1997

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PHYSICIAN-ASSISTED SUICIDE: A TRAGIC VIEW

John D. Arras, Ph.D.*

I. PROLOGUE-A REFLECTION ON THE CAREER OF JOHN FLETCHER

Throughout his long and distinguished career, John Fletcher has made major contributions to our public life in a wide variety of important policy debates. He has pursued his vision of a just and decent society with unremitting dedication to both the worthy goal of medical progress and to the moral rights of all human beings. His contributions to our ongoing struggles with the problems of biomedical research and reproductive technologies reflect not only an extraordinarily keen intellect, but also a host of moral virtues, not the least of which is a remarkable capacity to be led not by well-worn habit and bias, but rather by the power of evidence and argument. In rather stark contrast to a number of well-known scholars who have stuck to their ideologically driven positions well after the latter have been thoroughly discredited by critics, John Fletcher has had the courage and good sense to reverse his thinking and redirect his conclusions whenever he thought the arguments demanded it.

Perhaps nowhere is this capacity to rethink a well-entrenched position more evident than in John Fletcher's long-standing reflections on the difficult problem of euthanasia and physician-assisted suicide ("PAS"). Fifteen years ago, Fletcher led a new generation of critics who opposed these practices not on the narrow religious rationale that all such killing is inherently immoral, but rather on the basis of a thoroughly secular, consequentialist analysis of the likely bad effects of implementing the practices as a matter of social policy. In an influential essay published in 1982, he argued that allowing a policy of euthanasia would result both in probable harms to innocent parties—the poor, the psychologically disturbed, the vulnerable elderly—and in a loss of opportunity for achieving positive goods.¹

* Porterfield Professor of Biomedical Ethics and Professor of Philosophy University of Virginia. The author would like to thank Yale Kamisar, Tom Murray, and Bonnie Steinbock for helpful discussions and exchanges on the issues dealt with in this paper.

¹ See John Fletcher, Is Euthanasia Ever Justifiable?, in Controversies in Oncology 297 (Peter H. Wiernik ed., 1982).
Fletcher added a novel twist to an already voluminous literature by contending that allowing terminal patients to opt for an easy death would subvert current medical progress in pain management, gerontology, and the care of the dying. He suggested that once society removes the moral and legal barriers to killing terminally ill patients, the incentives for improving their conditions, which mainly derive from the existence of such barriers, will lose much of their force. Thus, while at that time Fletcher admitted the moral licitness of certain individual acts of "mercy killing" and what we today would call PAS, he argued strongly against establishing a social policy on the basis of such exceptional cases. The likely social risks and foregone humanitarian progress, he urged, would simply be too great.

In recent years, however, John Fletcher and the rest of society have been forced to reassess our positions in light of a reinvigorated social movement in favor of PAS and euthanasia. Confronted by widespread and largely unnecessary human suffering attendant upon the way we now die, by the insistent claims of individual autonomy, and by the example of compassionate and courageous physicians, Fletcher has abandoned his earlier opposition and embraced a highly qualified proposal to legalize and regulate these contested practices. He now argues that suffering can be ended, and autonomy honored, without unduly endangering the social fabric or the prospects for much-needed reforms in the care of the dying. While I regard his position on this matter to be the result of much soul searching and sober reflection, I strongly disagree with Fletcher regarding the social logic of attempting to regulate PAS. Instead of merely heaping additional praise upon John Fletcher, I offer him something more in spirit of his remarkable life and career, a counter-argument, that I hope will lead him to change his mind yet again.

II. Introduction

For many decades now, the call for PAS and euthanasia have been perennial lost causes in American society. Each generation has thrown up an assortment of earnest reformers and cranks who, after attracting their fifteen minutes of fame, inevitably have been defeated by the combined weight of traditional law and morality. Incredibly, two recent Federal appellate court decisions have suddenly changed the precedent landscape

2. Id.
in this area, making the various states within their respective jurisdictions the first governments in world history, excepting perhaps the Nazi regime in Germany, to officially sanction PAS. Within the space of a month, both an eight to three majority of the United States Court of Appeals for the Ninth Circuit,\(^4\) on the West Coast, and a three judge panel in the United States Court of Appeals for the Second Circuit,\(^5\) in the Northeast, struck down long-standing state laws forbidding physicians to aid or abet their patients in acts of suicide. Within a virtual blink of an eye, a seemingly unshakable consensus within the medical profession, the judiciary, the bioethics community, and the general public had been unceremoniously overturned.

Judge Reinhardt, writing for a majority of an *en banc* decision of the Ninth Circuit,\(^6\) held that competent, terminally ill patients have a powerful "liberty interest," what used to be called a Constitutional right, to enlist the aid of their physician in hastening death via prescriptions for lethal drugs.\(^7\) He argued that just as the right to privacy guarantees women the right to choose an abortion, this liberty interest protects a right to choose the time and manner of one's death.\(^8\)

In response to warnings against the expansion of this right to broader categories of patients (e.g., to the mentally incapacitated) and against the great likelihood of mistake and abuse, Judge Reinhardt permitted the regulation of PAS in order to avoid such evils; however, he pointedly ruled out any and all blanket prohibitions.\(^9\) In response to the traditional objections that allowing PAS would subvert the state's interests in preventing suicide and maintaining the integrity of the medical profession, Judge Reinhardt contended that our society already has effectively erased the distinction between merely allowing patients to die and killing them.\(^10\) Reinhardt claimed that by allowing patients or their surrogates to forgo life-sustaining medical treatments, including artificially administered nutrition and hydration, and by sanctioning the administration of pain-killing drugs that might also hasten death, our society already permits a variety of "death inducing" practices. Thus, the social risks of al-

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5. Quill v. Vacco, 80 F.3d 716, 731 (2nd Cir. 1996).
6. See Compassion in Dying, 79 F.3d at 790.
7. *Id.* at 816.
8. *Id.* at 813-14.
9. *Id.* at 816-32, 836-37 (reviewing state interests and illustrating the application of the balancing test and holding).
10. *Id.* at 822-23.
lowing PAS are only different in degree, not in kind, from risks that we already countenance.

Writing for the Second Circuit in striking down a similar New York statute, Judge Miner explicitly rejected the claim of the Second Circuit majority that a "substantive due process" right of PAS exists in the Constitution. He conceded that the Supreme Court is unlikely to extend the boundaries of the so-called right to privacy, but found nevertheless that the statute violated the equal protection clause of the Constitution.\textsuperscript{11} Echoing Judge Reinhardt's assertion that only a difference of degree separates PAS from the foregoing of life-sustaining treatments—claiming in effect that the administration of potentially death hastening analgesics constitutes a kind of suicide—Judge Miner observed that New York's law\textsuperscript{12} allowed some people relief from the ravages of terminal illness (i.e., those connected to some form of removable life-support) while denying relief to those not so connected, for whom PAS was the only remaining exit. Concurring with Judge Reinhardt that the social risks of PAS are identical to those of our more socially approved "death inducing" practices, Judge Miner concluded that this kind of differential treatment serves no legitimate state purpose. Thus, he held that the law was unconstitutional even in the absence of a new fundamental right to PAS.\textsuperscript{13}

What to think of these startling decisions? Are they harbingers of a new world brave enough to overcome centuries of religious censure and fear-mongering, a world that will no longer permit human beings to suffer unwillingly the torments of terminal illness? Or are they dangerous aberrations, decisions that simultaneously affirm the autonomy of some, while endangering the lives of society's most vulnerable citizens? While I find myself to be deeply sympathetic to the central values motivating the push for PAS and euthanasia, this Article shall argue that these practices pose too great a threat to be legalized.

