certain or practically certain consequence—i.e., where the actor’s conduct is either purposeful or knowing.¹³⁷ In *Washington v. Glucksberg*, Justice Souter states that Washington State “generally permits physicians to administer medication to patients in terminal conditions when the primary intent is to alleviate pain, *even when the medication is so powerful as to hasten death* and the patient chooses to receive it with that understanding.”¹³⁸ Justice O’Connor’s concurring opinion in *Vacco v. Quill* represents that the parties before the Court agreed as follows:

137. See *supra* notes 132-33 and accompanying text.

138. *Washington v. Glucksberg*, 521 U.S. 702, 780 (1997) (emphasis added). Justice Souter relies primarily on a Washington statute. See WASH. REV. CODE § 70.122.010 (1997). This statute does not explicitly authorize the result that Justice Souter proclaims. The measure is part of the introductory “findings” to Washington’s Natural Death Act. It expresses a legislative “belief” that providers should not withhold pain medication for terminal patients “where the primary intent . . . is to alleviate pain . . .” *Glucksberg*, 521 U.S. at 780. This language does not necessarily authorize an analgesic dosage certain or practically certain to cause death, though Justice Souter may have been reading it so.

[A] patient who is suffering from terminal illness and who is experiencing great pain has no legal barriers to obtaining medication from qualified physicians to alleviate that suffering, *even to the point of causing unconsciousness and hastening death*. . . . There is no dispute that dying patients in Washington and New York can obtain palliative care *even when doing so would hasten their deaths*.¹³⁹

Justice O'Connor's use of "would" rather than "might" implies the legality of analgesics that would be practically certain to bring about death.

Justice Breyer gives mixed signals about his understanding of the legal status of risky pain relief. At one point in both *Glucksberg* and *Quill*, he observes that state law authorizes analgesic drugs despite "the risk that those drugs themselves will kill."¹⁴⁰ That language is consistent with our risk-based analysis of analgesic usage. However, Justice Breyer later comments that he would reconsider his attitude (accepting the constitutionality of bans on assisted suicide) if a state barred pain relief "as needed" in end-of-life palliative care.¹⁴¹ That language could be read consistently with Justices Souter and O'Connor as endorsing a practice of using analgesics even when death is a certain or practically certain result, so long as such analgesics are necessary to achieve pain relief.

To the extent that these excerpts from concurring opinions by Justices Souter, O'Connor, and Breyer suggest that analgesics can be licitly used even when death is a certain or practically certain result, they probably reflect a misconception of the state of the law derived from a too ready acceptance of what some parties and amici curiae before the Court declared in the litigation.¹⁴² Carefully

139. *Vacco v. Quill*, 521 U.S. 702, 736-38 (1997) (emphasis added). Justice O'Connor relies on the Washington Revised Code statute cited by Justice Souter (see *supra* note 138) and also on New York's brief. Neither of those sources fully supports the contention that risky analgesics are lawful even when death is a certain consequence of their administration.

140. *Glucksberg*, 521 U.S. at 791 (Breyer, J., concurring) (emphasis added). Justice Breyer relies on the New York State Task Force on Life and the Law's 1995 report. There, the Task Force says "pain medication is ethically and professionally acceptable even when the treatment *may* hasten the patient's death . . ." NYSTF REPORT, *supra* note 101, at 163.

141. *Glucksberg*, 521 U.S. at 792 (Breyer, J., concurring).

142. Among the dozens of briefs submitted to the Court by parties or amici curiae, a few did suggest that use of analgesics would be licit even if death were a certain or practically certain consequence. None of them, however, made a

analyzed, neither presentations before the Supreme Court nor dicta in the concurring opinions in the assisted suicide cases establish that the law tolerates analgesics in dosages known to be lethal.

As to the actual state of the law when a doctor knows an analgesic dosage to be practically certain to cause death, precedent is scarce but several factors support our risk-based analysis (under which use of an analgesic certain to

convincing case for that proposition. Respondents asserted that petitioner (New York State Attorney General Dennis Vacco) had “conceded” that physicians may administer analgesics intended to relieve suffering “even with the foreseeable effect, indeed, the overwhelming likelihood, of causing death.” Respondent’s Brief at 15, *Vacco* (No. 95-1858). Yet the cited portion of Vacco’s brief made no such concession, merely describing, as legal, palliative treatment intended to relieve suffering where “death may be a possible side effect.” Petitioner’s Brief at 15 n.9, *Vacco* (No. 95-1858). Similarly confused interchanges occurred at oral argument. Laurence Tribe, arguing on behalf of Respondent Quill, asserted that palliative medication is licit “even when you [a physician] are pretty sure—or even when you know . . . that it will hasten . . . death.” Oral argument at 44, *Vacco* (No. 95-1858). When Justice O’Connor questioned Attorney General Vacco about the legality of palliative care certain to hasten death, he made a cryptic reply indicating that the conduct would be lawful in New York “even though there is a *risk* of death.” Oral argument at 21, *Vacco* (No. 95-1858).

Among the amici curiae briefs, a few—all without substantial reference to authority—contended that palliative care would be permitted even if such care would almost certainly hasten death. The Solicitor General’s brief for the United States as amicus curiae represented that “ethical standards” of medical practice allow pain relief medication “even when the necessary dose *will* hasten death.” (emphasis added). Brief of the United States, *amicus curiae*, at 17, *Glucksberg* (No. 96-110). Solicitor General Walter Dellinger made a similar representation at oral argument. *See* oral argument at 25, *Glucksberg*, (No. 96-110). The Solicitor General’s brief cited as authority only the AMA Code of Medical Ethics. Yet the AMA’s own amicus brief, joined by numerous medical professional organizations, appears to take a different position—indicating that pain relief medication can be used only where such medication “might hasten death” or “may foreseeably hasten death.” Brief for the American Medical Association, et al. at 19, *Glucksberg* (No. 96-110). Three other amicus briefs suggest that palliative care is permissible even in doses that are almost certainly lethal, but again without convincing authority. Brief of ACLU, *amicus curiae*, at 2, *Vacco* (No. 95-1858); Brief of Gay Men’s Health Crisis, *amicus curiae*, at 28, *Glucksberg* (No. 96-110); Brief of Dr. Julian Whitaker, *amicus curiae*, at 4, *Glucksberg* (No. 96-110). One of them erroneously cites as authority our 1996 article on the subject of risky pain relief—an article that in no way suggests the legality of dosages that are certain or practically certain to cause death. Other amicus briefs that speak to the issue of hastening death via analgesics appear to endorse only medication that risks death or “may cause death.” Brief of the Catholic Health Assoc. of the United States, *amicus curiae*, at 17-18, *Vacco* (No. 95-1858); Brief of Bioethics Professors, *amicus curiae*, at 18, *Vacco* (No. 95-1858).

be lethal is impermissible). A number of commentators on the legal status of analgesics concur that use of a dosage known to be lethal must be impermissible.¹⁴³ Part of this commentary is based on the artificiality of saying that an actor does not intend to cause death when death is foreseen as a practically certain consequence of an act.¹⁴⁴ We do not rely on this assertion that an actor who knows a consequence is certain must intend to produce that consequence. We noted earlier the problematic nature of determining a physician's specific intent when a dying, grievously suffering patient is seeking final relief from pain.¹⁴⁵ Also, as a person is generally presumed to intend the natural consequences of his or her actions, there is some impetus to say that a physician intends to cause death when he or she knows that the analgesic dosage used will be practically certain to cause death.¹⁴⁶ However, it is at least possible for a physician to have a primary intention of relieving suffering even when the physician knows that death is a certain or practically certain consequence of an analgesic dosage.¹⁴⁷ In a 1992 British prosecution of a doctor for administering a lethal dosage of potassium chloride to a

143. See Somerville, *supra* note 125, at 309; Barry & Maher, *supra* note 137, at 135, 139, 148; Donald B. Marquis, *Four Versions of Double Effect*, 16 J. MED. & PHIL. 515, 523, 529 (1991).

144. See Barry & Maher, *supra* note 135, at 148. "Can one withhold intending that which one knows in fact will occur?" RAYMOND G. FREY, INTENTION, FORESIGHT, AND KILLING, IN INTENDING DEATH 69 (T. Beauchamp ed., 1996). *But see* John Finnis, *Euthanasia, Morality, and Law*, 31 LOY. L.A. L. REV. 1123, 1129 (1998) (maintaining that even results known to be certain are not necessarily intended).

145. See *supra* notes 113-23 and accompanying text. In one prosecution of a physician for administering a lethal substance to a dying patient, the defendant's counsel commented on the problematic nature of specific intent: "[T]he line . . . between a primary purpose to alleviate pain which may, or even will, incidentally cause death and, on the other hand, a purpose to kill which may—for however short a time—incidentally alleviate suffering, is so finely and subtly drawn as to be incapable of sensible application [by practitioners]." *Regina v. Cox*, 12 BMLR 38 (1992), LEXIS at *10. Justice Stevens also noted "the illusory character" of intention in this context. *Glucksberg*, 521 U.S. at 751 (Stevens, J., concurring).

146. See Marquis, *supra* note 143, at 523 (arguing that when a consequence is certain or almost certain it must be deemed to have been intended in some sense).

147. By analogy, a person can expect death from a course of conduct yet not intend that death occur. Lance Stell gives the example of a Jehovah's Witness declining a critical blood transfusion. Stell, *supra* note 6, at 11; see also Finnis, *supra* note 144.

dying, suffering patient, the judge's instruction allowed for the possibility that the doctor's primary intention was to relieve suffering, "[g]iven that the injection had the effect of alleviating suffering as [the patient] died . . ." ¹⁴⁸ Thus, specific intent to kill is not inevitably present even when a lethal dose of painkillers is knowingly used.

While we do not argue that specific intent to kill necessarily accompanies use of a lethal or almost certainly lethal analgesic dosage, we still contend that any legal distinction between intentional and knowing use of a lethal dose of painkillers is untenable. Either mental state will sustain a criminal homicide conviction under the Model Penal Code. Glanville Williams described how criminal law encompasses both intentional and knowing conduct: ¹⁴⁹

There is no legal difference between desiring or intending a consequence as following from your conduct, and persisting in your conduct with a knowledge that the consequence will inevitably follow from it, though not desiring that consequence. When a result is foreseen as certain, it is the same as if it were desired or intended. ¹⁵⁰

If a physician uses a massive analgesic dosage intending to kill the patient or knowing that the dosage will certainly or almost certainly be fatal, she has the requisite state of mind—intentional or knowing—for criminal responsibility. ¹⁵¹

In essence, criminal law treats an intentional or knowing killing as intrinsically bad conduct even where there is a worthy reason, such as relieving suffering or even saving another person's life. As noted earlier, euthanasia is

148. *Regina*, LEXIS at *9. The jury's verdict of guilty indicated that it viewed the physician's conduct as primarily intended to cause death.

149. To collapse knowledge and purpose into a single culpability category when the actor is the one who has caused the harm is not inconsistent with our earlier argument that accomplice liability should fall only on those with a purposeful mens rea. See *supra* text accompanying notes 84-85.

150. See WILLIAMS, *supra* note 105, at 322. See *supra* notes 133-34 for our explanation of the Model Penal Code position that agrees with Williams.

Glanville Williams believed that relief of pain ought to be deemed a sufficient justification for administration of even a clearly lethal dosage of analgesics, at least where such dosage is necessary for pain relief, but he did not believe that current law authorized such a result. *Id.* at 322-24.

151. See Somerville, *supra* note 125, at 307-08, (conceding that administration of a pain relief dosage certain to cause death could be prosecuted as criminal homicide, i.e., either murder or manslaughter).

unlawful even where a competent patient has asked to be put out of her misery. As another example, it would be criminal homicide for a surgeon to remove a vital organ from a patient even if the patient so requested and even if the object was to save another person's life via a transplant.¹⁵² Even some commentators who see the philosophical doctrine of double effect, with its focus on the physician's primary intent, as informing the bounds of permissible medical behavior agree that it is illegal to administer pain relief in a dosage known to be lethal. They reach this conclusion by finding that the good effect (pain relief) is impermissibly tainted by the bad means (knowing killing of the patient).¹⁵³

Not all commentary agrees with our position. A British philosopher, John Keown, asserts that use of even a certainly lethal dosage of analgesics is defensible,¹⁵⁴ relying on the charge to the jury in the 1992 prosecution of a British doctor for injecting potassium chloride into a dying, suffering patient. There, the court instructed the jury:

It was plainly Dr. Cox's duty to do all that was medically possible to alleviate [the patient's] pain and suffering, even if the course adopted carried with it an obvious risk that, as a side effect of that treatment, her death would be rendered likely or even certain. There can be no doubt that the use of drugs to reduce pain and suffering will often be fully justified notwithstanding that it will, in fact, hasten the moment of death. What can never be lawful is the use of drugs with the primary purpose of hastening the moment of death.¹⁵⁵

152. See *In re T.A.C.P.*, 609 So. 2d 588 (Fla. 1992); Kathleen L. Paliokas, Note, *Anencephalic Newborns as Organ Donors: An Assessment of Death and Legislative Policy*, 31 WM. & MARY L. REV. 197, 207-08 (1989).

153. See Latham, *supra* note 110, at 630-31; Marquis, *supra* note 143, at 516, 534, 538.

154. "A doctor treating a terminally ill cancer patient suffering pain clearly has a sufficient justification for administering palliative drugs with the intent to ease the pain, even though a foreseeable side effect may, *or will*, be the shortening of life." Keown, *supra* note 2, at 258. (emphasis added). If a "foreseeable side effect" is that the dose *will* shorten life, Keown apparently means that the one who gives the dose is acting with the knowledge that death is a certain or practically certain consequence.

155. *Regina v. Cox*, 12 BMLR 38 (1992), LEXIS at *4. Judge Ognall's charge is grounded on a similar charge given in a 1957 British prosecution of a physician accused of killing a dying patient via analgesics. That case, *Regina v. Adams*, is described in PATRICK DEVLIN, *EASING THE PASSING: THE TRIAL OF DR.*

A few other commentators share the contention that analgesics necessary for pain relief are licit even when the dosage will certainly cause death, so long as the doctor's primary intent is to relieve suffering.¹⁵⁶

On the American scene, the principal ostensible endorsement of analgesics that would certainly or almost certainly be lethal comes from the President's Commission for the Study of Ethical Problems in Medicine. The Commission's 1983 report declares that there is "no moral or legal objection to using the kinds and amounts of drugs necessary to relieve the patient's pain"¹⁵⁷—whatever risk of death is entailed.¹⁵⁸ Nonetheless, the President's Commission (as do we) bases its analysis of permissible bounds of pain relief on justifiability grounded in professional norms of behavior that have gained social approval.¹⁵⁹ It is noteworthy, therefore, that professional norms of palliative care were not well developed as of 1983 and that the President's Commission cites no medical authority for the proposition that analgesics are permissible even in dosages practically certain to cause death.

