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ARTICLE

THE JUSTIFICATION OF PHYSICIAN-ASSISTED DEATHS

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INTRODUCTION

Decisions on physician-assisted suicide have recently been handed down by the Ninth and Second Circuit Court of Appeals.[1] These decisions are the latest developments in a rapidly unfolding legal history in which a consensus has been reached that no criminal liability exists for withholding or withdrawing a life-sustaining treatment when physicians are directed to do so by a patient or an authorized surrogate.[2] Given that there is a moral and legal right to refuse a life-sustaining treatment and that suicide has been decriminalized,[3] it might seem that patients and physicians are at liberty to reach an agreement about how death will occur, as the Ninth and Second Circuits' decisions faintly suggest. However, the

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This Article was the basis of Professor Beauchamp's McDonald-Merrill-Ketcham Lecture presentation to faculty and other professionals on November 17, 1994 at the Indiana University School of Law—Indianapolis.

1. Compassion in Dying v. State of Washington, No. 94-35534 (9th Cir. filed March 6, 1996); Quill v. Vacco, No. 95-7028 (2d Cir. April 6, 1996).

2. Recent legal history and legal complexities are thoroughly treated in ALAN MEISEL, THE RIGHT TO DIE (1993). *See also* Alan Meisel, *The Legal Consensus about Forgoing Life-Sustaining Treatment: Its Status and Its Prospects*, 2 KENNEDY INST. ETHICS J. 309 (1992); Robert F. Weir & Larry Gostin, *Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients*, 264 JAMA 1846 (1990).

3. ALLEN BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 85, 90-93, 332-36 (1989); Kate E. Bloch, *The Role of Law in Suicide Prevention: Beyond Civil Commitment—A Bystander Duty to Report Suicide Threats*, 39 STAN. L. REV. 929 (1987).

rule against *actively causing* the death of patients is among the most powerful prohibitions in law and medicine, and it severely restricts what patients and physicians are permitted to choose as a means to death.

Many writers in medical ethics and law are now questioning this traditional prohibition, using some of the same arguments presented in the two circuit court opinions.[4] They propose reforms that extend the scope of liberty rights and introduce more flexibility in the ways persons who are seriously or terminally ill can legally die. A few legal developments prior to the circuit court opinions have encouraged these proposals for reform. Among the most striking examples was the Canadian Supreme Court's decision in the case of Sue Rodriguez, who had been diagnosed with amyotrophic lateral sclerosis (Lou Gehrig's Disease) and had petitioned the Court to allow her the option of physician-assisted suicide. She attempted to invalidate section 241 of the Criminal Code of Canada, which prohibits physician-assisted suicide. The Court did not find in her favor, but several Justices delivered opinions that provided moral support for Rodriguez's goal of dying with a physician's direct assistance.[5] A handful of legal developments in the United States has likewise suggested that prohibitions of assisted suicide are unconstitutional,[6] that certain acts of direct assistance in dying do not constitute murder or manslaughter,[7] and that a physician's writing of a

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4. Diane E. Meier, *Doctor Attitudes and Experiences with Physician-Assisted Death*, *in* PHYSICIAN-ASSISTED DEATH 5-24 (James M. Humber et al. eds., 1994); David Orentlicher, *Physician-Assisted Dying: The Conflict with Fundamental Principles of American Law*, *in* MEDICINE UNBOUND: THE HUMAN BODY AND THE LIMITATIONS OF MEDICAL INTERVENTION 256 (Robert H. Blank et al. eds., 1994).

5. Rodriguez v. Attorney General of Canada, 3 S.C.R. 519 (Can. 1993) (on appeal from British Columbia Court of Appeal, Rodriguez v. British Columbia (Attorney General), B.C.J. No. 641 (Q.L.) (B.C.C.A.) (1993)). In early 1994 Sue Rodriguez killed herself with the assistance of an anonymous physician.

6. Compassion in Dying v. State of Washington, 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995). The District Court's opinion was influenced by Planned Parenthood v. Casey, 505 U.S. 833 (1992):

> This court finds the reasoning in Casey instructive and almost prescriptive on the latter issue. Like the abortion decision, the decision of a terminally ill person to end his or her life 'involves the most intimate and personal choices a person may make in a lifetime' and constitutes a 'choice central to personal dignity and autonomy.'

Compassion in Dying, 850 F. Supp. at 1459. *See also*, Stephanie B. Goldberg, *Death by Choice: Two Courts Clash on Constitutional Right to Assisted Suicide*, 80 A.B.A. J., July 1994, at 73; G. Steven Neeley, *The Constitutionality of Elective and Physician-Assisted Death*, *in* PHYSICIAN-ASSISTED DEATH 47-73 (James M. Humber et al. ed., 1994); Todd D. Robichaud, *Toward a More Perfect Union: A Federal Cause of Action for Physician Aid-in-Dying*, 27 U. MICH. J.L. REF. 521 (1994).