Central to the argument will be the claim that these decisions employ a form of case-based reasoning that is ill-suited to the development of sound social policy in this area. This Article shall argue that in order to do justice to the very real threats posed by the practices of PAS and euthanasia, we need to adopt precisely the kind of policy perspective that the courts reject on principle. Thus, this Article presents an argument for a forward-looking, legislative approach to PAS and euthanasia, as op-

\textsuperscript{11} Quill v. Vacco, 80 F.3d 716, 724-25 (2nd Cir. 1996).
\textsuperscript{12} Id. at 727-29.
\textsuperscript{13} Id. at 727.
posed to an essentially backward-looking, judicial or constitutional approach.\textsuperscript{14}

This Article develops this argument in sequential steps. First, it briefly identifies the central concerns and values of the pro-PAS/euthanasia position, and then attempts to articulate the variety of serious and predictable social risks attendant upon these practices, risks that take the form of two distinct "slippery slopes." Having thus exhibited the cases pro and contra PAS/euthanasia, this Article lays out the various "policy options" or ways of thinking about these disputed practices. It shall be argued that the judicial approach is blind to some very serious potential social dangers and that, in its enthusiasm for liberty interests and equal protection, it may actually end up prohibiting precisely the kinds of social checks that we need to curtail these dangers. On the other hand, this Article also argues that the specific legislative proposal made by John Fletcher and colleagues goes a long way towards mollifying the fears of critics like me, but that in the end it also represents too great a social risk at this time. The Article concludes with a plea to maintain the legal status quo, i.e., a regime that does not legally sanction PAS and euthanasia, but nevertheless covertly permits some particularly compassionate and courageous physicians to violate the law in fear and trembling. At the same time, the Article calls for a total revolution in the medical status quo governing the delivery of palliative care, the treatment of clinical depression, and the care for the dying.

III. ARGUMENTS AND MOTIVATIONS IN FAVOR OF PAS/EUTHANASIA

The philosophical case for PAS and euthanasia consists of two distinct prongs, both of which speak simply, directly, and powerfully to our commonsensical intuitions. First, there is the claim of autonomy, that all of us possess a right to self-determination in matters profoundly touching on such religious themes as life, death, and the meaning of suffering. Just as we should each be free to make important choices bearing on how we shall live our own lives, so we should be equally free in choosing the time and manner of our deaths. For some, more life will always be welcome as a gift or perhaps even as a test of faith, but for others, continued life signifies only disfiguring suffering and the unrelenting loss of everything.

\textsuperscript{14} My stance on these issues has been profoundly influenced by my recent participation in the efforts of the New York State Task Force on Life and the Law (hereinafter New York Task Force) to come to grips with this issue. Following a painstaking review of the moral, legal, and social arguments, this highly pluralistic advisory committee unanimously concluded against the legalization of either PAS or direct killing by physicians.
that invested their lives with meaning and dignity. As philosopher Ronald Dworkin has eloquently argued, it is a form of tyranny to force someone to endure unendurable suffering at the end of life merely for the sake of someone else's values. Each of us should be free to live or die as we see fit according to our own conceptions of the meaning of life and death.

Second, PAS and/or euthanasia are merciful acts that deliver terminally ill patients from painful and protracted death. According to the utilitarian, acts are morally right insofar as they promote happiness and alleviate unhappiness, and wrong insofar as they cause or allow others to suffer needlessly. Even according to the traditional ethic of the medical profession, physicians have a solemn duty not merely to extend life whenever possible (and desirable), but also to alleviate pain and suffering whenever possible. For patients suffering from the final ravages of end-stage AIDS or cancer, a doctor's lethal prescription or injection can be, and often is, welcomed as a blessed relief. Accordingly, we should treat human beings at least as well as we treat grievously ill or injured animals by putting them, at their own request, out of their misery.

These philosophical reflections can be supplemented with a more clinical perspective addressed to the motivational factors lying behind many requests to die. Many people advocate legalization because they fear a loss of control at the end of life. They fear falling victim to the technological imperative; they fear dying in chronic and uncontrolled pain; they fear the psychological suffering attendant upon the relentless disintegration of the self; they fear, in short, a bad death. All of these fears, it so happens, are eminently justified. Physicians routinely ignore the documented wishes of patients and all-too-often allow patients to die with uncontrolled pain. Studies of cancer patients have shown that over fifty percent suffer from unrelieved pain, and many researchers have found that uncontrolled pain, particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor for suicide and suicidal ideation.

Clinical depression is another major factor influencing patients' choice

16. A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 JAMA 1591, 1591-92 (Nov. 22, 1995).
18. Id. at xiv.
of suicide. Depression, accompanied by feelings of hopelessness, is the strongest predictor of suicide for both individuals who are terminally ill and those who are not. Yet most doctors are not trained to notice depression, especially in complex cases such as the elderly suffering from terminal illnesses. Even when doctors succeed in diagnosing depression, they often do not successfully treat it with readily available medications in sufficient amounts.

Significantly, the New York Task Force found that the vast majority of patients who request PAS or euthanasia are capable of being treated successfully both for their depression and their pain, and that when they receive adequate psychiatric and palliative care, their requests to die usually are withdrawn. In other words, patients given the requisite control over their lives and relief from depression and pain usually lose interest in PAS and euthanasia.

With all due respect for the power of modern methods of pain control, it must be acknowledged that a small percentage of patients suffer from conditions, both physical and psychological, that currently lie beyond the reach of the best medical and humane care. Some pain cannot be alleviated short of inducing a permanent state of unconsciousness in the patient, and some depression is unconquerable. For such unfortunate patients, the present law on PAS/euthanasia can represent an insuperable barrier to a dignified and decent death.

IV. OBJECTIONS TO PAS/EUTHANASIA

Opponents of PAS and euthanasia can be grouped into three main factions. One strongly condemns both practices as inherently immoral, as
violations of the moral rule against killing the innocent. Most members of this group tend to harbor distinctly religious objections to suicide and euthanasia, viewing them as violations of God's dominion over human life. They argue that killing is simply wrong in itself, whether or not it is done out of respect for the patient's autonomy or out of concern for her suffering. Whether or not this position ultimately is justifiable from a theological point of view, its imposition on believers and non-believers alike is incompatible with the basic premises of a secular, pluralistic political order.

A second faction primarily objects to the fact that physicians are being called upon to do the killing. While conceding that killing the terminally ill or assisting in their suicides might not always be morally wrong for others to do, this group maintains that the participation of physicians in such practices undermines their role as healers and fatally compromises the physician-patient relationship.

Finally, a third faction readily grants that neither PAS nor active euthanasia, practiced by ordinary citizens or by physicians, are always morally wrong. On the contrary, this faction believes that in certain rare instances early release from a painful or intolerably degrading existence might constitute both a positive good and an important exercise of personal autonomy for the individual. Indeed, many members of this faction concede that should such a terrible fate befall them, they would hope to find a thoughtful, compassionate, and courageous physician to release them from their misery. But in spite of these important concessions, the members of this faction shrink from endorsing or regulating PAS and active euthanasia due to fears bearing on the social consequences of liberalization. This view is based on two distinct kinds of so-called "slippery slope" arguments: one bears on the inability to cabin PAS/euthanasia within the confines envisioned by its proponents, the other focuses on the likelihood of abuse, neglect, and mistake.