To identify the legal bounds of risky medical behavior, it is critical to consult evolving professional standards. Unfortunately, that inquiry does not yield definitive results on the issue of whether a dosage certain or practically certain to cause death is tolerable. No professional standard aimed at end-of-life medical practice states unequivocally that risky analgesics may be used in dosages that are

JOHN BODKIN ADAMS (1985). Lord Devlin's 1957 charge indicated that a doctor may do "all that is proper and necessary to relieve pain and suffering, even if the measures . . . may incidentally shorten life. *Id.* at 171. Judge Ognall expanded Lord Devlin's 1957 description of defensible conduct by including physician action that is certain to cause death in addition to action that "may" shorten life.

156. See Casswell, *supra* note 104, at 129; Thomas A. Cavanaugh, *The Ethics of Death-Hastening or Death-Causing Palliative Analgesic Administration to the Terminally Ill*, 12 J. PAIN & SYMPTOM MGMT. 248, 253 (1996); Bernard M. Dickens, *Commentary on 'Slow Euthanasia'*, 12 J. PALLIATIVE CARE 42, 43 (1996).

157. See PRESIDENT'S COMMISSION, *supra* note 114, at 81.

158. *Id.* at 82.

159. *Id.* at 79, 81. Another study commission recently concurred in the notion that professional norms of palliative care have a significant role in shaping the legal bounds of analgesic administration. NYSTF REPORT, *supra* note 101, at 164 (asserting that "judgments about potentially risky and life-threatening interventions undertaken to cure the patient or relieve pain fall squarely within the scope of the physician's professional role.").

practically certain to cause death. To be sure, some medical sources do seem to endorse even lethal dosages where necessary for pain relief. A 1989 article by several eminent physicians comments: "Narcotics or other pain medication should be given in whatever dose and by whatever route is necessary for relief."¹⁶⁰ A few professional organizations appear to endorse that position.¹⁶¹ Other sources indicate, without documentation, that it is common practice to administer pain medication despite an awareness that the dosage will almost certainly hasten death.¹⁶² Yet even these sources do not claim that this conduct reflects a prevailing professional standard.

By contrast, most medical standards seem to speak in terms of risky analgesics that "may" hasten death or carry a "possibility" of hastening death.¹⁶³ For example, the American Academy of Neurology's position notes a "possibility" of hastening death and comments that it is "ethically permissible to risk producing this side effect" of pain medication.¹⁶⁴ The AMA appears to mirror that position.¹⁶⁵ A recent New York State Task Force report notes that "provision of pain medication is ethically and

160. Sidney Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 N. ENG. J. MED. 844, 847 (1989).

161. The Kansas Association of Osteopathic Medicine quoted the Wanzer article in its brief in *State v. Naramore*, 965 P.2d 211, 215 (Kan. Ct. App. 1998); see also Melissa L. Buchan & Susan W. Tolle, *Pain Relief for Dying Persons: Dealing with Physicians' Fears & Concerns*, 6 J. CLINICAL ETHICS 53, 55 (1995) (claiming that some professional associations believe that pain relief administration is permissible even in dosages likely to hasten death). For other clinical guidelines that are ambiguous as to whether dosages "necessary" for pain relief can include dosages practically certain to hasten death, see generally *infra* notes 168-69 and accompanying text.

162. See Brief of Gay Men's Health Crisis, *amicus curiae*, at 28, *Vacco* (No. 95-1858); Angell, *supra* note 116; Preston, *supra* note 116, at A27.

163. Howard Brody observes that the current ethical roadmap permits analgesic administration for terminally ill patients even if the dosages required approach levels that *might* hasten death. See Brody, *supra* note 8, at 949; Cherny & Portenoy, *supra* note 124, at 34, 36.

164. See American Academy of Neurology Position Statement, *Certain Aspects of the Care and Management of Profoundly and Irreversibly Paralyzed Patients with Retained Cognition*, 43 NEUROLOGY 222 (1993); James L. Bernat et al., *Competent Patients with Advanced States of Permanent Paralysis Have the Right to Forgo Life-Sustaining Therapy*, 43 NEUROLOGY 224, 225 (1993).

165. See John Glasson, *Report of the Council on Ethical and Judicial Affairs of the AMA: Physician-Assisted Suicide*, 10 ISSUES IN L. & MED. 91, 92 (1994); Council on Ethical and Judicial Affairs of the AMA, *Euthanasia Report*, Proceedings of the AMA House of Delegates 259 (1988).

professionally acceptable even when such treatment *may* hasten the patient's death."¹⁶⁶ In *Vacco v. Quill*, Chief Justice Rehnquist relied on the Task Force Report when he indicated that pain medication is recognized as permissible even when it "may" hasten the patient's death.¹⁶⁷ Finally, some professional standards as to permissibility of certainly lethal dosages are ambiguous in calling for use of effective doses of pain medication without specifying any boundaries. For example, the American Nurses Association endorses as ethically justified "the increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death . . ."¹⁶⁸ Similarly, the American College of Physicians calls relief of suffering a "highest priority" and suggests increasing analgesics to levels that successfully relieve pain "even if a side effect is to shorten life."¹⁶⁹ These latter formulations do not speak explicitly about the maximum tolerable level of risk of death, though they might be read as permitting any dosage level, even one certain to cause death.

What difference would it make if the medical armamentarium against suffering included a prerogative to administer a dosage of analgesics that is certain or practically certain to cause death? Yale Kamisar suggests

166. NYSTF REPORT, *supra* note 101, at 108, 162-63 (1994). That report allowed for "a significant risk" of hastening death. *Id.* The Kansas Medical Society took a similar position when it filed an *amicus curiae* brief in a recent case. See *State v. Naramore*, 965 P.2d 211, 214 (Kan. Ct. App. 1998) ("[T]here is an ethical distinction between providing palliative care which may have fatal side effects and providing euthanasia.")

167. 521 U.S. 793, 806-09 (1997).

168. American Nurses Association, Position Statement on Promotion of Comfort and Relief of Pain in Dying Patients, as quoted in Appendix to Brief of the AMA, *amicus curiae*, at 19a, *Vacco* (No. 95-1858). For other ambiguous statements about nursing practice, see Nessa Coyle, *Pain Management and Sedation in the Terminally Ill*, AACN, 5 CLINICAL ISSUES IN CRITICAL CARE NURSING 360, 362 (1994); Cindy Hilton Rushton & Peter B. Terry, *Neuromuscular Blockade and Ventilator Withdrawal: Ethical Controversies*, 4 AM. J. CRITICAL CARE 112, 114-15 (1995). For similar ambiguous policies authorizing incremental doses, without any "cap," as necessary to relieve suffering, see documents from the Hennepin County Medical Society and UCLA Medical Center presented in Haugen, *supra* note 103, at 369-70. For another ambiguous expression suggesting that physicians may do "all that is necessary" for pain relief consistent with "responsible medical practice," see House of Lords Select Committee on Medical Ethics ¶ 242, in JOHN KEOWN, EUTHANASIA EXAMINED: ETHICAL, CLINICAL, AND LEGAL PERSPECTIVES 103 (1995).

169. *American College of Physicians Ethics Manual*, 117 ANNALS INT. MED. 947, 955 (1992).

that such a medical prerogative would strengthen opposition to physician-assisted suicide and euthanasia by making this ultimate form of pain relief available without resort to assisted suicide.¹⁷⁰ This might be so and it might be good public policy to embrace the option of a certainly lethal analgesic dosage. But let us candidly recognize that use of a dosage that is almost certainly lethal is a form of euthanasia. According to the AMA: "Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering."¹⁷¹ That definition can be stretched to fit use of a dosage of an analgesic that is certain or practically certain to cause death.

A likely response is that euthanasia is characterized by a specific intent to kill, while analgesic administration involves an intent to relieve suffering. However, any pretense that the physician's primary specific intent in administering a dosage that is certain or practically certain to cause death is to relieve suffering ignores the real-world wisdom of Glanville Williams previously quoted: "When a result is foreseen as certain, it is the same as if it were desired or intended."¹⁷² To ignore Williams on this point is to engage in a charade that masks what is often, if not always, an actual object to cause death. Moreover, under the Model Penal Code (MPC), which reflects prevalent state law on this point, both purposeful and knowing conduct can prove murder. Using specific intent to determine the actor's culpability therefore fails to reflect modern American criminal law doctrine regarding homicide. Administration of an agent that is certain or practically certain to hasten death meets the MPC and state law definitions of murder, even if the actor's intent is to relieve suffering. Thus, euthanasia does not require specific intent to kill.

Of course, a prerogative to use certainly lethal analgesics would not be a full-blown legalization of euthanasia. This limited form of euthanasia would be confined to medical professionals, persons trained in

170. See Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 910 (1998).

171. AMA Council on Scientific Affairs, Opinion 2.21; see also Rushton & Terry, *supra* note 168, at 112.

172. WILLIAMS, *supra* note 105, at 322. For one group's assertion that any distinction in this context based on a provider's specific intent is "sophistry," see House of Lords Select Committee on Medical Ethics at ¶ 76 (1994).

assessing the unavoidability of death and the unavailability of alternative ways to relieve suffering. Professional standards would also constrain usage of certainly lethal analgesics. Careful assessment of the patient's competence would be required and only graduated escalation of dosage as necessary to control suffering would be permitted.¹⁷³ By insisting on careful assessment of "necessity" as a prerequisite to use of certainly lethal dosages, professional standards would be exhibiting concern for the sanctity of human life. Again, perhaps all this is good public policy. As further explained below, our point is that use of risky analgesics (even in dosages that will probably cause death) can be justified under a recklessness structure while the use of a dosage that is practically certain to cause death is a form of euthanasia and ought to be acknowledged as such if accepted into the medical armamentarium. Alternatively, if a categorical ban on euthanasia is to remain in place, then medical standards should clarify that relief of suffering can justify analgesics carrying a substantial risk of death, but not when the actor is practically certain that death will result.

Beyond the issue of dosages that will certainly or almost certainly hasten death, a hard question remains about the maximum degree of risk tolerable in palliative treatment. How should the law treat a physician who disregards a probability of death as long as that probability is less than awareness that death will be an almost certain consequence of the analgesic? Any conduct that creates a substantial risk of death is potentially reckless and therefore criminal, unless justified.¹⁷⁴ The Model Penal Code has no culpable mental state between acting recklessly and acting knowingly—between actors who unjustifiably disregard a substantial risk of death and those who act with awareness that death is a certain or practically certain outcome. Obviously, there is a wide range of probability outcomes within this range of risky behaviors—that is, between death as a substantial risk and as a practically certain consequence. Even a risk of a few percentage points that death will result seems like a substantial risk for

173. See NYSTF REPORT, *supra* note 101, at 150 (noting that provision of risky analgesics must conform to "accepted medical standards") and the medical standards described at *supra* notes 163-66 and accompanying text.

174. MODEL PENAL CODE § 210.2(1)(b).

purposes of assessing recklessness. At the other end of the spectrum, for a result to be “practically certain” it would have to approach 100%. Thus, the recklessness standard in criminal homicide cases potentially encompasses all perceived risks from a few percentage points above zero to almost 100%. A doctor who gives a dose of analgesics with a 5% risk of killing the patient and a doctor who gives a dose with a 80% or 85% risk of killing the patient are, under the Model Penal Code, potentially within the same mental state (recklessness) in terms of culpability. The question becomes how great a risk of death is justifiable and therefore non-reckless.

It seems intuitively obvious that a doctor who disregards a 5% risk of death is less culpable than a doctor who is practically certain that the dose will cause death. But what about the doctor at the upper end of the recklessness range—for example a doctor who disregards an 85% risk of death? Should the law regulating end-of-life medical practices draw a culpability line between a doctor who disregards an 85% risk of death and one who disregards a 5% risk that death will result? Under the MPC framework, both doctors can seek to defend the substantial risk (85% or 5%) by showing that it was the only way to achieve pain relief and that the pain was unbearable and persistent.

We previously explained that there is “no precise line for maximum tolerable risk that will work for all cases” because the “line will be affected by at least two elements—prevailing medical practices and jury attitudes toward the acceptability of . . . risk taking in individual cases.”¹⁷⁵ While professional standards are imprecise, they leave open the possibility that a probably lethal dosage (i.e., carrying a greater than 50% chance of death) can be justified. Professional standards that endorse palliative medications that “may” hasten death or that carry a “possibility” of hastening death can be read to uphold use of analgesics that will probably cause death. Thus, in our view, the 1983 Report of the President’s Commission was correct when it suggested that analgesic doses are permissible even when they “probably lead to death” in a grievously suffering terminal patient when less risky means have proved

175. Cantor & Thomas, *supra* note 122, at 120.

futile.¹⁷⁶ Those sources that seem to uphold use of probably lethal pain relief are in accord with our recklessness structure so long as the probability does not reach "practically certain."

All of this is not to suggest, however, that the doctor who disregards an 85% probability of death will have an easy time justifying her conduct. As we argued in an earlier paper, "[W]hen the risk of death exceeds 50 percent, the chance of achieving pain relief without causing prompt death necessarily becomes less than 50 percent and, accordingly, pain relief becomes a less likely outcome than death."¹⁷⁷ We believe, then, that it is much harder (but possible) to show a justification when the risk of death exceeds the chance of pain relief without prompt death.

A further question arises as to whether highly risky analgesic dosages are ever "necessary,"¹⁷⁸ given that sedation to unconsciousness looms as a less drastic means of providing relief from suffering. Another way to phrase the issue—pursuant to our framework of justification for risk taking—is whether there is a safer means (deep sedation) to relieve suffering than use of probably lethal analgesics. The AMA Council on Scientific Affairs contends that "profound sedation" can "always relieve pain."¹⁷⁹ Other clinicians observe that sedation to unconsciousness is available as a response to conditions such as extreme agitation, delirium, dyspnea, or pain that sometimes plague a person's dying process.¹⁸⁰ Such sedation is a not infrequent adjunct to end-stage care of cancer patients.¹⁸¹ While

176. PRESIDENT'S COMMISSION, *supra* note 114, at 80. One study of physician conduct in the Netherlands shows that Dutch physicians administering risky analgesics expect in approximately 70% of instances that their action will "probably shorten life." See Paul J. van der Mass et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 672 (1991); see LANCET, *infra* note 315.

177. Cantor & Thomas, *supra* note 122, at 120.

178. PRESIDENT'S COMMISSION, *supra* note 114, at 81.

179. AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996).

180. See Beth McIver et al., *The Use of Chlorpromazine for Symptom Control in Dying Cancer Patients*, 9 J. PAIN & SYMPTOM MGMT. 341, 342 (1994); Cherny & Portenoy, *supra* note 124, at 34; Balfour Mount, *Morphine Drips, Terminal Sedation, and Slow Euthanasia: Definitions and Facts, Not Anecdotes*, 12 J. PALLIATIVE CARE 31, 35 (1996); GREGG A. KASTING, *THE NON-NECESSITY OF EUTHANASIA*, IN *PHYSICIAN ASSISTED DEATH* 25, 40-41 (Humber et al., eds., 1993); Wanzer, *supra* note 160, at 847.