26. The author was a part of this faction during his tenure with the New York Task Force.
A. An Option Without Limits

The first version of the slippery slope argument contends that a socially sanctioned practice of PAS would in all likelihood prove difficult, if not impossible, to contain within its originally anticipated boundaries. Proponents of legalization usually begin with a wholesomely modest policy agenda, limiting their suggested reforms to a narrow and highly specified range of potential candidates and practices. "Give us PAS," they ask, "not the more controversial practice of active euthanasia, for presently competent patients who are terminally ill and suffering unbearable pain." But the logic of the case for PAS, based as it is upon the twin pillars of patient autonomy and mercy, makes it highly unlikely that society could stop with this modest proposal once it had ventured out on the slope. As numerous other critics have pointed out, if autonomy is the prime consideration, then additional constraints based upon terminal illness or unbearable pain, or both, would appear hard to justify. Indeed, if autonomy is crucial, the requirement of unbearable suffering would appear to be entirely subjective. Who is to say, other than the patient herself, how much suffering is too much? Likewise, the requirement of terminal illness seems an arbitrary standard against which to judge patients' own subjective evaluation of their quality of life. If my life is no longer worth living, why should a terminally ill cancer patient be granted PAS but not me, merely because my suffering is due to my "non-terminal" Arterio Lateral Sclerosis ("ALS") or intractable psychiatric disorder?

Alternatively, if pain and suffering are deemed crucial to the justification of legalization, it is hard to see how the proposed barrier of contemporaneous consent of competent patients could withstand serious erosion. If the logic of PAS is at all similar to that of forgoing life-sustaining treatments, and we have every reason to think it so, then it would seem almost inevitable that a case soon would be made to permit PAS for incompetent patients who had left advance directives. That would then be followed by a "substituted judgment" test for patients who "would have wanted" PAS, and finally an "objective" test would be developed for patients (including newborns) whose best interests would be served by PAS or active

27. See Christine Cassel et al., Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide, 327 NEW ENG. J. MED. 1380, 1380-84 (1992) (approving of PAS but not of active euthanasia because it poses excessive social risks).


29. ALS also is known as Lou Gerhig's disease.
euthanasia even in the absence of any subjective intent.\textsuperscript{30}

In the same way, the joint justifications of autonomy and mercy combine to undermine the plausibility of a line drawn between PAS and active euthanasia. As the authors of one highly publicized proposal have come to see, the logic of justification for active euthanasia is identical to that of PAS.\textsuperscript{31} Legalizing PAS, while continuing to ban active euthanasia, would serve only to discriminate unfairly against patients who are suffering and wish to end their lives, but cannot do so because of some physical impairment. Surely these patients, it will be said, are "the worst off group," and therefore they are the most in need of the assistance of others who will do for them what they can no longer accomplish on their own.

None of these initial slippery slope considerations amount to knockdown objections to further liberalization of our laws and practices. After all, it is not obvious that each of these highly predictable shifts (e.g., from terminal to "merely" incurable, from contemporaneous consent to best interests, and from PAS to active euthanasia), are patently immoral and unjustifiable. Still, in pointing out this likely slippage, the consequentialist opponents of PAS/euthanasia are calling on society to think about the likely consequences of taking the first tentative step onto the slope. If all of the extended practices predicted above pose substantially greater risks for vulnerable patients than the more highly circumscribed initial liberalization proposals, then we need to factor in these additional risks even as we ponder the more modest proposals.

\textbf{B. The Likelihood of Abuse}

The second prong of the slippery slope argument argues that whatever criteria for justifiable PAS and active euthanasia ultimately are chosen, abuse of the system is highly likely to follow. In other words, patients who fall outside the ambit of our justifiable criteria will soon be candidates for death. This prong resembles what I have elsewhere called an "empirical slope"\textsuperscript{32} argument, as it is based not on the close logical resemblance of concepts or justifications, but rather on an empirical predic-

\begin{itemize}
\item \textsuperscript{30} In re Conroy, 486 A.2d 1209 (1985) (summarizing the logic of foregoing life-sustaining treatments).
\item \textsuperscript{31} See Cassel \textit{et al.}, supra note 27, at 1380-84. Cf. Miller \textit{et al.}, supra note 3, at 199-23 (conceding by the untenability of the previous distinction).
\item \textsuperscript{32} See John Arras, \textit{The Right to Die on the Slippery Slope}, 8 SOC. THEORY \& PRAC. 285 (1982) (describing the "slippery slope" argument in favor of PAS).
\end{itemize}
tion of what is likely to happen when we insert a particular social practice into our existing social system.

In order to reassure skeptics, the proponents of PAS/euthanasia concur that any potentially justifiable social policy in this area must meet at least the following three requirements. The policy would have to insist: first, that all requests for death be truly voluntary; second, that all reasonable alternatives to PAS and active euthanasia must be explored before acceding to a patient's wishes; and, third, that a reliable system of reporting all cases must be established in order to effectively monitor these practices and respond to abuses. As a social pessimist on these matters, I worry, given social reality as we know it, that all three assumptions are problematic.

With regard to the voluntariness requirement, we pessimists contend that many requests would not be sufficiently voluntary. In addition to the subtly coercive influences of physicians and family members, perhaps the most slippery aspect of this slope is the highly predictable failure of most physicians to diagnose reliably and treat reversible clinical depression, particularly in the elderly population. As one geriatric psychiatrist testified before the New York Task Force, we now live in the "golden age" of treating depression, but the "lead age" of diagnosing it. We have the tools, but physicians are not adequately trained and motivated to use them. Unless dramatic changes are effected in the practice of medicine, we can predict with confidence that many instances of PAS and active euthanasia will constitute abuses of the original criterion of voluntariness.

Second, there is the lingering fear that any legislative proposal or judicial mandate would have to be implemented within the present social system marked by deep and pervasive discrimination against the poor and members of minority groups. We have every reason to expect that a policy that worked tolerably well in an affluent community like Scarsdale or Beverly Hills, might not work so well in a community like Bedford-

33. See, e.g., Cassel et al., supra note 27; Miller et al., supra note 3; Charles H. Baron et al., Statute: A Model State Act to Authorize and Regulate Physician-Assisted Suicide, 33 HARV. J. LEGIS. 1 (1996) (illustrating examples of proposals offered).

34. Dr. Gary Kennedy, Division of Geriatrics, Montefiore Medical Center—Albert Einstein College of Medicine, Testimony before the New York Task Force on Life and the Law (on file with author).

35. See New York Task Force, supra note 17, at 143 (illustrating discrimination against minority groups). See also C.S. Cleeland et al., Pain and Its Treatment in Outpatients with Metastatic Cancer, 320 NEW ENG. J. MED. 592, 592-96 (1994) (illustrating a study that found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain).
Stuyvesant or Watts, where your average citizen has little or no access to basic primary care, let alone sophisticated care for chronic pain at home or in the hospital. There is also reason to worry about any policy of PAS initiated within our growing system of managed care, capitation, and physician-incentives for delivering less care.\(^3\) Expert palliative care no doubt is an expensive and time-consuming proposition, requiring more, rather than less, time spent just talking with patients and providing them with humane comfort. It is highly doubtful that the context of physician-patient conversation within this new dispensation of "turnstile medicine" will be at all conducive to humane decisions untainted by subtle economic coercion.

In addition, given the abysmal track record of physicians in responding adequately to pain and suffering,\(^3\) we also can confidently predict that in many cases all reasonable alternatives will not have been exhausted: Instead of vigorously addressing the pharmacological and psycho-social needs of such patients, physicians no doubt will continue to ignore, undertreat, or treat patients in an impersonal manner. The result will be more depression, desperation, and requests for physician-assisted death from patients who could have been successfully treated.\(^3\) The root causes of this predictable lapse are manifold, but include such factors as the inaccessibility of decent primary care to over thirty-seven million Americans. Other notable causes are: an appalling lack of training in palliative care even among primary care physicians and cancer specialists;\(^3\) discrimination in the delivery of pain control and other medical treatments on the basis of race and economic status; various myths shared by both physicians and patients about the supposed ill effects of pain medi-

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37. See New York Task Force, supra note 17, at 43-47. "Despite dramatic advances in pain management, the delivery of pain relief is grossly inadequate in clinical practice . . . . Studies have shown that only 2 to 60 percent of cancer pain, is treated adequately." Id. at 43.
38. See Wolf, supra note 33.
39. See New York Task Force, supra note 17, at 44.

In general, researchers report that many doctors and nurses are poorly informed about, and have limited experience with, pain and symptom management. Health care professionals appear to have a limited understanding of the physiology of pain and the pharmacology of narcotic analgesics. Accordingly, many lack the understanding, skills, and confidence necessary for effective pain and symptom management.

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Finally, with regard to the third requirement, pessimists doubt that any reporting system would adequately monitor these practices. A great deal depends here on the extent to which patients and practitioners will regard these practices as essentially private matters to be discussed and acted upon within the privacy of the doctor-patient relationship. As the Dutch experience conclusively has demonstrated, physicians will be extremely loath to report instances of PAS and active euthanasia to public authorities, largely for fear of bringing the harsh glare of publicity upon the patients' families at a time when privacy is most needed. The likely result of this predictable lack of oversight will be society's inability to respond appropriately to disturbing incidents and long-term trends. In other words, the practice most likely will not be as amenable to regulation as the proponents contend.

V. THREE APPROACHES TO SOCIAL POLICY

We come now to the difficult task of assessing the capacity of various social policy approaches to address adequately all of the conflicting values implicated in this debate. This Article shall contrast a forward-looking, policy-oriented legislative approach to the backward-looking, case-oriented judicial approach taken in the Compassion in Dying and Vacco cases. Before coming to that comparison, however, a crucial preliminary point must be noted. Central to any serious evaluation of competing policy approaches to PAS and euthanasia is the distinction between the morality of individual acts and the wisdom of social policy. Much of the debate in the popular media is driven by the depiction of especially dramatic and poignant instances of suffering humanity, desperate for release from the painful thrall of terminal illness. Understandably, many of us are prompted to respond: "Should such a terrible fate ever befall me, I certainly would not want to suffer interminably; I would want the option


41. One source estimates that in the early 1990s, no more than 30% of cases of PAS were reported. During 1994, the rate of reporting increased to roughly 50% of cases. See John Keown, Further Reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and the Van Der Maas Survey, in EUTHANASIA: CLINICAL PRACTICE AND THE LAW, 219, 235 (Luke Gormally ed., 1994); see also Daniel Callahan & Margot White, The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village, 30 U. RICH. L. REV. 1, 17 (1996).

42. See Tom Kuntz, Helping a Man Kill Himself, As Shown on Dutch TV, N. Y. TIMES (Nov. 13, 1994), at E7 (describing the first national broadcast of an actual mercy killing in the Netherlands).
of an early exit and the help of my trusted physician in securing it.” The problem, however, lies in getting from such compelling individual cases to social policy. The issue is not simply, “What would I want?,” but rather, what the best social policy is, all things considered. Social pessimists warn that we cannot make this jump from individual case to policy without endangering the autonomy and the very lives of others, many of whom are numbered among our most vulnerable citizens.

A. A Judge-Made Policy Based on Constitutional Law

Appellate judges in the Ninth and Second Circuits have authored powerful opinions giving constitutional protection to PAS for competent patients facing terminal illness. While these opinions fully vindicate patients’ important stake in having a freely chosen and pain free death, they seriously and fatally discount the states’ important interests in preventing the kinds of slippage and abuse catalogued above.

1. Dismissal of Social Consequences

The opinion of the Ninth Circuit, *Compassion in Dying*, authored by Judge Reinhardt, is particularly troubling with regard to the dismissal of social consequences. In response to the objection that legalizing PAS inevitably will prove “infinitely expansive,” the court acknowledges the difficulty that it may be hard to distinguish the moral logic of PAS from that animating the call for direct physician-administered euthanasia. He further concedes that in some cases, patients will need the help of a physician in carrying out their choice of an autonomous and painless death. Instead of carefully weighing this sobering possibility in the balance, or asking whether this likelihood of slippage should make us hesitate in taking the first step onto the slope, the court immediately dismisses it as a problem for future cases, not this one, noting that, “here we decide only the issue before us.” For those who worry that direct euthanasia carried out by physicians might impose too great a risk in the current social climate, the dictum will prove less than comforting, for in effect he is saying that “it [is] less important who administers the medication than who determines whether the terminally ill person’s life shall end.”

43. *Compassion in Dying v. Washington*, 79 F.3d 790, 830-32 (9th Cir. 1996).
44. Id. at 831.
45. Id. at 832.
46. This group once included such distinguished physicians and advocates of PAS as Dr. Timothy Quill, Christine Cassel, and Diane Meier. See Cassel et al., supra note 27.
47. *Compassion in Dying*, 79 F.3d at 832.
Thus, although we have argued that this kind of forward-looking, policy-oriented perspective is crucial for adequately assessing the individual benefits and social risks involved in the proposal to legalize PAS, the judicial approach to the problem operates fully equipped with social blinders, and willfully dismisses the very real dangers lurking further down the slope, all in the name of individual rights. Indeed, at one point Judge Reinhardt implies that a refusal to contemplate such dangers is demanded by the judicial role itself.\textsuperscript{48} To put it mildly and most charitably, this rights-orientated mind-set does not put us in a learning mode! When life and death are at stake, we need to base our social policy on a more comprehensive picture of the likely benefits and risks.

Judge Reinhardt’s grasp of the clinical realities of depression and the ubiquitous absence of adequate pain control is no more impressive than the scope of his social vision. In response to the objection that the legalization of PAS eventually would lead physicians to treat requests to die in a routine and impersonal manner, Judge Reinhardt reassures us, in the face of massive evidence to the contrary, that “doctors would not assist a terminally ill patient to hasten his death as long as there were any reasonable chance of alleviating the patient’s suffering or enabling him to live under tolerable conditions.”\textsuperscript{49} Judge Reinhardt’s faith in professional and governmental regulations to ensure that all requests truly are voluntary (i.e., not due to depression), and free from the taint of untreated pain and suffering, is perhaps refreshing in the age of governmental regulation-bashing, but it is a naive and dangerous faith all the same.