181. See Greene & Davis, *supra* note 126, at 333, 336; McIver, *supra* note

sedation to unconsciousness can carry risks of respiratory depression and acceleration of death,¹⁸² careful use of the technique can avoid hastening death.¹⁸³ Thus, at least in some instances, profound sedation offers a less dangerous form of relieving suffering than a dosage of analgesics that probably will hasten death.

The catch is that the prospect of lingering for days or weeks in an unconscious or semi-conscious state may be repugnant to some patients. As some commentators have noted, “[c]ontinuous sedation, while awaiting ‘natural death’ is a possible option, but may be contrary to the preferences of patients who see no point in prolonging their existence in a state of unconsciousness.”¹⁸⁴ A helpless, insensate limbo is seen by some dying patients as undignified or as an unwanted imposition on surrounding family conducting a deathwatch.¹⁸⁵

As to those patients deeming profound sedation to be intolerably undignified, the question—for purposes of legal justification of risky conduct—becomes whether such personal opposition disqualifies sedation as a less dangerous pain relief option than riskier analgesics. In the context of a competent patient’s rejection of life-sustaining medical intervention, the patient’s distaste for a proposed treatment, including distaste for loss of cognitive function, would indeed be a legitimate basis on which to disqualify that life-sustaining treatment. However, a competent patient has an almost unlimited prerogative to determine what bodily invasions to tolerate in the face of a fatal affliction. A patient’s rejection of life support can be

180, at 344.

182. See Greene & Davis, *supra* note 126, at 333, 336; Cherny & Portenoy, *supra* note 124, at 34.

183. See McIver, *supra* note 180, at 345; Mount, *supra* note 180, at 35; Rushton & Terry, *supra* note 168, at 115. Of course, profound sedation accompanied by withholding of nutrition and hydration can be particularly dangerous. We speak to that more hazardous mode of sedation *infra* Part IV.

184. See Franklin G. Miller & John C. Fletcher, *Criticism or Caricature*, 25 HASTINGS CENT. REP. 3 (1995); AMA Council on Scientific Affairs, *supra* note 171, at 45.

185. See Brief of Coalition of Hospice Professionals, *amicus curiae*, at 11-12, *Glucksberg* (No. 96-110); see also Respondent’s Brief at 17, *Vacco* (No. 95-1858) (calling profound sedation a “monstrous” fate—the “very essence of degradation”); WEBB, *supra* note 86, at 388 (describing the strong aversion of some patients to a comatose or semi-comatose state—for them an indignity worse than death).

grounded on distaste for a proposed treatment, concern about being a burden on surrounding family or care providers, or distaste for the deteriorated status that the patient has reached. A patient presumably has a similar prerogative to reject profound sedation—as an unwanted bodily invasion. The prerogative to choose a highly risky analgesic, however, may be narrower.

In our prior analysis of this topic, we suggested that distaste for prolonged unconsciousness would justify selection of a more dangerous form of pain relief in preference to profound sedation.¹⁸⁶ This position can be defended by a common sense analogy to risky surgery. A patient can choose a more risky surgical intervention than an available alternative intervention if the more risky operation would yield a very significant quality of life gain. By analogy, a patient should be able to choose a somewhat riskier form of pain relief if that riskier form would yield a very significant quality of life gain such as alertness in place of prolonged unconsciousness.

Does the justification analysis change where the risk of hastened death from the analgesics is highly probable, but less than “practically certain”? Consider by analogy a patient mired in a very debilitated state who faces a 60% risk of death from surgery that, if successful, would restore him to normal functioning. We tentatively conclude that this choice should be left with the patient and that the surgeon would be legally justified—i.e., not criminally reckless—in performing the surgery. Would the same result obtain if the choice were between probably lethal pain relief and less risky profound sedation? Can a suffering patient choose an analgesic with a 60% chance of causing death (but which preserves alertness) rather than deep sedation with a 10% risk of provoking death?

Our response hinges on principles of recklessness and justification. For an act to be justified when the actor disregards a substantial risk, the potential benefit that is sought must outweigh the risk of harm. In the surgery hypothetical, the risk of harm is a 60% chance of death; the potential benefit is that survival will produce a fully functioning rather than very debilitated individual—i.e., a considerable gain in quality of life. In the pain relief case, the potential benefit of relief from unbearable pain even for

186. See Cantor & Thomas, *supra* note 122, at 117.

a few days might weigh as heavily in the justification balance as the surgery patient's much improved quality of life, but the cases are different in that the patient seeking pain relief can get relief through the less dangerous profound sedation. Unlike the surgery patient who can obtain the benefit of recovering normal function *only* by taking a 60% risk of death, the pain relief patient can get pain relief either through the highly risky analgesic or the less risky profound sedation. Thus, the balance for the pain relief patient is whether avoidance of prolonged unconsciousness is worth the greatly increased risk of death compared to the modest risk of hastened death from profound sedation.

For illustration purposes, assume a 60% risk of death from the analgesics and only a 10% risk from the profound sedation, thus creating a 50% greater risk of death from the analgesics. It is difficult to know whether alertness is a benefit that is "worth" more than an added 50% risk of hastened death. One argument in favor of tipping the balance toward alertness and justifying a 60% risk of death is that the insentient stupor alternative is little different from death itself. Many sources conclude that consciousness—capacity to experience an environment and to interact with people—is the essence of life.¹⁸⁷ If this is right, then permitting a patient and her doctor to risk a high probability of death in order to achieve pain relief with continued alertness may be akin to permitting the surgery patient to elect surgery that risks a high probability of death. In both instances, there is an important quality of life gain that can justify choosing the riskier alternative.

This does not mean, however, that a quality of life gain justifies use of an analgesic dosage that is practically certain to cause death. In an early musing on the legal bounds of pain relief administration, Glanville Williams speculated that avoidance of existence in a "drugged torpor" would not furnish a legal justification for administration of a lethal drug.¹⁸⁸ Although there are no judicial precedents

187. Indeed some commentators assert that a permanently unconscious being is not a person and should be deemed dead. See Ronald E. Cranford & David Randolph Smith, *Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood*, 13 AM. J.L. & MED. 233, 233-34 (1987); Steven Goldberg, *The Changing Face of Death: Computers, Consciousness, and Nancy Cruzan*, 43 STANFORD L. REV. 659, 669 (1991).

188. See WILLIAMS, *supra* note 105, at 325.

on point, the justification risk/benefit balance suggests that Williams was correct. The patient who rejects profound sedation in favor of analgesics that are practically certain to cause death has traded a death-like state for a near certainty of death. However, for the purpose of legally justifying a mortal risk, the balance must clearly favor the benefit sought before disregard of the risk can be justified, and a "death for death" potential exchange is a net wash. Thus, we conclude that a physician can be justified in disregarding a substantial, even a probable, risk of death in administering analgesics, but can never be justified under current law when aware that the dosage is practically certain to cause death.

Of course, if profound sedation is sometimes a necessary means to achieve relief from distressing disease symptoms, and if the resulting unconscious or semi-conscious status would itself be a repugnant prospect for the terminally ill patient, there is a powerful impetus for the patient to decline in advance artificial nutrition or hydration and thus to ensure a relatively quick death while under profound sedation. The next section of our paper addresses that option under the heading of "terminal sedation."

IV. TERMINAL SEDATION

As used here, "terminal sedation" refers to administration of sedatives sufficient to render a dying patient somnolent during the remainder of the dying process. The object, as in the case of risky analgesics, is to preclude refractory suffering in the end-stage of a patient's struggle against a fatal affliction.¹⁸⁹

Resort to deep sedation can be triggered by diverse circumstances. In some instances, deep sedation is used because analgesic interventions do not succeed in controlling physical pain while still leaving the patient alert.¹⁹⁰ In other instances, physical discomfort associated

189. Indeed, terminal sedation might be considered a subcategory of risky analgesics. It is an extreme means of relieving suffering used when customary analgesics have failed or where the suffering flows from sources other than physical pain. As we explain in the text, the legal frameworks are essentially the same for both risky analgesics and terminal sedation. See discussion *supra* pp. 134-35.

190. NYSTF Report, *supra* note 101, at 40; Robert D. Truog et al.,

with nausea, vomiting, or dyspnea may be intolerable to the patient and unrelievable by means other than deep sedation.¹⁹¹ Other times, a patient may be experiencing refractory emotional suffering associated with respiratory distress, agitation, anxiety, incontinence, or fatigue—emotional suffering relievable only by deep sedation.¹⁹² While relief of suffering is a common thread within terminal sedation, there are actually three variations of deep sedation that deserve separate examination.¹⁹³ We will analyze in succession sedation accompanying the withdrawal of mechanical life support, deep sedation in response to the above-mentioned intolerable and refractory symptoms, and deep sedation (in response to intolerable symptoms) accompanied by withholding of artificial nutrition and hydration (ANH).

All forms of terminal sedation end in death. Deep sedation carries some risk of respiratory depression,¹⁹⁴ and may sometimes hasten death.¹⁹⁵ However, cause of death is usually uncertain in the context of terminal sedation.¹⁹⁶

Barbiturates in the Care of the Terminally Ill, 327 N. ENG. J. MED. 1678, 1680 (1992); Cherny & Foley, *supra* note 126, at 79, 97.

191. See Greene & Davis, *supra* note 126, at 335; Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 ARCHIVES INTERNAL MED. 1785 (1996) [hereinafter Rousseau, *Terminal Sedation*]; see generally Robert E. Enck, *Drug-induced Terminal Sedation for Symptom Control*, AM. J. HOSPICE & PALLIATIVE CARE 3 (1991).

192. See *id.*; see also Casswell, *supra* note 104, at 129-30; Rousseau, *Hospice*, *supra* note 44, at 831; Mount, *supra* note 180, at 34; Cherny & Portenoy, *supra* note 124, at 34.

193. See Truog et al., *supra* note 190, at 1680.

194. See Russell K. Portenoy, *Morphine Infusions at the End of Life: The Pitfalls in Reasoning from Anecdote*, 12 J. PALLIATIVE CARE 44, 45 (1996); Lawrence Schneiderman & Roger Spragg, *Ethical Decisions in Discontinuing Mechanical Ventilation*, 318 N. ENG. J. MED. 984, 987 (1988).

195. Cherny & Foley, *supra* note 126, at 97; Cherny & Portenoy, *supra* note 124, at 34. The AMA maintains, though, that properly managed sedation will not precipitate respiratory failure. Brief of AMA, *amicus curiae*, at 22, *Glucksberg* (No. 96-110).

196. See Brody, *supra* note 135, at 38; Patrick F. Norris, *Palliative Care and Killing: Understanding Ethical Distinctions*, 13 BIOETHICS FORUM 25, 27 (1997). In part because this form of deep sedation is usually confined to the last days or weeks of a dying patient's existence, and in part because the sedation can be administered without prompting respiratory depression (NYSTF REPORT, *supra* note 101, at 162), attributing death to the sedatives is highly problematic. Not surprisingly, some examples of deep sedation presented in the literature do not assign sedation as a cause of death. See Coyle, *supra* note 168, at 362-63 (cancer patient died after 4 days of unconsciousness); Truog, et al., *supra* note 190, at

Because the practice usually occurs with patients who are gravely deteriorated and within days of dying, no one knows whether the patient succumbed to the underlying disease process or to the effects of sedation.¹⁹⁷ Even where ANH is withheld incident to the deep sedation, cause of death might be attributable to the underlying disease, to the sedation, or to dehydration associated with withholding ANH.¹⁹⁸ At the least, deep sedation entails some risk of hastening death and, depending on the dosage of sedatives used and the length of time ANH is withheld, may in fact hasten death.¹⁹⁹ The various practices therefore warrant legal examination.

The most common form of terminal sedation is that accompanying withdrawal of life support mechanisms such as respirators, dialysis, or ANH. When Chief Justice Rehnquist referred to terminal sedation, he did so in that context—as an incident to withdrawal of life sustaining medical interventions.²⁰⁰ At the point of withdrawal of life support, the patient is expected to die. The concern is alleviation of suffering accompanying and following the withdrawal process. The potential harms include acute anxiety, agitation, shortness of breath, and physical pain. Both analgesics and deep sedation are customarily administered to prevent these harms.²⁰¹ Again, cause of

1679 (cancer patient died after 2 days in barbiturate coma). Rather, death is attributed to the underlying disease, such as cancer. See Greene & Davis, *supra* note 126, at 335 (death of sedated patients attributed to “end-stage malignant disease.”) Nonetheless, in some instances the deep sedation may hasten a patient’s death and in all instances the sedation maintaining unconsciousness prevents the patient from changing his or her mind and requesting aggressive medical intervention.

197. See Greene & Davis, *supra* note 126, at 335, 337 (attributing death to “end-stage malignant disease” while admitting “possible shortening of life”); see also Robert Dozor, *Intentionally Hastening Death*, 38 J. FAM. PRACTICE 295, 297 (1994); Portenoy, *supra* note 194, at 45.

198. Some commentators assert that dehydration is “often” the operative cause of death while conceding that the cause might be the underlying disease or some “intervening complication.” Quill et al., *Palliative Options*, *supra* note 6, at 2100, 2102; see also Orentlicher, *supra* note 107, at 1237.

199. Anecdotal reports describe use of excessive sedative doses probably precipitating death. See Billings & Block, *supra* note 6, at 22; see also Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1088 (1998).

200. See *Vacco v. Quill*, 521 U.S. 793, 798 (1997).

201. See William C. Wilson et al., *Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from*

death is uncertain. Upon removal of life support, the patient is expected to die from the underlying ailment but administration of large doses of sedatives has some potential to hasten death.²⁰²

The legal rationale for the validity of heavy sedation accompanying withdrawal of life support is identical to the rationale for risky analgesics. Once a patient exercises the prerogative to reject life-sustaining medical intervention, health care providers have an ethical and legal obligation to minimize suffering via palliative care.²⁰³ That obligation apparently extends to amelioration of mental, as well as physical, suffering.²⁰⁴ Amelioration of suffering thus provides the legal justification for the risk that deep sedation may hasten death. As in the case with risky analgesics, the deep sedation is supposed to be the least dangerous means of palliation and the dosage is supposed to be commensurate with the object of relieving suffering.²⁰⁵ Use of a dosage that would be certain or practically certain to hasten death would be inconsistent with the recklessness framework, discussed above,²⁰⁶ that permits palliative risk taking only if death is less than a practically certain consequence. Professional practice seems compatible with this framework. That is, deep sedation seems to be used on the assumption that the sedation “may” hasten death,²⁰⁷ a

Critically Ill Patients, 267 JAMA 949, 951 (1992); Carol A. Riddick & Lawrence J. Schneiderman, *Distinguishing Between Effect and Benefit*, 5 J. CLINICAL ETHICS 41, 42 (1994); see generally Margaret L. Campbell, *Case Studies in Terminal Weaning from Mechanical Ventilation*, 2 AM. J. CRITICAL CARE 354 (1993); Barbara J. Daly et al., *Withdrawal of Mechanical Ventilation: Ethical Principles and Guidelines for Terminal Weaning*, 2 AM. J. CRITICAL CARE 217 (1993).