2. \textit{Equal Protection and the Fate of Responsible Regulation}

The ability of a constitutional right to assisted suicide to provide adequately for safeguards against abuse, neglect, and mistake is especially problematic within the context of the Second Circuit’s equal protection analysis in \textit{Vacco}. The court’s assertion of the moral and legal equivalence of withholding life-sustaining treatments, the provision of potentially death-hastening analgesics, and assisted suicide\textsuperscript{50} raises extremely troubling questions about the constitutionality of a wide variety of possibly effective regulations. The basic question is: If we have a constitution-

\textsuperscript{48} Id. at 831 (“In fact, the Court has never refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly.”).

\textsuperscript{49} Id. at 827.

\textsuperscript{50} Quill v. Vacco, 80 F.3d 716, 729 (2nd Cir. 1996).
ally protected liberty interest in determining the time and manner of our deaths, then to what extent will various regulatory schemes cut too deeply into our personal choices?

We actually have seen this script played out before in the context of abortion law. Prior to *Roe v. Wade*, many states already had begun liberalizing their statutes to allow women to opt for abortion under specified conditions. One regulatory constraint that had been placed on women’s choice in some jurisdictions was mandatory review by a hospital-based committee. Now, whether or not we think that such committee review was a good idea in the context of abortion, it is interesting to note that this regulatory mechanism, along with a host of others, was discarded unceremoniously by the Supreme Court in *Doe v. Bolton*, the companion case to *Roe v. Wade*. In sum, the Court held that such mechanisms only serve to encumber the woman’s choice, which really belongs to her (and perhaps also her doctor) alone.

Now, if the Second Circuit’s equal protection analysis prevails and courts come to see no cognizable legal or moral differences between “allowing to die” and assisted suicide, then presumably the regulatory mechanisms surrounding the two sets of practices will have to be more or less congruent. This kind of legally-mandated parity will have two likely consequences. First, all the paraphernalia of surrogate decision-making that currently surrounds decisions to forgo treatment would have to be extended to PAS. Just as we presently allow family or close friends to make life and death decisions for loved ones on the basis of so-called “substituted judgment” (“What would the patient have wanted?”) or best interests determinations, so we would have to allow family members the same role in those cases in which suicide “would have been chosen” by the patient or “would have been” in his best interest. Obviously, this implication of the equal protection approach would require proponents

54. Id. at 198.
55. Id.
57. Id. at S-143.
58. For a comprehensive account of practices and laws governing the forgoing of life-sustaining treatment and surrogate decision making, see *Alan Meisel, The Right to Die* (2d ed. 1995).
of PAS to bite a very large bullet regarding the charge of infinite expansion.

The second implication of the equal protection analysis is that a broad range of possibly helpful regulatory mechanisms, including waiting periods, committee review, second opinions, mandatory reporting, and perhaps even the requirement of terminal illness, might well be swept aside in the name of individual liberty. Currently, we do not require these kinds of substantive and procedural constraints for most decisions to forgo life-sustaining treatments by competent, terminally ill patients. If, however, there is really no moral or legal difference between “allowing to die” and “assisting suicide” — if, as Judge Miner opines, adding PAS to our repertoire of choices would not add one iota of additional risk to individuals or society over and above those we already countenance—then encumbering the choice for PAS with all sorts of extra protective devices would seemingly lack constitutional validity. In sum, then, the equal protection analysis currently regnant in the Second Circuit threatens precisely those braking mechanisms that arguably would make the slippery slope a safer place on which to practice physician-assisted death.

3. The Conflation of Killing and Allowing to Die

Proceeding directly to the fulcrum of Judge Miner’s analysis, we now consider the denial of a significant moral or legal difference between allowing a patient to die by means of forgoing life-sustaining treatments and assisting a patient in committing suicide. According to both circuit court opinions, there is not a significant difference between withdrawing a ventilator, discontinuing a feeding tube, administering pain-killing but (potentially) life-shortening opioids, and prescribing a lethal dose of barbiturates. In all these cases, the judges allege, the intention is the same (i.e., to hasten death), the cause of death is the same (an act attributable to human agency), and the social risks of mistake and abuse are the same (e.g., misdiagnosis, undue pressure, etc.). Consequently, Judge Reinhardt concludes that PAS poses no greater threat than forgoing treatment to the state’s interests in preventing suicide and in safeguarding the integrity of the medical profession, and Judge Miner sees no point in a more

59. Id.
60. Id.
61. Id.
62. See Quill v. Vacco, 80 F.3d 716, 729 (2nd Cir. 1996); see also Compassion in Dying v. Washington, 79 F.3d 790, 822-24 (9th Cir. 1996).
63. Miller, supra note 56, at S-139.
restrictive public policy towards PAS. This Article argues against this conflation of forgoing treatment and assisting suicide. Although the boundaries between these two practices at times are admittedly quite fuzzy, this Article contends that the failure to attend to relevant differences contributes to their failure to discern the very real social risks inherent in their judicial approaches to policy.

First, some concessions. As Judges Miner and Reinhardt and numerous commentators have pointed out, it is sometimes difficult to discern any meaningful differences between forgoing life-sustaining treatments and what happens in PAS. If one focuses on the physician’s intent as marking a crucial difference, the problem arises that often physicians have mixed intentions. In the act of discontinuing a life-sustaining ventilator, for example, some physicians actually intend not just to rid the patient of unwelcome technology, but to help the patient end her suffering by dying sooner. That is, they intend the patient’s earlier death, and no one views this as especially problematic so long as the other conditions for acceptable termination of treatment are in place.

The same is true for cases involving the administration of potentially life-shortening opioids. While many physicians and nurses intend merely to alleviate the patient’s pain, even at some risk of shortening life, it is no doubt true that others participating in such decisions actually intend or welcome the patient’s earlier death. In spite of the fact that such intentions may be operative, we do not abandon the practice of administering adequate amounts of opioids. Even with these intentions in mind, we do not abandon the practice. Likewise, if one stresses a difference in causation, i.e., claiming that in the one case the cause of death is the patient’s underlying disease, while in PAS and euthanasia the cause is the physician’s direct or indirect action, it often is difficult to avoid the conclusion that whatever causation we might attribute to an underlying disease in determining whether a patient will die, it remains true that human actors still are responsible for deciding when and how the patient dies. When a doctor detaches a feeding tube from a patient who could have lived for an

64. Id. at S-140.
66. For the best exposition of this position, see id.
additional decade, albeit in a profoundly diminished state, she certainly is “the cause” of death insofar as she determines when and how the patient dies.

All of this can be granted without conceding the judges’ claim that there are no significant differences between these practices. With regard to the administration of opiates, a doctor can still argue for their aggressive deployment even if there is no intention whatsoever of shortening the patient’s life. Just as a surgeon might undertake risky heart surgery knowing that the patient may die on the table, so the conscientious physician can risk suppressing the patient’s respiratory drive and thus hasten death so long as she is pursuing a valid medical objective and there are no better options.\(^6\)

Similarly, a physician who withdraws a ventilator from a dying patient can do so without intending the patient’s premature death. Such an act can be entirely justified either on the ground that the patient is rejecting this bodily encroachment or that the treatment no longer is proportionately beneficial. As for the rebuttal to the standard causation analysis, the fact that the physician somehow is causally responsible for the patient’s death does not make the physician morally responsible in exactly the same manner as she would have been had she administered or prescribed a fatal dose.\(^7\) Indeed, even in the case of detaching a feeding tube from a non-terminally ill patient, arguably the case where the distinction between allowing to die and killing is fuzziest, one can still maintain that “the cause” of death (or at least the most important cause for purposes of moral accountability) remains the patient’s underlying medical condition, which includes the inability to eat or swallow, just as the cause of the ventilator-dependent patient’s death is that patient’s inability to spontaneously breathe.

Whatever the outcome of such conceptual skirmishes\(^7\) bearing on the

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69. In view of the manifest resistance of most physicians to participate in acts of assisted suicide or direct killing, the attempts of Judges Reinhardt and Miner to conflate the provision of adequate pain control with assisted suicide or euthanasia constitutes, in my opinion, a reckless, ill-informed, and counterproductive gesture: ill-informed because both judges seem to assume that adequate doses of such opioids invariably will shorten life, whereas the truth is that the expert administration of such drugs usually will not have this effect; reckless and counterproductive because many physicians would sooner give up their allegiance to adequate pain control than their opposition to assisted suicide and euthanasia. If they are convinced by the judges reasoning, many will be reluctant to practice adequate pain control techniques on their dying patients. Compassion in Dying v. Washington, 79 F.3d 790, 833 (9th Cir. 1996).

70. See CALLAHAN, supra note 28, at 76-82.

71. For a helpful review of the arguments surrounding the distinction between “letting
"intrinsic" distinctions between PAS, direct euthanasia, and forgoing life-sustaining treatments, the crucial question remains whether any of the purported distinctions between these activities constitute important differences for purposes of social policy. As a slippery slope opponent of PAS and euthanasia, I have already conceded that individual acts involving either PAS or active euthanasia can be morally justified under certain circumstances. Having thus conceded that certain individual actions can be morally appropriate even when the intent is simply and unambiguously to end the patient's life, and even when "the cause" of death is simply and unambiguously attributable to the action of the physician, the crucial question is whether there are any remaining distinctions between allowing to die and actively killing (or assisting in a suicide) that might illuminate the negative policy implications of PAS and euthanasia.

Two points can be made in this connection. First, as the New York Task Force pointed out, the social consequences of not honoring requests to forgo treatment are very different from the consequences of failing to honor requests for PAS and euthanasia. When society fails to honor requests to prescribe or deliver a lethal dose, the results can be onerous for individual patients. The patient may face a prolonged period of deterioration before death, with increased pain and decreased dignity, contrary to what they otherwise would have wished. It is important to note, however, that in many such cases there are alternatives to prolonged and painful deaths. Under the present legal regime it is still permissible for a patient to seek out effective and compassionate hospice care, to refuse further administration of life-sustaining treatments, and even to starve to death with the aid of a physician. It is also legal for an individual truly to take matters into his own hands and to kill himself, perhaps with the aid of a popular "self-help" book on the matter. Finally, it is possible for many patients with a good and trusting relationship with a compassionate physician to achieve their objective within the bounds of a private and discreet relationship, but without the cover and consolations of law.

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See Kamisar, supra note 28, at 753-60. For those wishing to go deeper into these troubled waters, see Killng and Letting Die (Bonnie Steinbock & Alastair Norcross eds., 1995). See also Intending Death: The Ethics of Assisted Suicide and Euthanasia (Tom L. Beauchamp ed., 1996).

72. See New York Task Force, supra note 17, at 146-47.

73. See David M. Eddy, A Conversation with My Mother, 272 JAMA 179 (1994) (illustrating the possibility of death by starvation).


75. See Dick Lehr, Death and the Doctor's Hand: Increasingly, Secretly, Doctors Are
By contrast, were society, systematically and as a matter of policy, to refuse to honor requests to forgo life-sustaining treatments, then everyone would have to submit to the imposition of unwanted and often invasive measures. Whereas the refusal to honor a request for PAS or direct euthanasia amounts to a refusal of a positive benefit or assistance, the imposition of medical treatment against one's will represents a violation of personal autonomy and physical integrity totally incompatible with the deepest meaning of our traditional respect for liberty. Such a refusal would entail the virtual imprisonment of the entire population of terminally ill and dying patients. While the failure to offer a deadly drug to a dying patient represents a failure of mercy requiring moral justification, the forced imposition of medical treatment against a patient's will arguably constitutes a trespass, or technically a legal battery, so profound that it simply cannot be justified, especially at the level of broad-gauged social policy.

Without trying to be especially hyperbolical, we can say that the practice of forgoing treatment is by now so deeply embedded in our social and medical practices that a reversal of policy on this point would throw most of our major medical institutions into a state approaching chaos. The same cannot be said of a refusal to honor requests for PAS and euthanasia. Thus, while there may well be many overlapping similarities between withholding treatment and participating in PAS or euthanasia, their respective denial at the level of social policy would entail vastly different individual and social consequences.

The second point in this connection is that the practice of PAS and/or active euthanasia would be bound to implicate many more persons than the practice of forgoing treatment. While we should definitely worry about the possibility of error, neglect, and abuse in the context of allowing patients to die, it is at least somewhat comforting to realize that just about every patient in this category must be very bad off indeed. By the time that physicians resort to discussing forgoing treatment with a patient or family, the patient usually will be well along in the process of dying.

With regard to PAS and euthanasia, however, we can expect that many candidates will be perfectly ambulatory and far from the dreaded scene of

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*Helping the Incurably Ill to Die, BOSTON GLOBE (Apr. 25, 1993), at 1 (featuring the experience of physicians who have helped patients to commit suicide).

76. See Restatement (Second) of Torts § 13 (1965) (defining battery).

painful terminal illness depicted by advocates. Depending on how great
the social slippage, this category may well come to encompass "merely"
those with an incurable condition but who are not presently "terminal,"
such as persons in the early stages of HIV infection or Alzheimer dis-
ease.\textsuperscript{78} It also may come to encompass patients suffering from prolonged
and intractable depression who exhibit no other symptoms of physical
illness. While one important legislative proposal specifically excludes pa-
tients whose only symptoms are psychiatric in nature,\textsuperscript{79} this reluctance
was likely motivated in no small measure by political considera-
tions.\textsuperscript{80} Once PAS or active euthanasia, or both, are firmly in place, however, it
will be extremely difficult to withhold them from persons whose suffering
is every bit as real but whose source is entirely psychological rather than
physical. That, Judge Miner and many others will surely object, consti-
tutes an invidious distinction and thus a form of unconstitutional discrimi-
nation against the mentally ill.

The point, then, is that a policy that countenances only allowing pa-
tients to die will encompass fewer categories of people; thus it will pres-
ent fewer possibilities for mistake and abuse than a policy that also
encompasses a right to PAS or active euthanasia. In addition, by refusing
to extend explicit legal sanction to \textit{any} PAS or euthanasia, such a cautious
policy would be much better equipped to prevent highly predictable slip-
page in the direction of such questionable categories of patients as the
chronically depressed or those who do not wish to wait for the predict-
able symptoms of their illness to emerge before killing themselves.