202. See Wilson et al., *supra* note 201, at 952-53 (stating that it is unclear whether death is actually hastened but acknowledging the “hemodynamic and respiratory depressant qualities” of the sedatives used); Daly et al., *supra* note 201, at 222 (admitting that medications used to relieve suffering “may hasten as well as ease death”); Riddick & Schneiderman, *supra* note 201, at 42.

203. See Cherny & Portenoy, *supra* note 124, at 36; Daly et al., *supra* note 201, at 222; Schneiderman & Spragg, *supra* note 194, at 987; see also Matter of Farrell, 529 A.2d 404, 419 (N.J. 1987) (Handler, J. concurring).

204. See Cornelius J. van der Poel, *Ethical Aspects in Palliative Care*, AM. J. HOSPICE AND PALLIATIVE CARE 49, 53 (1996); Robert D. Truog, *Pain Management and Sedation in the Terminally Ill*, 5 AACN 363, 364 (1994).

205. See Quill, *Risk Taking*, *supra* note 6, at 707; Campbell, *supra* note 201, at 356; Cushing, *supra* note 104, at 944.

206. See *supra* notes 122-28, 133-34 and accompanying text.

207. See Cherny & Portenoy, *supra* note 124, at 34; Portenoy, *supra* note

level of risk lower than practically certain.

Specific intent is indeterminate in this context as it was in the area of risky analgesics. Deep sedation accompanying withdrawal of life support (at least in non-excessive palliative dosages) is certainly consistent with an intention to prevent and relieve suffering. Yet the patient ordering cessation of life support may well be intending to die and the cooperating professional may well share that intent to end life. In one study, 36% of surveyed professionals reported that hastening death was at least a secondary object in administering sedatives in tandem with withdrawal of life support.²⁰⁸

While sedation accompanying withdrawal of life support seems appropriate and lawful, use of paralytic agents in that same context is highly suspect.²⁰⁹ Paralytic agents, such as curariform, have no analgesic, sedative, or therapeutic qualities.²¹⁰ Their sole function is to prevent the dying patient from exhibiting signs of struggle or gasping that might distress surrounding family or caregivers.²¹¹ At the same time, paralytic agents might prevent a suffering, dying patient from communicating distress and/or could incapacitate muscles and cause death by asphyxiation.²¹² Because of these possible consequences, and because the agents have no therapeutic value to the patient, commentators condemn the use of paralytics incident to withdrawal of life support as "ethically unjustifiable."²¹³ For these commentators, the benefit to others of avoiding a distressing spectacle does not justify the possible hastening

194, at 45; Schneiderman & Spragg, *supra* note 194, at 987.

208. See Wilson et al., *supra* note 201, at 951. The same study indicated that most professionals using sedation wanted to decrease pain (88%), decrease anxiety (85%), or ease air hunger (67%). See *id.*

209. See Robert D. Truog & Jeffrey P. Burns, *To Breathe or Not to Breathe*, 5 J. CLINICAL ETHICS 39 (1994); see also Rushton & Terry, *supra* note 168, at 112 (describing a case and examining ethical questions regarding the issue of using a neuromuscular blocking agent while removing a ventilator); Schneiderman & Spragg, *supra* note 194, at 988 (stating the use of paralytic agents is ethically unjustifiable when shortening a patient's survival only for the benefit of family or others).

210. Paralytic agents "relieve suffering only to the extent they are effective in causing the death of the patient." Truog & Burns, *supra* note 209, at 39.

211. See Rushton & Terry, *supra* note 168, at 113-14.

212. See Riddick & Schneiderman, *supra* note 201, at 42.

213. See Schneiderman & Spragg, *supra* note 194, at 988; Truog & Burns, *supra* note 209, at 41.

of death. It is conceivable that a patient might competently choose administration of a paralytic agent in order to spare the sensibilities of loved ones attending withdrawal of life support. But, common practice does not appear to involve getting informed consent to such an agent.²¹⁴ Even if the patient did consent, administration of a paralytic agent that hastens death without palliative justification would be homicide. In short, deep sedation, but not the use of paralytics, may be a justifiable adjunct to removal of life-sustaining medical intervention.

A second form of terminal sedation involves sedation to somnolence at the end-stage of a dying process even though the patient is not dependent on mechanical life support.²¹⁵ Again, the object is preclusion of suffering or indignity associated with diverse intractable symptoms such as pain, nausea, dyspnea, anxiety, or delirium. Deep sedation is often cited in the literature as an "end-stage" process, but the precise definition of end-stage is unclear. Some commentators consider terminal sedation as occurring when death is imminent, apparently meaning unavoidable death is looming within hours or days.²¹⁶ Other sources refer to the practice in the context of the last days "or weeks" of life.²¹⁷ There is even an occasional reference to deep sedation for patients unavoidably dying within "weeks or months."²¹⁸ Clinical reports²¹⁹ usually refer to the last hours or days of an unavoidable dying process. As predicting death is notoriously imprecise in terminal patients, even if the practice is aimed at patients within days of unavoidable death, some of those patients would presumably have survived for more than a week.

214. Moreover, such consent would not generally be forthcoming because of the potential for a paralytic agent to mask distress symptoms and thereby make a dying process more burdensome.

215. See Cherny & Portenoy, *supra* note 124, at 31, 34-36; Greene & Davis, *supra* note 126, at 335-37; Rousseau, *Hospice*, *supra* note 44, at 830-32; Truog, *supra* note 204, at 364; NYSTF REPORT, *supra* note 101, at 40, 164; Rousseau, *Terminal Sedation*, *supra* note 191, at 1785-86.

216. See Rousseau, *Hospice*, *supra* note 44, at 832; Rousseau, *Terminal Sedation*, *supra* note 191, at 1785; Brody, *supra* note 135, at 38-39; Enck, *supra* note 191, at 4-5.

217. NYSTF REPORT, *supra* note 101, at 40; Brief of AMA, *amicus curiae*, at 23, *Vacco* (No. 95-1858).

218. J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. PALLIATIVE CARE 21, 23 (1996).

219. See *supra* note 215.

The same framework applicable to risky analgesics²²⁰ should govern the legality of this form of deep sedation. That is, relief of intractable and intolerable symptoms may provide a legal justification for deep sedation even if the sedation poses a substantial risk of hastening death.²²¹ First, the patient (or an appropriate surrogate) must consent to the process. Second, no less risky means of relief must be available. Finally, sedative effects must be monitored and dosage carefully titrated in order to achieve the palliative effect without killing the patient. Clinical practice largely appears to conform to these parameters.²²² While anecdotal reports speak of some physicians increasing sedative dosage without palliative need in order to hasten death,²²³ the frequency of such conduct is vigorously disputed.²²⁴ Again, so long as deep sedation reflects a considered choice by an informed patient or

220. See *supra* notes 123-30 and accompanying text.

221. As noted, palliative care for the dying patient is an integral part of professional responsibility. See *supra* note 203, and accompanying text. Some sources insist that specific intent of the care providers differentiates terminal sedation from euthanasia. See generally Mount, *supra* note 180, at 34-35 (criticizing Billings and Block's analysis); see also Campbell, *supra* note 201, at 358; Rousseau, *supra* note 194, at 831 (stating "the explicit intent of sedation is the alleviation of suffering, whereas the intent of physician assisted suicide/euthanasia is death."). We dispute that explanation, not just because specific intent is so elusive in this context but because common sense says that some providers do seek to hasten death when they administer terminal sedation knowing that the patient must remain insensate to avoid refractory suffering and that only death will end that patient's insensate limbo. In other words, there is strong impetus for the provider to want the patient to die sooner rather than later once the palliative regime (here deep sedation) reduces the patient to permanent unconsciousness. One study of sedation accompanying removal of life support confirms this intuition about providers' mixed reasons in using deep sedation. See Wilson et al., *supra* note 201, at 951-53. This intuition about providers' specific intent is even stronger in the third form of terminal sedation when ANH is also withheld. See Quill et al., *Palliative Options*, *supra* note 6, at 2101.

222. See Cherny & Foley, *supra* note 126, at 82, 92; Greene & Davis, *supra* note 126, at 336-37; Rousseau, *Terminal Sedation*, *supra* note 191, at 1785; Brief of Coalition of Hospice Professionals, *amicus curiae*, at 14, *Glucksberg* (No. 96-110). But see Riddick & Schneiderman, *supra* note 201, at 41-42 (speaking of using large doses of sedatives causing profound respiratory depression).

223. See Billings & Block, *supra* note 218, at 21-22.

224. See Portenoy, *supra* note 194, at 44; see also Mount, *supra* note 180, at 31-32 (critically examining the evidence used by Billings and Block); Brody, *supra* note 101, at S156 (arguing that increased doses of narcotics does not necessarily produce a fatal overdose or reduce survival time).

surrogate, and the sedative dosage is reasonably geared to preventing intolerable suffering, deep sedation seems appropriate and justified.

A third form of terminal sedation mirrors the second form (sedation to somnolence in order to avoid intractable suffering) with the important addition that ANH is not provided once the patient becomes unconscious. Absent ANH, the patient is sure to die; however, it will always be difficult to fix cause of death among the underlying disease, the sedation, and dehydration. If the patient were already dependent on ANH because of a natural affliction, no legal or ethical problem would arise from withdrawing ANH pursuant to the patient's instruction. ANH is generally equated with other forms of life support subject to a patient's control. Sedation would then be a palliative adjunct to the withdrawal of life-sustaining medical intervention (in this instance, ANH) as described earlier in this section.²²⁵ The more troublesome scenario, though, involves a patient previously capable of eating whose dependence on ANH accompanies the deep sedation administered to relieve intractable symptoms during the patient's dying process.

We can envision several scenarios where cessation of ANH is associated with deep sedation. For example, a competent patient requests deep sedation and the physician administers that sedation and, without consent of the patient, also withholds ANH once the patient is unconscious. The deep sedation itself is not problematic at the request of a patient suffering unbearably. Sedation posing some risk to an egregiously suffering patient (for example, a risk of respiratory depression) may be justified as a necessary concomitant of a palliative regime. However, that rationale does not apply to withholding of hydration once deep sedation has fully secured the palliative object of relieving suffering. Once relief of suffering has been achieved by deep sedation, the only function of withholding ANH seems to be to hasten death.²²⁶ Deep sedation accompanied by a physician's unilateral withholding of ANH then seems closely akin to non-voluntary euthanasia.

225. See *supra* notes 202-07 and accompanying text.

226. See Quill et al., *Palliative Options*, *supra* note 6, at 2101; see also Respondents' Brief at 49, *Quill* (No. 95-1858); Billings & Block, *supra* note 218, at 21.

The patient will inevitably die in the wake of the sedation and ensuing absence of hydration. At least where it can be shown that the patient succumbs to dehydration rather than the underlying disease process whose symptoms necessitated the sedation, the process might be regarded as "slow euthanasia" precipitated by the sedation incapacitating the normal processes of ingestion and digestion.²²⁷ Thus, if a physician has merely secured consent to deep sedation, it would indeed be homicide to go further and unilaterally withhold ANH.²²⁸

We can envision other scenarios in which a competent patient consents in advance to withholding of ANH in conjunction with deep sedation. The first such scenario is simply a variation of the VSED patient we discussed earlier in this paper. We argued earlier that a suffering, dying patient has a prerogative to stop eating and drinking (VSED) and to refuse any ANH proffered at that time by

227. See Billings & Block, *supra* note 218, at 25; see also Orentlicher, *supra* note 107, at 1237-39. One Australian proponent of euthanasia proposed a "coma machine" as a means of carrying out the then-legal prerogative of assisting suicide of a competent, terminally ill person. Dr. Philip Nitschke sought to design a machine that would constantly infuse enough medications (a mix of morphine and midazolam) to keep a suffering, terminally ill patient permanently unconscious until death. See Christopher Zinn, *Euthanasia Fight Renewed with 'Coma Machine,'* SEATTLE POST-INTELLIGENCER, May 15, 1997, at A2; This proposed machine illustrates the conceptual analogy between one form of terminal sedation and physician-assisted suicide or euthanasia.

228. Again, in this scenario we assume that dehydration can be shown as the cause of death. Cause of death is often a puzzle even where terminal sedation is accompanied by withholding of ANH. Some sources assign death to "dehydration or other intervening complications [of dehydration]." Timothy E. Quill et al., *The Rule of Double Effect—A Critique of Its Role in End-of-Life Decision Making*, 337 N. ENG. J. MED. 1768, 1769 (1997) [hereinafter Quill et al., *The Rule of Double Effect*]; "Generally, nutrition and hydration are also discontinued when the patient is under sedation, and the patient then dies of starvation and/or dehydration." *Brief of Coalition of Hospice Professionals, amicus curiae*, at 11, *Glucksberg* (No. 96-110). Dehydration can indeed have fatal consequences and will eventually cause death. See Gillian M. Craig, *On Withholding Nutrition and Hydration in the Terminally Ill: Has Palliative Medicine Gone Too Far?* 20 J. MED. ETHICS 139, 140 (1994). However, as the dying patient was already in the end-stage of an unavoidable dying process and as sedation sufficient to cause unconsciousness has been administered, assigning cause of death to dehydration is difficult. Death might as well be attributable to the underlying disease process (or possibly to the sedation) as to dehydration. See Orentlicher, *supra* note 107, at 1237; see also Craig, *supra* note 228, at 141. We assume, though, that dehydration can sometimes be shown to be at least a contributing cause of death, so that the legality of profound sedation coupled with withholding of ANH must be examined.

medical staff.²²⁹ Ordinarily, this would mean that a competent patient can decide to refuse all nutrition and hydration (including ANH) and then request sedation (presumably light sedation) to relieve anxiety or agitation during the ensuing dying process. In some instances, though, a patient initiating VSED might be suffering so egregiously, either from the preexisting medical conditions and their intractable symptoms or from emotional distress accompanying VSED, that the patient subsequent to initiation of VSED might choose deep sedation. Deep sedation at that juncture would be legally justified if necessary to relieve the patient's suffering. Non-lethal amounts of sedatives could then be regarded as a palliative measure relieving anxiety, agitation, or any discomfort associated with the underlying disease or with dehydration. From that perspective, this form of terminal sedation (deep sedation accompanied by withholding of ANH) could be sustained as a variation on a patient's prerogative to initiate VSED. Of course, this must be an actual rather than a fictitious rationale. The patient must make an informed, considered choice regarding all three elements: refusal to eat, deep sedation, and withholding of ANH. Further, the deep sedation must be necessary in order to relieve severe distress or suffering that materializes during the VSED process. Under those conditions, profound sedation (and concomitant withholding of ANH) may be justified.²³⁰ In such instances, the patient is likely to die from VSED rather than profound sedation.