\textsuperscript{78} The prospects for slippage here are excellent. The step from a requirement of
terminal illness, viewed by these courts as canonical, to one of merely "untreatable" or
"incurable" illness, already has been recommended by a panel of distinguished proponents
of PAS. \textit{See} Miller et al., \textit{supra} note 3. It is interesting to note in this connection that one
of Jack Kevorkian's earliest "patients," Janet Atkins, reportedly was playing tennis a week
or two before her assisted suicide.

\textsuperscript{79} Baron et al., \textit{supra} note 33, at 11. At an American Philosophical Association sym-
posium on PAS in December, 1995, Professor Brock conceded that politics played a signif-
icant role in his group's decision not to sanction PAS for the chronically mentally ill.

\textsuperscript{80} Appeals to legalize PAS draw much of their popularity from advocates' assurances
that the class of permissible cases will be tightly circumscribed. Endorsing the claims of
those who are not terminally ill but suffering from severe psychological distress would no
doubt reinforce the public's fears of the slippery slope and thereby erode public support
for legalizing PAS. It thus makes good strategic sense for the advocates of PAS to defer
approval of suicide for purely psychiatric indications until after the initial battle for legali-
zation has been won. Once the goal of legalization is accomplished, it will be easier politi-
cally to take this additional step—a conclusion to which both the advocates of PAS and its
slippery slope opponents can agree.
B. If the States are the Laboratory, What's the Experiment?

Although the Ninth Circuit is prepared to grant that states have a legitimate interest in avoiding the possibly adverse social consequences of PAS, the court insists that regulation, rather than prohibition, is the only constitutionally permissible means of so doing. Toward that end, it would assign the challenging task of crafting appropriate regulations to the “laboratory of the states.” In view of the very real possibility that the social and individual harms attendant upon the legalization of PAS eventually would prove disproportionate to their benefits, this division of labor between the judiciary and the state legislatures is highly problematic. Were the Supreme Court to affirm the Ninth Circuit’s reasoning in granting constitutional protection to the liberty interest in choosing death, then in effect, there would be no turning back, short of a constitutional amendment. Even if a number of the predicted bad social consequences were to materialize, such that we faced a vastly expanded right coupled with widespread abuse and neglect, the judicial response would not be to revoke constitutional protection; rather, the judges would merely rebuke the states for not doing their job of regulation.

Instead of putting ourselves into this precarious position, we should assign a different and more fundamental task to the laboratory of the states. Given the very real possibilities for extension and abuse of this liberty interest, state legislatures should be entrusted with the basic questions of whether, when, and under what circumstances such a risky social experiment should be attempted in the first place. As these Circuit Court decisions amply demonstrate, state legislatures are in a better position than federal judges to study the social and clinical facts and come to a reasonable conclusion on the likely balance of individual benefit and social risks. Given the social and medical realities of this country, I would hope that most states would follow the lead of the New York Task Force in refusing to countenance the legalization and routinization of PAS at this time. However, even if some states do decide to run these risks as a social experiment, i.e., to determine empirically for themselves whether more good than harm will come from legalizing PAS, they would have the flexibility, absent rigidly defined constitutional mandates, both to impose very strict regulations and, if necessary, to stop the experiment cold in the

82. See Carl E. Schneider, Making Sausage: The Ninth Circuit’s Opinion, 27 Hastings Center Rep. 27-28 (1997) (reviewing the shortcomings of judges in coming to terms with the complexities of highly contextualized social problems such as PAS).
face of disconcerting evidence of serious moral slippage. Not only is this legislative approach more democratic, it also is much better suited to asking the relevant policy questions and taking (and possibly revoking) appropriate and prudent action.\textsuperscript{83}

C. A Legislative Alternative

The type of legislative proposal outlined above has been made recently by John Fletcher and colleagues.\textsuperscript{84} Eschewing any and all court-mandated solutions, these proponents offer a daring but carefully hedged plan to legalize PAS within a framework that conceives of it as a last-ditch effort to address the pain and suffering of incurably ill or dying patients. First, the authors concede two important points that some of them had denied in a previous proposal for legalizing and regulating PAS. In that earlier essay, Timothy Quill and Diane Meier had argued on traditional grounds of autonomy and mercy that PAS should be allowed, but not active euthanasia by physicians. They claimed that a moral and practical distinction could be drawn between PAS and euthanasia on the grounds of the latter's (but not the former's) threat to vulnerable patients in a society so flawed by social injustice. Quill and Meier also had attempted to distinguish cases involving terminal illness, for which they felt PAS was appropriate, from those involving patients whose conditions were "merely" incurable, in which they felt PAS was not appropriate. In their most recent policy recommendation, (co-authored with professors Fletcher, Miller, and Brody), Quill and Meier conceded that these two distinctions cannot be logically or practically maintained. They now admit that allowing PAS effectively commits us to permitting active euthanasia, especially for that most vulnerable class of patients who are too weak and disabled to kill themselves. They also conceded that both autonomy and mercy justify extending the practices of PAS and euthanasia to encompass those who are merely incurable but not terminally ill. Whether or not one agrees with their reformulated position, these authors should at least be commended for forthrightly admitting what is at stake in this debate.

\textsuperscript{83} For similar reasons, I am highly skeptical of state ballot initiatives, such as the 1994 initiative in Oregon, which do not make use of the legislatures' superior fact-finding capabilities. Legislatures are not restricted, as the courts are, to the individual case; they can adopt a more comprehensive vision that encompasses a wide spectrum of individual and social risks and benefits. Should a particularly disturbing trend materialize, a legislature could put an end to the social experiment or suspend it until appropriate remedies are deployed.

\textsuperscript{84} Miller et al., supra note 3, at 120.
Second, the authors propose an additional safeguard designed to address most of our "empirical slope" objections: a requirement of independent and impartial oversight by a certified palliative-care consultant within a national network of palliative-care committees.\(^8\)

Before any choice for death arrived at by patient and physician could be sanctioned within this proposed system, a certified consultant would have to review the physician's diagnosis, the patient's prognosis, the possibility of available but untried alternatives for palliative care, and the voluntary nature and strength of the patient's wish to die, etcetera. All consultants presumably would be well versed in the techniques of palliative care, the nuances of competency determinations, bioethics and law, and the realities of life for dying patients. Should a patient, physician, or both, disagree with the verdict of a consultant, they could appeal the case to the consultant's regional committee.

This part of the proposal marks a significant improvement over many past proposals and legislative ballot initiatives.\(^8\) The requirements that voluntariness and competency be verified by a skilled diagnostician/clinician, and that either PAS or active euthanasia be permitted only after the failure of all other reasonable alternatives, would both go a long way toward providing serious safeguards and assuaging the Task Force's fears of an unalterably slippery slope. I, however, have reservations.

First, there is the lingering fear expressed throughout the Task Force's report that any legislative proposal would have to be implemented within the present context of deep and pervasive discrimination against the poor and members of minority groups.\(^87\)

Second, it must be noted that the impressive safeguards required by this proposal would entail significant costs, not only in purely monetary terms, but also with regard to privacy and autonomy for both patients and physicians. Even though the authors deny that their proposal is based upon a right to PAS, which itself would be based upon the right to privacy in the same manner as abortion,\(^88\) they will have a hard time explaining

\(^8\) Id. at 119 (describing the basic plan on palliative care).


\(^87\) See supra note 35 and accompanying text.

\(^88\) See DWORKIN, supra note 15 (providing an elegant and powerful restatement of the view that in a pluralistic society individuals should have rights against governmental interference with deeply personal "private choices," such as abortion and euthanasia).
this to patients whose appeals have been rejected by the palliative-care consultant and committee. Just as the elaborate paraphernalia of committee review of abortion decisions was swept aside by autonomy-driven judicial decisions in *Roe v. Wade*\(^8\) and *Doe v. Bolton*,\(^9\) so here patients imbued with the rhetoric of autonomy will surely ask, “Who do these so-called ‘consultants’ and ‘God-committees’ think they are, passing judgment on the quality of my own personal suffering?”

Physicians and patients surely will be highly offended by the implication that they cannot be trusted to handle these matters in a competent and sensitive way within the privacy of the physician-patient relationship, without a new layer of intrusive and expensive bureaucracy. Indeed, to my mind, the biggest problem for the proponents of this plan would come, not from opponents of PAS on slippery slope grounds, but rather from patients and physicians eager to cast off all remaining vestiges of state-sponsored bureaucracy. In short, the proposed regulations are plausible, at least in theory; but whether they could be sold to skeptical legislatures, physicians, and patients’ rights groups is a different and much more difficult question.

**D. A Policy of Prudent (Legal) Restraint and Aggressive (Medical) Intervention**

In contrast to the judicial approach, which totally vindicates the value of patient autonomy at the expense of protecting the vulnerable, and in contrast to the Fletcher, Miller, et al. proposal which assumes (erroneously, I believe) that we simultaneously can pursue both goals without incurring undue social costs; my own preferred approach to a social policy of PAS and euthanasia conceives of this debate as posing essentially a “tragic choice.”\(^9\) It frankly acknowledges that whatever choice we make, whether we opt for a reaffirmation of the current legal restraints or for a policy of legitimation and regulation, there are bound to be “victims.” The victims of the current policy are easy to identify: they are on the news, the talk shows, the documentaries, and often on Dr. Kevorkian’s roster of so-called “patients.” The victims of legalization, by contrast, will be largely hidden from view; they will include the clinically depressed eighty-year-old man who could have lived for another year of good quality if only he had been adequately treated, and the fifty-year-old woman

89. 410 U.S. 113 (1973).
91. For an explication of the notion of a “tragic choice” in the sense that I employ here, see GUIDO CALABRESI & PHILIP BOBBIT, TRAGIC CHOICES (1978).
who asks for death because doctors in her financially stretched HMO cannot, or will not, effectively treat her unrelenting, but mysterious, pelvic pain. Perhaps eventually, if we slide far enough down the slope, the uncommunicative stroke victim, whose distant children deem an earlier death to be a better death, will fall victim. There will be others besides these, many coming from the ranks of the uninsured and the poor. To the extent that minorities and the poor already suffer from the effects of discrimination in our health care system, it is reasonable to expect that any system of PAS and euthanasia will exhibit similar effects, such as failure to access adequate primary care, pain management, and psychiatric diagnosis and treatment. Unlike Dr. Kevorkian's "patients," these victims will not get their pictures in the papers, but they all will have faces and they will all be cheated of good months or perhaps even years.

This "tragic choice" approach to social policy on PAS/euthanasia takes the form of the following argument, with four basic steps. First, the number of "genuine cases" justifying PAS, active euthanasia, or both, will be relatively small. Patients who receive good personal care, good pain relief, treatment for depression, and adequate psycho-social supports tend not to persist in their desire to die.

Second, the social risks of legalization are serious and highly predictable. They include the expansion of these practices to nonvoluntary cases, the advent of active euthanasia, and the widespread failure to pursue readily available alternatives to suicide motivated by pain, depression, lack of access to good medical care, and hopelessness.

Third, rather than propose a momentous and dangerous policy shift for a relatively small number of "genuine cases" — a shift that would surely involve a great deal of persistent social division and strife analogous to that involved in the abortion controversy—we should instead attempt to redirect the public debate toward a goal on which we can and should all agree, namely the manifest and urgent need to reform the way we die in America. Instead of launching a highly divisive and dangerous campaign for PAS, we should attack the problem at its root with an ambitious program of reform in the areas of access to primary care and the education of physicians in palliative care. At least as far as the "slippery slope" opponents of PAS and euthanasia are concerned, we should thus first see to it that the vast majority of people in this country have access to adequate, affordable, and nondiscriminatory, primary and palliative care. At the end of this long and arduous process, when we finally have an equitable, effective, and compassionate health care system in place, one that
might be compared favorably with that in the Netherlands, then we might well want to reopen the discussion of PAS and active euthanasia.

Finally, there are those few unfortunate patients who truly are beyond the pale of good palliative, hospice, and psychiatric care. The opponents of legalization can take limited solace from the fact that many such patients still will be able to find compassionate physicians who, like Dr. Timothy Quill, will ultimately be willing, albeit in fear and trembling, to "take small risks for people [they] really know and care about."92 Such actions will continue to take place within the privacy of the patient-physician relationship, however, and thus will not threaten vulnerable patients and the social fabric to the same extent as would result from full legalization and regulation.

To be sure, this kind of continuing covert PAS unfortunately will not be subject to regulation, but the threat of possible criminal sanctions and revocation of licensure will continue to serve, for the majority of physicians, as powerful disincentives to abuse the system. Moreover, as suggested earlier, it is highly unlikely that the proposals for legalization would result in truly effective oversight.

VI. Conclusion

Instead of conceiving this momentous debate as a choice between, on the one hand, legalization and regulation with all of their attendant risks, and on the other hand, the callous abandonment of patients to their pain and suffering,93 enlightened opponents must recommend a positive program of clinical and social reforms. On the clinical level, physicians must learn how to really listen to their patients, to unflinchingly engage them in sensitive discussions of their needs and the meaning of their requests for assisted death, to deliver appropriate palliative care, to distinguish fact from fiction in the ethics and law of pain relief, to diagnose and treat clinical depression, and finally, to ascertain and respect their patients' wishes for control regarding the forgoing of life-sustaining treatments. On the social level, opponents of PAS must aggressively promote major initiatives in medical and public education regarding pain control, in the sensitization of insurance companies and licensing agencies to issues of the quality of dying, and in the reform of state laws that currently hinder

93. In framing the question in just this way, Ronald Dworkin is guilty of posing a false dilemma in his otherwise admirable book. See DWORKIN, supra note 15, at 198.
access to pain relieving medications.\textsuperscript{94}

In the absence of an ambitious effort in the direction of aggressive medical and social reform, I fear that the medical and nursing professions will have lost whatever moral warrant and credibility they might still have in continuing to oppose physician-assisted suicide and active euthanasia. As soon as these reforms are in place, however, we might then wish to proceed slowly and cautiously with experiments in various states to test the overall benefits of a policy of legalization. Until that time, however, we are not well served as a society by court decisions allowing for legalization of PAS. I hope and trust that the Supreme Court will strike them down. Finally, I hope that continued sober reflection on the likely consequences of PAS and euthanasia will prompt John Fletcher to revive his earlier well-founded skepticism regarding the current social risks of these practices.

\textsuperscript{94} This brief sketch of suggested reforms merely summarizes the careful work of the New York Task Force. \textit{See New York Task Force, supra note 17.}