A possible legal obstacle might arise regarding the role of this form of deep sedation in maintaining unconsciousness and thus preventing the patient from changing his or her mind about the fatal VSED course. An action that obstructs a person's natural life-sustaining process, such as placing one's hand over a person's mouth in a fashion asphyxiating the person, is homicide.²³¹ An action that prevents a person from extricating himself or herself

229. See *supra* notes 67-76 and accompanying text.

230. To be justified, the sedation must be "necessary" because some risk of hastening death accompanies the use of sedation. By "necessary," we mean that the benefit of relieving distressing symptoms outweighs the risk of hastening death by depressing respiratory function.

231. Cf. Dena S. Davis, *Legal Trends in Bioethics*, 5 J. CLINICAL ETHICS 62 (1994) (noting indictment of a neonatologist for placing a hand over an infant's mouth as the infant struggled for air).

from a life-threatening situation is also homicide. For example, tying the hands of a person who is attempting suicide via hanging, in a manner that does not allow the person to loosen the rope, has been deemed a homicide.²³² Arguably, rendering the VSED patient insensate materially advances the terminal enterprise by precluding discomfort or other thoughts and sensations that might prompt the patient's change of mind.²³³ However, that objection would also be present in the first two forms of terminal sedation. That is, deep sedation always renders a formerly competent individual incapable of changing his/her mind. If the sedation is indeed a "necessary" palliative measure, its incidental impact of preventing a change of mind should not disqualify its use. Even a patient who engages in VSED without deep sedation will eventually lapse into a coma and thus be unable in this last stage to change her mind. Again, we suggest that cessation of ANH incidental to deep sedation is licit where a competent patient has first made a considered determination to stop eating and drinking, and has then chosen deep sedation in the face of severe suffering or distress that has materialized.

A final scenario involves a suffering patient who has not previously opted for VSED, but who confronts the ANH issue when unbearable symptoms prompt the patient's request for deep sedation. In this case, when the physician concurs that deep sedation is justified, the patient also requests withholding of ANH. Timothy Quill argues that this form of terminal sedation is probably legal.²³⁴ From his perspective, the deep sedation is warranted as a palliative measure in the face of patient suffering. As to the withholding of ANH, Quill, apparently assuming that the patient is giving informed consent to that medical course, sees it as a legitimate exercise of self-determination and bodily integrity by the patient.²³⁵

232. See *United States v. Varraso*, 21 M.J. 129, 133 (C.M.A. 1985); see also *People v. Cleaves*, 280 Cal. Rptr. 146, 150-51 (Cal. Dist. Ct. App. 1991) (describing the circumstances of the case where the defendant tied the suicide into a position from which the suicide could not escape).

233. Cf. *Somerville*, *supra* note 125, at 309 (calling sedation to prevent a gravely impaired infant from waking and demanding nourishment a form of "death-inflicting pain relief.")

234. See Quill et al., *Palliative Options*, *supra* note 6, at 2100, 2103, 2106; Quill et al., *The Rule of Double Effect*, *supra* note 228, at 1768-70.

235. See Quill et al., *Palliative Options*, *supra* note 6, 2100; Quill et al., *The*

We have already endorsed the legality of withholding ANH following deep sedation where the competent patient had previously initiated a VSED course and deep sedation then became necessary and was subsequently chosen by the patient. Does it matter legally that in the current scenario the choice to reject ANH is being made simultaneously with the request for deep sedation? Our answer must be very tentative, because there is no precedent on point.

We can perceive three arguable distinctions based on the change in sequence—rejection of hydration simultaneous with, instead of prior to, choice of terminal sedation. The first distinction relates to the amount of time available to test a patient's firmness of purpose in forgoing food and drink. In the typical VSED case, a person who initiates VSED without recourse to deep sedation will have several days to reflect upon the decision and perhaps change her mind. By contrast, a person who decides to forgo nutrition and hydration simultaneously with a request for deep sedation may lose that period for lucid reflection—at least if deep sedation is initiated shortly after the person requests it. At the very least, the diminished time span for reflection requires the health care provider to be especially careful when eliciting informed consent.

A second possible distinction relates to the justification that underlies our endorsement of VSED. A dying patient who initially opts for VSED is escaping intolerable suffering; that patient has determined that death would be preferable to the dismal existence the patient is experiencing. Sympathy with that experiential plight of the dying patient helps account for willingness to accept the VSED course. But a patient who simultaneously achieves deep sedation is relieved from the experiential suffering that helped prompt recognition of the patient's prerogative to forgo nutrition and hydration.²³⁶ Thus, one of the

Rule of Double Effect, *supra* note 228, at 1237 (“death results from omitting medical interventions refused by patients who are exercising their rights to self-determination and protection of their physical integrity”); *see also* Respondents’ Brief at 16, *Vacco* (No. 95-1858) (arguing that terminal sedation involves a lawful exercise by a patient of a right to resist ANH).

236. It is worth noting that the concurring Justices in *Glucksberg*—those most sympathetic with dying patients’ interests—were particularly concerned to ensure the relief of suffering as an adjunct of the dying process. *See* *Washington v. Glucksberg*, 521 U.S. 702, 791 (1997) (Ginsburg, J., Breyer, J. concurring). Hence their ostensible endorsement of terminal sedation.

elements that helped reinforce respect for VSED might be lacking where nutrition is forgone simultaneous with initiation of deep sedation.

A third possible distinction has to do with the consequences of disrupting a patient's choice of forgoing nutrition and hydration. Our projection of legal acceptance of VSED was grounded in part on the revulsion that would accompany administration of forced nutrition to a competent, resisting patient.²³⁷ The distasteful specter of forcing ANH on a conscious, struggling patient is absent when the patient is undergoing deep sedation.

For all these reasons, it is difficult to assess the legal status of this form of terminal sedation—deep sedation accompanied by simultaneous choice to forgo ANH. Given that the dying patient would likely be permitted to forgo nutrition if that choice had preceded deep sedation, and given that the sedated patient retains autonomy and bodily integrity interests in avoiding ANH, judges might rule that sequence does not matter. On the other hand, if a suffering patient can lawfully precipitate death by getting deep sedation together with withholding of ANH, then the distinction between risky palliative intervention and euthanasia indeed blurs.²³⁸

Interestingly, although proponents of assisted suicide and euthanasia tend to view terminal sedation as a form of euthanasia, they disparage resort to terminal sedation.²³⁹ For them, the terminal sedation process is undignified, gruesome, and distorts the recollections that loved ones will have of the dying patient. This is so, they say, because the profoundly sedated patient must linger in an insensate state until death ensues from dehydration, from the underlying affliction, or from effects of the sedation. The brief in *Vacco v. Quill* on behalf of physicians favoring assisted suicide deemed it “monstrous to have . . . [patients’]

237. See *supra* notes 70-73 and accompanying text (discussing the distasteful restraints that would be necessary to force-feed a competent, yet resisting patient).

238. David Orentlicher has commented on the strong similarity between this form of terminal sedation and euthanasia. He argues that once a patient is deeply sedated the only function of withholding ANH is to precipitate death. See Orentlicher, *supra* note 107, 337 N. ENG. J. MED. 1237-39.

239. See Orentlicher, *supra* note 107, at 1238; Respondents' Brief at 17, 49-50, *Vacco* (No. 95-1858); see also Ronald Dworkin, *Euthanasia, Morality, and Law*, 31 LOY. L.A. L. REV. 1147 (1998).

minds chemically shut down and to be imprisoned in their decaying bodies and deliberately starved to death, while loved ones keep a gruesome vigil. [Terminal sedation is] an assault on [the patients'] humanity and the very essence of degradation."²⁴⁰ While permanent unconsciousness is indeed an undignified status, it is not clear that terminal sedation is an intrinsically inhumane or "monstrous" process. Certainly, physicians employing terminal sedation see it as a vehicle to help maintain the dignity of a dying patient in the face of refractory suffering.²⁴¹ Refractory suffering is regarded as even more degrading than unconsciousness. Moreover, immersion in the insensate state of profound sedation is relatively brief—no more than hours when critical life support is being withdrawn and no more than days when a patient invoking VSED dies of dehydration.²⁴²

Some people nonetheless insist that physician-assisted suicide and euthanasia offer more expeditious relief than terminal sedation and therefore should be lawful. And they assert that the end-of-life techniques thus far discussed are morally and legally indistinguishable from euthanasia. We turn to those assertions.

V. PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA

Recall Herman Michelle's basic circumstances—stricken with an unavoidably fatal cancer condition and suffering unbearably from discomfort, distress, and anxiety to the point where he prefers to die rather than persevere. We have identified several licit ways in which medical professionals might facilitate Herman's wish to hasten his

240. Respondents' Brief at 17, *Vacco* (No. 95-1858).

241. See Greene & Davis, *supra* note 126, at 337; Cherny & Portenoy, *supra* note 124, at 34, 36.

242. We do suggest that a terminal sedation prerogative need not be confined to the end-stage of a dying process. Terminal sedation, i.e. sedation to somnolence until the patient's demise, has customarily been confined to the end stages (last days or weeks) of an inexorable dying process. Yet close proximity of death does not seem like a necessary element of the practice. The severe discomfort or distress that justifies profound sedation might occur when death is still months away. If ANH is not withheld in such instances, the patient might subsist in an unconscious or semi-conscious state for a protracted period. As we noted above, some patients might opt first for VSED, then for refusal of ANH, and thus shorten the dying period to days. When a choice of VSED is accompanied by profound sedation, death ensues within days. See *supra* notes 229-30 and accompanying text.

demise. If Herman decides to stop taking nutrition and hydration (including by artificial means), medical staff may provide comfort care until Herman dies from dehydration (or perhaps from the underlying natural affliction). If Herman seeks pharmacological relief from his suffering, medical staff may administer analgesics that should ease suffering but *might* (depending on the dosage needed to achieve relief) hasten Herman's death. If Herman's is the rare case in which the analgesics fail to ease suffering without intolerable side effects, or if Herman's emotional suffering remains intractable, medical staff may, upon Herman's request, administer sedatives that will render Herman somnolent and insensate until he dies (probably from the underlying lung cancer, but possibly from the impact of the sedatives). Finally, if Herman's condition deteriorates to the point where he is ventilator dependent, medical staff must respect his decision to forgo such mechanical ventilation even though death will promptly follow disconnection of the machine. By contrast, if Herman at any stage requests provision of a lethal poison to ingest, or seeks administration of a poisonous substance into his veins, health care personnel must decline to participate. Assisted suicide and euthanasia (hereinafter PAS)²⁴³ are patently illegal in the vast majority of American jurisdictions.

Are these sensible lines that American law has drawn? In all the previously discussed scenarios, Herman Michelle was essentially in the same fatally afflicted state with the same state of mind (desirous of death). And all these modes of hastening death have the same underlying object—promotion of patient control in order to minimize suffering

243. In the ensuing discussion in this section, we use PAS primarily as a shorthand for both physician-assisted suicide and voluntary active euthanasia. This is for ease of expression and not because the two forms of ending life are identical. Some sources deem assisted suicide to be more tolerable than euthanasia, primarily because the patient's performance of the final lethal step gives some reassurance of voluntariness and desire to die. See John Deigh, *Physician Assisted Suicide and Voluntary Euthanasia: Some Relevant Differences*, 88 J. CRIM. L. & CRIMINOLOGY 1155, 1157-59 (1998); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician Assisted Suicide*, 327 N. ENG. J. MED. 1380, 1381 (1992) [hereinafter Quill et al., *Proposed Clinical Criteria*]. Other sources contest whether the two practices can be meaningfully distinguished. See, e.g., Nicholas Dixon, *On the Difference between Physician-Assisted Suicide and Active Euthanasia*, 28 HASTINGS CTR. REP. 25 (1998).

and preserve dignity in the dying process. Is PAS, then, such a distinctive mode of bringing about death as to warrant its distinctive legal treatment?

Some ostensible differences do exist between PAS and each of the established lawful means of hastening death. PAS involves introduction into the body, at the patient's initiative, of a lethal substance that the patient knows will cause death. By contrast, withdrawal of life support, as noted, involves conduct that allows a natural disease process to run its course and involves respect for a patient's prerogative to resist bodily invasions. VSED does not exactly facilitate a natural dying process as the patient has initiated the dying process by rejecting nutrition and hydration,²⁴⁴ but it does involve maintenance of bodily integrity against unwanted invasions. While administration of risky analgesics and terminal sedation entail active introduction of substances into the body, they generally involve only a justifiable risk of death made necessary by absence of alternative means to relieve unbearable suffering²⁴⁵ as opposed to conduct that knowingly causes death. These two active modes of hastening death (risky analgesics and terminal sedation) arguably constitute less of a "taking" of life than PAS.

While differences thus exist between the lawful and unlawful end-of-life practices, are they meaningful differences for purposes of fixing public policy? Or do the existing lines shaping end-of-life practices present only "a patina of rationality and fairness"²⁴⁶—lines possessing

244. It is a common phenomenon for dying patients to experience loss of appetite and disinterest in nutrition. *See, e.g.,* McCann, *supra* note 42, at 1266. To that extent, VSED can be viewed as a "natural" adjunct to the dying process. However, our description of permissible VSED includes patients whose determination to cease eating and drinking is not prompted by natural appetite loss.

245. Most forms of terminal sedation involve only some risk of hastening death—a risk justified by the need to relieve unbearable suffering. Deep sedation accompanied by withholding of ANH may make ultimate death certain, but attributing death to dehydration is often not easy. In any event, we have suggested that deep sedation accompanied by withholding of ANH is only lawful where the sedation is justified by intractable suffering and where the withholding of ANH is preceded by a considered patient decision to engage in VSED. In other instances, for example where the patient consents to deep sedation but has not deliberated about cessation of nutrition, withholding of ANH seems to qualify as homicide. *See supra* notes 226-28 and accompanying text.

246. Robert A. Burt, *Disorder in the Court: Physician-Assisted Suicide and*

sufficient rationality to withstand constitutional challenge yet artificially obstructing humane dying practices.

We do not purport to resolve whether PAS should be legalized. The literature addressing that issue is vast and resolution of the issue is beyond the scope of this paper. Our object instead is to highlight some anomalies or tensions on both sides of the debate— anomalies that stand out in the wake of our scrutiny of currently lawful end-of-life practices.

The tension is perhaps most glaring between the differential treatment of withdrawal of mechanical life support (lawful) and PAS (unlawful). The rote explanation—one accepted by the Supreme Court as sufficiently rational to satisfy equal protection requirements—is that withdrawal of life support involves letting nature (a fatal affliction) take its course. A poison is an entirely independent and unnatural cause of death, easier to deem a killing or taking of life. This is the letting die versus killing distinction long debated by moral philosophers.²⁴⁷ The Supreme Court never explained, though, *why* it is rational to distinguish between pulling the plug (letting die) and providing a poison (assisting a killing) in the context of a competent dying patient who seeks relief from an intolerably painful or undignified dying process.²⁴⁸ Should public policy continue to make this distinction in modes of hastening death?

The best explanation for differential treatment is grounded on the important symbolic message embodied in society's strict prohibition of killing. Government reinforces the sanctity of human life principle by banning all killings,

the Constitution, 82 MINN. L. REV. 965, 981 (1998).

247. See KILLING AND LETTING DIE (Bonnie Steinbock ed., 1997). For arguments that no moral distinction exists between killing and letting die see ELKE-HENNER W. KLUGE, *THE ETHICS OF DELIBERATE DEATH* (1981); JAMES RACHELS, *THE END OF LIFE* (1986); Dan Brock, *Voluntary Active Euthanasia*, 22 HASTINGS CTR. REP., Mar.-Apr. 1992, at 10. Numerous commentators insist that the line between killing and letting nature take its course is artificial. They maintain that the predominant interest is patient autonomy in shaping a dignified and painless dying process in the face of a fatal affliction. And they favor PAS as a useful means of promoting that patient interest. See Meisel, *supra* note 15, at 849-50; Quill, et al., *Palliative Options*, *supra* note 6, at 2099; Quill et al., *The Rule of Double Effect*, *supra* note 228, at 1768.

248. See Ezekiel J. Emanuel, *The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy*, 82 MINN. L. REV. 983, 997 (1998).

including self-killings, except in extremely limited circumstances. The common exceptions for capital punishment, self-defense, and war have extraordinary justifications as responses to mortal injury or threat of mortal injury—a response to a murderer (capital punishment), an attacker (self-defense), or a hostile force (war).²⁴⁹ Relief of suffering has not traditionally been deemed a justification for killing, as the almost universal ban on euthanasia shows. This intuition about the symbolic rationale for banning PAS is supported by the commentary to the MPC. In explaining why aiding suicide is criminal even though suicide and attempting suicide are not, the commentary asserts that society's sanctity of life interest is "threatened by one who expresses a willingness to participate in taking the life of another"²⁵⁰

This rationale—aversion to killings as a symbolic justification for banning PAS while tolerating other forms of hastening death—is debatable at best. Yes, a broad prohibition on killings reflects society's respect for sanctity of life. Still, from the perspective of the lay public, a doctor's pulling the plug and precipitating death may seem as much a killing as provision of a prescription for a poison.²⁵¹ If that is so, and we think it is, the symbolic message embodied in the distinction between killing and letting die becomes confused and hollow.

A limited incursion upon the sanctity of life principle is already widely accepted when a dying patient seeks to reject life support and thereby avoid a painful and/or undignified dying process. Acceptance of PAS might not

249. See DANIEL CALLAHAN, *WHAT KIND OF LIFE* 230 (1990).

250. MODEL PENAL CODE § 210.5 commentary at 100 (1980); see also Philip G. Peters, Jr., *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891, 969 (1989) (supporting the symbolic importance of maintaining a stringent limit on active killing).

251. Indeed, as many commentators have noted, pulling a plug without authorization from the patient or a patient's agent would in fact be treated as a homicide. A recent experience in Israel illustrates the public tendency to associate withdrawal of life support with killing. In October 1998, a Tel Aviv district court authorized withdrawal of a respirator from a competent patient suffering at the end stage of Lou Gehrig's disease (ALS). The machine was detached and the patient died. The press report in Haaretz (Israel's most intellectual newspaper) proclaimed the event as the first official mercy killing in Israel. See Ron Resnick, *At 10 O'clock Itai Arad Was Detached From the Respirator*, HAARETZ, Dec. 3, 1998. The point is the perception that detachment of a respirator was a form of mercy killing.

further erode the symbolic moral message involved. A patient ordering the withdrawal of life support is often conveying a distasteful message—"my prospective existence as a gravely debilitated, dying person is so dismal that I prefer death." However, the message is morally acceptable, despite its suicidal content, because patients, families, judges, and society as a whole understand that a patient seeking final refuge from an unendurable fatal affliction is not denigrating life or its value. That patient is simply seeking to die with dignity in the face of an unavoidable natural affliction.²⁵²

This point applies as well to the patient seeking PAS. The abstract societal interest in sanctity of life does not seem threatened by offering relief to persons suffering unbearably in the face of an unavoidable fatal affliction. Again, respect for the individual dignity interests at stake—including freedom from physical or emotional suffering and preservation of survivors' wholesome recollections of the patient—accounts for the deviation from a strict sanctity of life approach.

Reliance on a symbolic distinction between withdrawal of life support and PAS is reminiscent of the futile effort to invoke symbolism to constrain the bounds of withdrawal of life support itself. In that context, some commentators contended that patient self-determination should not include a prerogative to refuse ANH, for provision of ANH expresses a sacrosanct symbolic message of human caring and nurturing.²⁵³ Courts have almost universally rejected that asserted symbolic rationale and have instead treated ANH like other forms of medical intervention—subject to patient control.²⁵⁴

The legal status of VSED and use of risky analgesics further compromise the force of the symbolism argument. VSED is a form of self-destruction impelled by the patient's current suffering and distaste for the dismal existence facing the patient during the remainder of the dying

252. See Norman L. Cantor, *Two Opinions in Search of a Justice: The Constitution and Physician-Assisted Suicide*, 28 RUTGERS L.J. 435, 441 (1997).

253. See Dan Callahan, *On Feeding the Dying*, 13 HASTINGS CTR. REP. 22 (1983); Mark Siegler & Alan Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES INT. MED. 129 (1985).

254. See *In re Conroy*, 486 A.2d 1209, 1236 (N.J. 1985); *In re Longeway*, 549 N.E.2d 292, 296 (Ill. 1989).

process. If symbolic harm to sanctity of life is the gravamen of the objection to PAS, then the same concern is applicable to medical cooperation with a patient deliberately resisting hydration because of distaste for his or her current and prospective existence. That is, if self-killing by self-starvation is morally wrong based on its violation of sanctity of life,²⁵⁵ then by analogy, medical cooperation in VSED is also wrong. Indeed, the symbolic harm from VSED is arguably greater than the harm from PAS, as the certainty of death from dehydration and any accompanying affront to sanctity of life is greater. A physician writing a prescription for poisonous barbiturates may at least think that the patient only needs reassurance that relief will be available if suffering ultimately becomes unbearable; the physician's expectation might still be that the lethal substance will never be used.²⁵⁶ A patient steadfastly rejecting nutrition and hydration will inevitably die. And yet it is almost unthinkable that law would compel medical personnel to cease cooperation with a competent, dying patient's determination to stop eating and drinking and to resist ANH.²⁵⁷ The tension here with the illegality of PAS seems plain.

Any distinction between use of risky analgesics and PAS grounded on society's symbolic aversion to killing or taking of life is eroded as well by the recent expressions in some concurring Supreme Court opinions in *Glucksberg*²⁵⁸ and in some bioethics commentary²⁵⁹ suggesting that analgesics and sedation may lawfully be used even in dosages certain or practically certain to cause death. As we explained,²⁶⁰ the only tenable distinction between risky pain relief and euthanasia is the distinction between risky conduct and conduct known to be lethal. That distinction

255. For one opinion that self-starvation is indeed a moral wrong, see Keown, *supra* note 2.

256. See *Washington v. Glucksberg*, 521 U.S. 702, 750-51 & n.14 (1997) (Stevens, J., concurring); WEBB, *supra* note 86, at 387; ANNAS, *supra* note 87, at 220, 231-32.

257. We previously noted the empathy with the dying patient's plight and the revulsion toward forced feeding of a resisting, dying patient that help explain law's reluctance to intervene against VSED. See *supra* notes 70-73 and accompanying text.

258. *Glucksberg*, 521 U.S. at 751 (O'Connor, J., Breyer, J.); see also *supra* notes 138-42 and accompanying text.

259. See *supra* note 154.

260. See *supra* notes 132-34 and accompanying text.

helped explain the lawful status of both risky analgesics and terminal sedation. If the medical prerogative to provide palliative care in fact includes analgesic dosages known to be lethal, then the main theoretical basis for distinguishing PAS from lawful practices disappears.²⁶¹ Even if the Supreme Court expressions are wrong, as we contend, some tension remains between the illegality of PAS and the legality of risky analgesics. The line seems tenuous between active administration of analgesics that will probably kill the patient in the face of unbearable suffering (the legal limit we perceive) and active administration of poisons that will certainly kill the patient in the face of unbearable suffering. Continued illegality of PAS then seems shaky unless there are other supports for distinctive treatment of PAS.

One such possible support is maintenance of the integrity of the medical profession. According to the AMA, and according to the Supreme Court brief submitted in 1997 by the AMA and the major professional organizations representing nurses, psychologists, and hospitals, PAS is "fundamentally incompatible with the physician's role as healer . . ." ²⁶² Their contention is that public trust and confidence in physicians will be negatively affected if physicians are known to function as killers—providers or administrators of lethal poisons—rather than healers. Our response is that the medical role has already irrevocably shifted. As medical science became capable of sustaining life well beyond a point that many patients deem desirable, physicians inevitably became managers of the dying process.²⁶³ While this medical management normally includes strenuous efforts to heal and to extend life, it sometimes includes resignation that comfort care is all that medicine can provide. And this palliative focus, particularly the strong impetus to relieve suffering, sometimes involves using risky analgesics or risky sedation or cooperating in a patient-dictated course (VSED or removal of life support) that hastens death. There is no reason to think that

261. We repudiate the conventional distinction between risky analgesics and PAS grounded on the specific intent to relieve suffering reflected in use of risky analgesics. See *supra* notes 109-21 and accompanying text.

262. AMA CODE OF MEDICAL ETHICS § 2.21 (1992); Brief, *Amici Curiae*, *Glucksberg* (Nos. 1295-1858, 96-110).

263. Norman L. Cantor, *The Real Ethic of Death and Dying*, 94 MICH. L. REV. 1718, 1718 (1996).

physician involvement in these modes of hastening death has eroded patient confidence. Relief of suffering is such an integral part of palliative behavior that many medical professionals view cooperation in hastening death as a legitimate step.²⁶⁴ So many professionals view PAS as ethical that it is difficult to see its prohibition as a pillar of medical integrity. As to patient confidence, dying patients might well view PAS as a humane, desirable tool in the medical armamentarium rather than a basis for apprehension.²⁶⁵

Of course, the principal impediment to legalization of PAS may be pragmatic rather than theoretical. That is, even some observers who concede that assisting a suicide can be a humane, moral step in certain circumstances still oppose legalization because of a variety of perceived hazards.²⁶⁶ One basic notion is that legalization would inevitably produce "undue killing"²⁶⁷ in measure that would outweigh whatever palliative benefits might flow from making PAS an available option to dying patients. A principal fear is that physicians—having considerable impact on patient choice²⁶⁸ by controlling information,

264. See Julia Pugliese, Note, *Don't Ask, Don't Tell*, 44 HASTINGS L.J. 1290, 1297-99 (1993); Dan Brock, *Voluntary Active Euthanasia*, 22 HASTINGS CTR. REP. 10, 22 (1992); Wanzer et al., *supra* note 160, 847-48; David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. ENG. J. MED. 1374 (1996). For results of a nationwide survey indicating that 6% of doctors had participated in assisted suicide or euthanasia and that approximately 24% would do so if the practices were legal, see Diane E. Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 N. ENG. J. MED. 1193 (1998); *Nationwide Survey finds 6% of MD's Admit Helping Patients Die*, NEWARK STAR LEDGER, Apr. 23, 1998, at 10. For results of other studies showing considerable physician involvement in and acceptance of assisted suicide, see Robert M. Hardaway et al., *The Right to Die and the Ninth Amendment: Compassion and Dying after Glucksberg and Vacco*, 7 GEO. MASON L. REV. 313, 321-22 (1999).

265. The notion that a physician who believes in PAS will necessarily be seen as a potential threat is like saying that pregnant women will see a physician who believes in abortion as a potential threat.

266. See, e.g., John Arras, *Physician Assisted Suicide*, 13 J. CONTEMP. HEALTH L. & POL'Y 361, 365 (1997); James F. Childress, *Dying Patients: Who's in Control?*, 17 L., MED. & HEALTH CARE 227, 230 (1989); Emanuel, *supra* note 9, at 1003; Joan Teno & Joanne Lynn, *Voluntary Active Euthanasia: The Individual Case and Public Policy*, 39 J. AM. GERIATRICS SOC'Y 827 (1991).

267. Giles Scofield, *Natural Causes, Unnatural Results, and the Least Restrictive Alternative*, 19 WEST. N. ENG. L. REV. 317, 351 (1997); Wesley J. Smith, *FORCED EXIT* 143-49, 180-92 (1997).

268. See David Orentlicher, *The Illusion of Patient Choice in End-of-Life*

persuasion, and imperiousness—would subtly coerce or manipulate patient choice of PAS.²⁶⁹ The danger of coerced or ill-considered selection of PAS is perceived as particularly acute because dying patients tend to be depressed and health care providers often have difficulty discerning and treating clinical depression.²⁷⁰ Commentators also fear patients' premature selection of PAS resulting from widespread undertreatment of pain.²⁷¹ Patients in unrelieved agony are obvious candidates to utilize any PAS option. Concerns about undue pressure on patients also arise from the expensive nature of terminal care and cost containment practices prevalent in an era of managed care.²⁷² Certain vulnerable populations—including the elderly, ethnic minorities, the poor, and the disabled—are cited as the most likely victims of the various social and economic pressures toward opting for suicide.²⁷³ This vulnerability could stem from the patient's poverty or hostility or prejudice of health care providers.

The litany of potential abuses of PAS indeed warrants pause and reflection. However, no one knows whether such abuses would ensue in the wake of legalization; speculation is at the core of almost all the projections.²⁷⁴ The anomaly, to our minds, is that similar potential for pressured or

Decisions, 267 JAMA 2101 (1992).

269. See John Finnis, *Euthanasia, Morality, and Law*, 31 LOY. L.A. L. REV. 1123, 1139-40 (1998); Sandra H. Johnson, *End-of-Life Decision Making: What We Don't Know, We Make Up; What We Do Know, We Ignore*, 31 IND. L. REV. 13, 34-35 (1998); Yale Kamisar, *Physician-Assisted Suicide: The Problems Presented by the Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121, 1134-35 (1998) (noting that apprehensions also exist about family coercion).

270. James J. Bopp, *Just the Medical Facts: An Argument in Support of the Continued Ban on Physician-Assisted Suicide*, 12 ST. JOHN'S J. LEGAL COMMENT. 610, 615-18 (1997); Emanuel, *supra* note 9, at 984; Johnson, *supra* note 269, at 34-35.

271. See M. Conolly, *Alternative to Euthanasia: Pain Management*, 4 ISSUES L. & MED. 497 (1989); Kathleen Foley, *Competent Care of the Dying Instead of Physician-Assisted Suicide*, 336 N. ENG. J. MED. 54, 55 (1997); Kamisar, *supra* note 269, at 1132; Steven H. Miles, *Physicians and their Patients' Suicides*, 271 JAMA 1786 (1994).

272. M. Cathleen Kaveny, *Managed Care, Assisted Suicide, and Vulnerable Populations*, 73 NOTRE DAME L. REV. 1275 (1998); WEBB, *supra* note 86 at 393; Kamisar, *supra* note 269, at 1131 (commenting that the financial aspects of death and dying "loom large" in the PAS context).

273. See Johnson, *supra* note 269, at 33; Smith, *supra* note 267.

274. See Deigh, *supra* note 243, at 1164; Buchanan, *supra* note 19, at 32.

premature or ill-considered end-of-life decisions underlies all the currently legal modes of hastening death previously discussed, and yet apprehended abuses have not materialized in those contexts in any measure that would jeopardize their validity.²⁷⁵

An artificial impetus to choose death—whether from financial pressures, depression, undertreatment of pain, physician prejudice, or physician domination of decision making—could affect patients contemplating VSED, withdrawal of life support, risky analgesics, or terminal sedation.²⁷⁶ “[T]he patient who asks to be allowed to die by removal from a ventilator is at least as likely as a patient who requests a prescription for lethal drugs to be making the request because of undue influence, financial pressure, clinical depression, or inadequately treated pain.”²⁷⁷ And these extraneous pressures would also potentially impact in a disproportionate manner on vulnerable populations such as the elderly, the poor, and the disabled. In fact, the kind of in-terrorem arguments now leveled at PAS were once leveled at the notion that life support might legally be withdrawn from some patients.²⁷⁸ Despite initial apprehensions of abuse and manipulation of patient end-of-life decisions, the prerogatives of competent patients to reject life-sustaining medical intervention and to demand adequate analgesic relief are now well entrenched in both American medicine and jurisprudence—all without significant showing of patient abuse. To the extent that abuse surfaces in contemporary end-of-life medical practices, it still tends toward unwanted prolongation of the

275. See Deigh, *supra* note 243, at 1160 (observing that “any act by which a person deliberately hastens his or her death raises concerns about voluntariness”); Orentlicher, *supra* note 107, at 1237-38 (noting that terminal sedation poses risks similar to PAS); Orentlicher, *supra* note 41, at 963.

276. See Dworkin, *supra* note 239, at 1157-58.

277. STELL, *supra* note 6, at 247. Any argument that can be made against actively hastening death can be leveled with equal vigor against passively hastening death. See Meisel, *supra* note 15, at 856.

278. See Jeffrey Blustein, *The Family in Medical Decisionmaking*, 23 HASTINGS CENT. REP. 7-9 (1993) (arguing that patients are readily subject to manipulation and coercion); Daly, *supra* note 201, at 223 (arguing that withdrawal of life support might become “so easy” that it would result in unnecessary deaths). The arguments grounded on potential abuse in the context of withdrawal of life support were especially strident as to surrogate decision making on behalf of incompetent patients.

dying process rather than premature termination of life.²⁷⁹ Moreover, this record of non-abusive administration of end-of-life practices transpired without the elaborate safeguards proposed for PAS.²⁸⁰ Finally, the initial report on Oregon's incipient experiment in legalized assisted suicide shows no indication of exploitation of vulnerable populations.²⁸¹

Opponents of PAS—in stressing various dangers supposedly accompanying legalization of PAS—have paid scant attention to the fact that similar feared abuses have not materialized in the context of presently accepted modes of hastening death. One exception is the New York State Task Force on Life and the Law. In an addendum to its report opposing legalization of PAS, the Task Force contends that PAS would be more dangerous than current practices because current practices usually occur within health care institutions—thus ensuring some visibility and collective responsibility.²⁸² The apparent assumption is that PAS would be implemented in a relatively insulated home setting; that is, PAS would be a matter for individual patients, physicians, and pharmacists without the scrutiny provided by an institutional setting.

The visibility argument is not particularly convincing. Not all current end-of-life practices have broad exposure to

279. See *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments*, 274 JAMA 1591 (1995). In New Jersey, judges endorsing a competent patient's prerogative to dictate withdrawal of life support initially insisted on special safeguards—specifically, certification of the patient's competence and prognosis by two independent physicians beside the attending physician. See *In re Farrell*, 529 A.2d 404 (N.J. 1987). That precaution proved burdensome and excessive in light of the fact that no abusive practices surfaced in New Jersey. The New Jersey State Board of Medical Examiners has therefore eliminated the requirement of additional physician certification.

280. See, e.g., Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996) (discussing the proposed statute to regulate PAS); Timothy Quill et al., *Care of the Hopelessly Ill: Proposed Criteria for Physician-Assisted Suicide*, 327 N. ENG. J. MED. 1380, 1381-82 (1992) (detailing the proposed safeguards for PAS) [hereinafter Quill et al., *Care of the Hopelessly Ill*].

281. See Sam Howe Verhovek, *Oregon Reporting 15 Deaths in 1998 Under Suicide Law*, N.Y. TIMES, Feb. 18, 1999, at A7; Patients Choosing Assisted Suicide Defied Predictions, MEDICAL ETHICS ADVISOR, (May 1999), pp. 51-52; Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon—The First Year's Experience*, 340 N. ENG. J. MED. 577 (1999).

282. See NEW YORK STATE TASK FORCE, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 15 (Supp. 1997).

institutional personnel. Hundreds of thousands of deaths occur outside of institutions in the presence of few observers, if any, beyond an attending physician or nurse or home health care aide. Of the 2.3 million annual deaths in the United States, at least 20% (460,000) occur in private residences.²⁸³ Another approximately 20% of deaths (and that percentage is constantly increasing) occur in nursing homes in which scrutiny and monitoring of patient and staff interactions are markedly less stringent than in hospitals. These statistics also gloss over the many older patients who were exposed to long periods of home care and were transferred to hospitals only on the day they died.²⁸⁴ Even within an institution like an acute care hospital, not all terminal practices involving competent patients are widely scrutinized. This is especially so regarding use of risky analgesics and terminal sedation.²⁸⁵ All this effectively means that current end of life practices—including withdrawal of life support, use of risky analgesics, and terminal sedation—result in hundreds of thousands of deaths without rigid scrutiny. Yet no source has demonstrated or even suggested systematic or widespread abuse.

On the PAS side of the coin, it would be possible to make PAS a carefully monitored process. Because of the novelty of PAS, proponents are willing to prescribe procedural safeguards, including verification of patient competence, prognosis, and deliberateness of decision making.²⁸⁶ Not only does Oregon's statute call for such protections,²⁸⁷ but initial reports of the statute's application indicate no sign of abuse.²⁸⁸ It would even be possible to

283. See INSTITUTE OF MEDICINE, *APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE* 39 (Marilyn J. Field & Christine K. Cassel eds., 1997).

284. See *id.* at 40. The National Hospice Organization estimates that, in 1997, 77% (381,000) of the 495,000 hospice-connected deaths were at home and that the percentage of hospice-connected patients is increasing by about 16% annually. *Hospice Fact Sheet*, NAT'L HOSPICE ORG. (Arlington, Va.), Nov. 18, 1988 (on file with the *Buffalo Law Review*).

285. See Finnis, *supra* note 269, at 1133 (noting how easy it is for physicians to kill via analgesic doses). See generally Orentlicher *supra* note 107 (arguing that terminal sedation is more susceptible to abuse than PAS).

286. See Baron, *supra* note 280, at 18.

287. See Oregon Death with Dignity Act, ORE. REV. STAT. § 127.800, §§1.01(7)(a-e) (1997).

288. See Verhovek, *supra* note 281, at A1.

confine PAS to institutional settings.²⁸⁹ In short, opponents of legalizing PAS do not adequately explain why PAS is more dangerous than accepted end-of-life practices.²⁹⁰

A few opponents of PAS draw a perverse inference from the apparently abuse-free history, even absent procedural safeguards, surrounding a competent patient's prerogative to reject life support when compared to the abuses projected to accompany PAS. They suggest that in order to preclude uneven treatment of end-of-life practices, procedural restrictions on withdrawal of life support might be instituted, despite the abuse-free history, together with any procedural safeguards regulating PAS.²⁹¹ This would indeed be a perverse result—increasing constraints on current practices despite their proven safety—just to ensure parity of treatment with PAS. Nor is identical procedural handling of PAS and other end-of-life practices logically compelled. Special procedural protections accompanying legalization of PAS would be rational and justifiable just from the relative novelty of the practice.²⁹²

We promised to underline anomalies or tensions on both sides of the PAS debate. The proponents of legalizing PAS are by no means immune from criticism. The principal flaw or tension in the pro-PAS position concerns the ultimate scope of any prerogative to hasten death either by assistance to suicide or by active euthanasia.

Most proposals for legalization of physician-assisted

289. See Buchanan, *supra* note 19, at 41 n.24.

290. Ezekiel Emanuel speaks to the comparative magnitude of danger from a quantitative perspective. That is, he argues that many more people would be "at risk" from PAS because every dying patient would be a potential candidate for PAS and many more people are dying than are institutionalized and connected to life support. Emanuel, *supra* note 9, at 1012. This perspective tends to minimize both the abuse-free history of removal of life support and the possibility of procedural safeguards accompanying legalization of PAS. It also tends to overlook the potential for abuse in existing practices such as use of risky analgesics and terminal sedation.

291. For arguments that commentators who (like us) see the moral equivalence of letting die and killing will end up precipitating increased constraints on current end-of-life practices such as withdrawal of life support, see Johnson, *supra* note 269, at 37; George J. Annas, *The Promised End — Constitutional Aspects of Physician-Assisted Suicide*, 335 N. ENG. J. MED. 683, 686 (1996).

292. Another anomaly of the anti-PAS position is its reliance on feared abuses even while evidence grows that underground euthanasia occurs at a significant rate without any indications of exploitation of vulnerable populations.

suicide confine the beneficiaries to competent, terminally ill individuals.²⁹³ Oregon's authorization of physician assistance to suicide is limited to patients who will, according to medical judgment, unavoidably die within six months.²⁹⁴ The litigants urging the Supreme Court to find a constitutional right to assistance to suicide restricted that putative right to competent, terminally ill people at the end stage of the dying process.²⁹⁵ These efforts to restrain PAS are disingenuous and unpersuasive both from a legal and public policy perspective.

On a legal plane, the Ninth Circuit (in its decision ultimately reversed by the Supreme Court) half-heartedly justified limiting the patient prerogative in issue to the end stages of terminal illness by claiming a "substantially diminished" state interest in preserving life in the final stages of an unpreventable dying process.²⁹⁶ That rationale is unconvincing. As we pointed out earlier,²⁹⁷ a state's abstract interest in preserving life endures unwaveringly up to the moment of death.²⁹⁸ If an individual prerogative to hasten death prevails, as in the case of rejecting life-sustaining medical intervention, it is because the individual interests outweigh the state interests in issue—not because of the short duration of a remaining existence.²⁹⁹ Those individual interests (in self-determination and bodily integrity) prevail in the balance even where the patient is

293. See, e.g., Baron, *supra* note 280, at 11; Dworkin, *supra* note 239, at 1158.

294. See Oregon Death With Dignity Act, OR. REV. STAT. § 127.800, §1.01(12) (1997).

295. See Respondent's Brief, at 10, *Glucksberg* (No. 96-110).

296. *Compassion in Dying v. State of Wash.*, 79 F.3d 790, 820-21 (9th Cir. 1996).

297. See *supra* notes 81-82 and accompanying text.

298. See also Yale Kamisar, *The 'Right to Die': On Drawing (and Erasing) Lines*, 35 DUQ. L. REV. 481, 509-10 (1996) (ridiculing the notion of a diminished state interest in life at its boundaries) [hereinafter Kamisar, *The Right to Die*]; Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 742-43 (1995) [hereinafter Kamisar, *Against Assisted Suicide*].

299. "The state's indirect and abstract interest in preserving the life of the competent patient generally gives way to the patient's much stronger personal interest in directing the course of his own life." *In re Conroy*, 486 A.2d 1209, 1223 (N.J. 1985). Even when the U.S. Supreme Court rejected the constitutional challenge to state laws banning assistance to suicide, several justices expressed strong sympathy with a competent patient's prerogative to avoid suffering.

forgoing a long preservable existence.³⁰⁰

On a policy plane, any effort to limit a PAS prerogative to the end stage of existence is also likely to fail. The whole movement toward greater patient autonomy is grounded in avoidance of prolonged suffering and/or indignity during a dying process. Yet the greater the span of a projected dying process, the more suffering and/or indignity to be faced. To quote Justice Scalia: "[T]he patient who has 10 years of agony to look forward to has a more appealing case than the patient who is at the threshold of death."³⁰¹ Excluding dying persons who face protracted dying processes would be both cruel and imperfectly connected to the legitimate government interests in play.³⁰² In short, PAS cannot realistically be confined to patients at the end stage of an unavoidable dying process.

Nor can a dying patient's prerogative to actively hasten death be practicably confined to assisted suicide to the exclusion of active euthanasia. Some proponents of PAS contend that assistance to suicide is less susceptible to abuse and constitutes a less radical alteration of the medical role than active euthanasia because the patient rather than a physician performs the final lethal act.³⁰³ The patient's performance of the final act supposedly emphasizes the voluntariness and steadfastness involved, as self-killing is ostensibly harder than submitting to

300. Cases upholding a competent individual's right to reject life sustaining medical intervention do not limit the patient prerogative to the end-stage of a disease process. See *Thor v. Superior Ct.*, 855 P.2d 375 (Calif. 1993); *In re Peter*, 529 A.2d 419 (N.J. 1987). In fact, numerous cases uphold a patient's prerogative to reject treatment—usually but not always inspired by religious scruples—even when the patient is salvageable to a long existence and death is indefinitely avoidable. See, e.g., *Fosmire v. Nicoleau*, 551 N.E.2d 77, 85 (N.Y. 1990); *Public Health Trust v. Wons*, 541 So.2d 96, 98 (Fla. 1989); *McKay v. Bergstedt*, 801 P.2d 617, 623 (Nev. 1990).

301. Oral Argument at 28, *Glucksberg v. Washington*, 517 U.S. 1241 (1997) (No. 96-110).

302. See Kamisar, *The Right to Die*, *supra* note 298, at 504-09; Kamisar, *Against Assisted Suicide*, *supra* note 298, at 739-41; Brody, *supra* note 101, at 157-58, (noting the appeal of people suffering from degenerative neurologic disease); Quill et al., *Care of the Hopelessly Ill*, *supra* note 280, at 1381 (arguing that it would be arbitrary to exclude people suffering from progressive illness although not imminently dying).

303. See Baron, *supra* note 280 at 10; Quill et al., *Care of the Hopelessly Ill*, *supra* note 280, at 1381. For a contrary position, see Nicholas Dixon, *On the Differences between Physician-Assisted Suicide and Active Euthanasia*, 28 HASTINGS CTR. REP. 25, 25-29 (1998).

administration of death (for example, injecting oneself with a poison may be harder than accepting a lethal injection).³⁰⁴ Also, the physician's more indirect involvement in death by assisted suicide might ease the conscience of individual physicians and constitute less of an offense to traditional medical ethics than injection of a poison.³⁰⁵ Whatever the validity of these distinctions, the line between assistance to suicide and active administration of euthanasia cannot in practice be maintained. Yale Kamisar convincingly argues that circumstances would inevitably impel resort to euthanasia, not just assistance to suicide.³⁰⁶ The impetus would come in part from patients who are competent to request aid in dying but are either physically or emotionally unable to perform the final step necessary for suicide.³⁰⁷ A quadriplegic's case, or the case of someone physically weakened by diseases, provide examples.³⁰⁸ Another impetus would surface in the context of botched suicide attempts. Under a regime of lawful assistance to suicide, some percentage of suicide attempts would fail (from vomiting or from miscalculation of poison dosage) and the humane course would then be to allow someone to intervene and complete the fatal event (euthanasia).³⁰⁹ We agree with Ezekiel Emanuel's conclusion:

Practically speaking, then, there will be no distinction between PAS and euthanasia. . . . While . . . [the two] are conceptually

304. See John Deigh, *Physician-Assisted Suicide and Voluntary Euthanasia: Some Relevant Differences*, 88 J. CRIM. L. & CRIMINOLOGY 1155, 1159 (1998).

305. But see Dixon, *supra* note 303, at 25 (arguing that physician involvement in suicide is just as blameworthy as performance of euthanasia).

306. See Patrick M. Curran, Jr., *Regulating Death: Oregon's Death with Dignity Act and the Legalization of Physician-Assisted Suicide*, 86 GEO. L.J. 725, 743 (1998); Kamisar, *The Right to Die*, *supra* note 298, at 515-16; Kamisar, *Against Assisted Suicide*, *supra* note 298, at 745-47; see also Emanuel, *supra* note 9, at 984, 1001-03 (attacking "The Myth of Separation" between assisted suicide and euthanasia).

307. "Fairness requires that if we legalize [PAS], then we also make active euthanasia legally available to patients who are physically unable to commit [PAS] or who prefer to die by lethal injections that cannot easily be self-administered." Dixon, *supra* note 303, at 29.

308. See '60 Minutes' *Will Air Death by Kevorkian*, NEWARK STAR-LEDGER, Nov. 20, 1998, at 28 (reporting Dr. Kevorkian's admission that he euthanized an ALS patient incapable of ingesting a poison).

309. See Curran, *supra* note 306, at 743; Emanuel, *supra* note 9, at 1002. The perfect poison cocktail is not yet known. As long as there are failed attempts, euthanasia will be needed as a backup. See *id.*

distinct, from a social policy perspective this distinction cannot be sustained. The real choice is to legalize both physician-assisted suicide and euthanasia, or to legalize neither.³¹⁰

A strong impetus would also exist to extend any prerogative to assist suicide not only to active euthanasia, but also to non-voluntary active euthanasia. Both American experience regarding withdrawal of life support and Dutch experience regarding euthanasia confirm the likelihood of this course. Once competent patients are accorded a particular prerogative to hasten death in order to avoid intolerable suffering and indignity, as in rejection of mechanical life support, the overwhelming impulse is to accord the same benefit to incompetent patients. The easiest cases will be those where now incompetent patients have, by advance directive or other prior competent expression, requested euthanasia. But even in the absence of prior expressions, an impetus will surface to extend euthanasia to now incompetent patients—at least where surrogate decision-makers are confident that the patient, if competent, would have wanted that course. To some extent, this consequence derives from judicial unwillingness to say that people lose their “rights” upon becoming incompetent or that the developmentally disabled do not have comparable “rights” to the abled. State judiciaries considering withdrawal of life support from incompetent patients often strive to extend “the same panoply of rights and choices” to incompetent as competent patients.³¹¹ While recognition of the dignity and worth of incompetent beings does entail according them a variety of rights, a *choice* of medical treatment involves an autonomous weighing of options that is simply beyond the capability of an incompetent person.³¹² The dignity and worth of

310. Emanuel, *supra* note 9, at 1003.

311. *In re Grant*, 747 P.2d 445, 449 (Wash. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 634 (Mass. 1986); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 428 (Mass. 1977). “Nor does the fact that Nancy Cruzan is now incompetent deprive her of her fundamental rights.” *Cruzan v. Director, Missouri Dep’t Health*, 497 U.S. 261, 308 (1990) (Brennan, J., dissenting); *see also* Scofield, *supra* note 267, at 328.

312. “Whatever rights an incompetent person may be said to possess, how can autonomous choice be one of them when incompetency means precisely the inability to exercise choice?” Sanford Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CALIF. L. REV. 857, 870 (1992); Neal F. Splaine, Note, *The Incompetent Individual’s Right to Refuse Life-Sustaining Medical Treatment:*

incompetent persons are promoted, though, by allowing surrogates to make decisions that advance the interests of their now incompetent charges. And that is what American courts have largely done in the context of dying incompetent patients.³¹³ This effectively means that when a competent patient would choose death because of intolerable suffering and/or indignity, surrogates will seek to afford the same beneficent relief to incompetent patients. That tendency will exist in the active euthanasia context just as it has in the passive euthanasia (withdrawal of life support) context. The motivating force is not so much extension of "rights" as solicitude for the suffering and/or indignity of an incompetent patient. "Compassion for those who suffer may obscure the distinction between those who ask for death and those who may be unable to request it."³¹⁴

The tendency to extend a euthanasia prerogative to the context of dying incompetent patients has clearly appeared in the Netherlands experience. All empirical studies of the Dutch experience show that some percentage of euthanasia acts are performed on incompetent patients despite the ostensible impermissibility of such acts under Dutch law.³¹⁵ This slide into some non-voluntary euthanasia appears not to be symptomatic of abuse, for there is no showing that such acts are impelled by cupidity, prejudice, or pressure, or that they are performed contrary to patients' wishes. Rather, a measure of non-voluntary euthanasia seems to be a product of humane impulses to relieve extreme suffering of some never-competent patients (primarily infants with

Legislating, Not Litigating, A Profoundly Private Decision, 27 SUFFOLK L. REV. 905, 932 (1993).

313. See *Drabick v. Drabick*, 245 Cal. Rptr. 840, 855 (Cal. Ct. App. 1988); *In re Guardianship of L.W.*, 482 N.W.2d 60, 68 (Wis. 1992); JAMES M. HOEFLER, *MANAGING DEATH* 105-12 (1997). This substituted judgment approach is not universally accepted. See Lawrence Nelson & Ronald Cranford, *Michael Martin and Robert Wendland: Beyond the Vegetative State*, 15 J. CONTEMP. HEALTH L. & POL'Y 427 (1999) (detailing some judicial reluctance to authorize terminal decisions by surrogates where the now incompetent patient retains consciousness).

314. *Washington v. Glucksberg*, 521 U.S. 702, 783 (1997) (Souter J., concurring).

315. See, e.g., Paul J. van der Mass et al., *supra* 176, at 672 (indicating 0.8% of Dutch deaths involved administration of lethal drugs without patient request); CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* 135-37 (1991); Herbert Hendin, *The Slipping Slope: The Dutch Example*, 35 DUQ. L. REV. 427, 433-34 (1996).

multiple deficits) or to provide relief for severely deteriorated patients on the verge of unavoidable death.³¹⁶ Similar humane impulses can be expected to impel extension of euthanasia from competent to incompetent patients in this country.

All this is not to say that the specter of non-voluntary euthanasia warrants preclusion of PAS. Non-voluntary euthanasia is often cited as the ultimate horror on a slippery slope flowing from legalization of assisted suicide. Yet, as the Dutch experience tends to show, non-voluntary euthanasia is not necessarily abusive of vulnerable persons. Assessment of the handling of incompetent dying patients to date—especially in the contexts of withdrawal of life support and use of risky analgesics—might convince public policy makers that incompetent patients can be protected against abuse in the euthanasia context as well. Appropriate decision-making standards to guide surrogates might be available whether the ultimate issue is withdrawal of life support or euthanasia.³¹⁷ Our point is that proponents of PAS are disingenuous when they assert that legal end-of-life practices can be extended to physician-assisted suicide without entailing some voluntary active euthanasia and, ultimately, some active euthanasia on incompetent patients.

Perhaps the hardest question about PAS is whether the practice can be confined to people suffering from natural afflictions as opposed to people suffering from unbearable existential distress provoked by life's general circumstances. If unbearable suffering is the keystone of a prerogative to control time of dying, why should not the rejected lover or humiliated criminal or bankrupted entrepreneur have that prerogative, at least where the dismal life circumstance is accompanied by unbearable

316. See van der Maas, *supra* note 176, at 672 (indicating that half the non-voluntary deaths in the Netherlands involved patients who were "near to death and clearly suffering grievously" yet verbal contact had become impossible). Also, some percentage of these Dutch patients had made prior competent requests to die, but slipped into incompetency before the request could be implemented. See *id.*

317. Regarding decision-making standards for incompetent patients, see generally Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 RUTGERS L. REV. 1193, 1248-50 (1996).

suffering? Indeed, one case in the Netherlands did authorize euthanasia for a competent, despondent individual suffering from existential distress rather than a disease.³¹⁸

Our response is that a moral line separates the disease-afflicted from the simply despondent. A person's response to a natural pathology is regarded, at least in our culture, as a matter of private choice. While avoidance of suffering can be an element affecting choice, autonomy in end-of-life decision making is not primarily grounded in avoidance of suffering. The moving force is more likely avoidance of indignity.³¹⁹ Many reported cases upholding decisions to withdraw life support involve permanently vegetative patients where suffering is simply not an issue; avoidance of indignity then becomes the primary justification for allowing such patients to die.³²⁰ And where conscious but gravely debilitated patients are allowed to die, the impetus may well be avoidance of indignity rather than avoidance of suffering.³²¹ This focus on dignity in an inexorable dying process helps substantiate a moral line differentiating assistance in dying given to a fatally stricken patient from assistance to the existentially distressed person.³²² Dismal life circumstances, such as the loss of loved ones, loss of job, and bankruptcy, can indeed impel deep suffering and despondency, but such despondency does not generate the same kind of sympathy and moral understanding of despair as for an afflicted person facing unavoidable death. Life circumstances are transitory; physical afflictions often are not. Indeed, rational suicide over transitory life circumstances is an oxymoron because of its implicit

318. See Gene Kaufman, *State v. Chabot: Euthanasia Case from the Netherlands*, 20 OHIO N.U. L. REV. 815, 816-19 (1993).

319. See Norman L. Cantor, *The Real Ethic of Death and Dying*, 94 MICH. L. REV. 1718, 1730-31, 1735-36 (1996); cf. van der Maas, *supra* note 315, at 672 (noting that 57% of Dutch requests for euthanasia inspired at least in part by avoidance of indignity versus 46% pain-inspired). HOEFLER, *supra* note 313, at 156-57. See generally Alan Handler, *Individual Worth*, 17 HOFSTRA L. REV. 493 (1989).

320. See Cantor, *supra* note 317, at 1249-50.

321. See *In re Grant*, 747 P.2d 445, 451, 457 (Wash. 1987); *In re Conroy*, 486 A.2d 1209, 1246 (N.J. 1986) (Handler, J., concurring).

322. For a description of the immorality of despair as a rationale for condemning suicide, see David A.J. Richards, *Constitutional Privacy, The Right to Die, and the Meaning of Life: A Moral Analysis*, 22 WM. & MARY L. REV. 327, 377 (1981).

repudiation of possibilities for change. The same moral objection is not generally leveled against a fatally afflicted patient who may opt to die sooner rather than later. Hence, the boundary line of permissible assisted suicide can probably be drawn at people facing an unavoidable dying process.³²³

VI. CONCLUSION

We have surveyed various ways in which medical personnel might respond to a terminally ill patient who is suffering unbearably and wishes to die. Each of these medical courses either hastens, or creates a risk of hastening, death and thus potentially implicates criminal law.

Several modes of hastening death seem consistent with medical ethics and criminal law. In some instances, a dying patient's autonomy interest in timing death—deciding if and how to struggle against an inexorable and debilitating fatal affliction—is reinforced by a bodily integrity interest producing a legal prerogative to avoid bodily intrusions even when death will ensue. These elements explain why medical personnel may withdraw life support systems; when the afflicted patient rejects medical invasions, the disease is deemed to kill the patient rather than the acts of the medical personnel. Similarly, we suggest that medical personnel may provide comfort care to a patient who has decided to forgo eating and drinking. This form of care also respects the dying patient's invocation of bodily integrity and would not be viewed as assisting the patient's suicide.

Moving to situations in which the palliative act of a physician may kill the patient, we conclude that the line between legal and illegal conduct depends on application of principles of criminal recklessness. The primary issue becomes: when is risk of death justifiable? That is, when does the benefit to the patient (relief of suffering) warrant the increased risk of death posed by the palliative acts of medical personnel. We suggest that the use of risky

323. See, e.g., *People v. Kevorkian*, 1993 WL 603212, *18 (Mich. Cir. Ct., Dec. 13, 1993) (drawing the boundary at presence of "an objective medical condition"), reversed by *Hobbins v. Attorney General*, 518 N.W.2d 487 (1994). The remaining question would be whether patients suffering grievously from chronic pain should have a PAS prerogative even though they are not terminally ill, that is, their natural affliction is not fatal.

analgesics is lawful as long as the dosage is necessary to relieve pain and does not create a practical certainty of hastening death. When the patient's symptoms and suffering are best addressed by deep sedation, we suggest that this too is legally permissible as long as this palliative course does not create a practical certainty that death will result from the sedation. This conclusion insulates certain forms of terminal sedation but leaves unclear the legal status of deep sedation simultaneous with withholding of artificial nutrition and hydration.

Current law draws the line at physician-assisted suicide and euthanasia. The main distinction between this kind of conduct (PAS) and other palliative intervention is that death is certain or practically certain so that the physician knows that the patient will die. This line between conduct that poses a substantial risk of death and conduct that is practically certain to cause death reflects a profound distinction in the criminal law. Actors who are engendering risk (who are potentially reckless) can always seek to assert a general justification for the risk they create—in this context, a justification that the act confers a net benefit (relief of suffering) on the person who ultimately dies. Actors who know that their conduct is practically certain to cause death cannot assert that kind of justification.³²⁴ One simply cannot argue that a knowing or purposeful killing is justifiable because the victim is better off dead. Thus, to place physician-assisted suicide and euthanasia on the criminal side of homicide is consistent with centuries of criminal law.

Whether this is the best policy for the future is a difficult question. We sketched certain difficulties with both sides of the argument for legalization of PAS, highlighting tensions and anomalies between the currently lawful and unlawful modes of hastening death. However public policy toward PAS comes out, the other forms of medical assistance that we discussed in this paper (VSED, risky analgesics, and certain modes of terminal sedation) are in our view lawful and should be made widely available to dying patients who make informed choices to take the risks entailed by these medical courses.

324. For a brief discussion of the kinds of justification that can be offered when one acts purposely or knowingly to cause death, see *supra* note 136.