7. *See* Hobbins v. Attorney General, 518 N.W.2d 487 (Mich. Ct. App. 1994); Michigan v. Kevorkian, 517 N.W.2d 293 (1994); Michigan v. Kevorkian, Case No. CR-92-115190-FC (July 21, 1992). *See also* JACK KEVORKIAN, PRESCRIPTION MEDICIDE: THE GOODNESS OF PLANNED DEATH (1991); Michael J. Roth, Note, *A Failed Statute, Geoffrey Feiger, and the Phrenetic*

lethal prescription is legally permissible.[8]

These developments have encouraged many observers to think of the primary moral and legal questions about physician-assisted suicide and euthanasia as questions of *legalization*. Almost lost in the recent discussion is the fundamental issue regarding the justification of *individual acts* by physicians of killing and letting die. I will argue that certain acts by physicians of assisting persons in bringing about their deaths are morally justified forms of either euthanasia or physician-assisted suicide, but this argument will not be sufficient to justify the legalization of physician-assisted suicide or active euthanasia.[9] Defense of this conclusion requires that I first examine the meanings of "euthanasia" and "physician assisted suicide," as well as the meanings of "killing" and "letting die." After this conceptual clarification I will treat some related problems in the notion of causing death. Finally, I will treat forms of justification that have been offered for and against acts of physician assistance in dying.

I. THE LANGUAGE OF "EUTHANASIA" AND "PHYSICIAN-ASSISTED SUICIDE"

Discussion of these subjects has been thwarted by conceptual confusion that has surrounded the terms *euthanasia* and *physician-assisted suicide*.[10] I begin by defining these terms.

Originally derived from Greek roots for "good death," the term "euthanasia" now has two general meanings: (1) the act or practice of painlessly putting to death those who suffer from terminal or severely painful conditions (active euthanasia); and (2) intentionally forbearing from preventing death in those who suffer from terminal or severely painful conditions (passive euthanasia). The second meaning emerged only after technology made it possible to prolong the lives of persons with little hope of recovery.[11] The requirements of a terminal or

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Physician: Physician-assisted Suicide in Michigan and a Patient-oriented Alternative, 28 VAL. U. L. REV. 1415 (1994).

8. Oregon Legislature Measure No. 16., Oregon Death with Dignity Act (1994), approved by voters in a 1994 referendum. Under this Act, terminally ill adults are allowed to obtain lethal drugs from physicians in order to hasten death and escape unbearable suffering. This initiative, once scheduled to become law, was permanently enjoined by a federal district court. *See* Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995), Lee v. State, 869 F. Supp. 1491 (D. Or. 1994); Alexander M. Capron, *Sledding in Oregon*, HASTINGS CENTER REP., Jan.-Feb. 1995, at 34; Courtney S. Campbell, *When Medicine Lost its Moral Conscience: Oregon Measure 16*, BIOLAW: A LEGAL AND ETHICAL REPORTER ON MEDICINE, HEALTH CARE, AND BIOENGINEERING, Special Sections 2(1), Jan. 1995, at S1-S16; Courtney S. Campbell et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, HASTINGS CENTER REP., May-June 1995, at 36.

9. On the many distinct problems of legalization and regulation, see Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1 (1996).

10. *See* Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 LAW MED. & HEALTH CARE 116 (1992).

11. *See* Ezekiel J. Emanuel, *The History of the Euthanasia Debate in the United States and*

severely painful condition have also been dropped in many proposed definitions of euthanasia on grounds that some persons suffer severely from conditions that are not terminal and may not cause them pain.[12]

The two general meanings can be consolidated into a single definition, as follows: Euthanasia occurs if and only if: (1) The death of a person is intended by at least one other person who is either the cause of death or a causally relevant factor in bringing about the death; (2) the person killed is terminally ill, acutely suffering, or irreversibly comatose, which alone is the primary reason for intending the person's death; and (3) the means chosen to produce the death are as painless as possible, or there is a sufficient moral justification for choosing a more painful method.[13]

If a person capable of voluntary action requests the termination of his or her life under these three conditions, the action is *voluntary* euthanasia. If the person is not mentally competent to make an informed request, the action is *nonvoluntary* euthanasia. Both are distinguished from *involuntary* euthanasia, a designation restricted to a person capable of informed choice, but who has not requested euthanasia. Involuntary euthanasia is universally condemned and plays no role in current moral and legal controversies, but the first two forms are actively under discussion.

Active and *passive* euthanasia were distinguished once the intentional omission of life-sustaining treatment came to be categorized as euthanasia. When this distinction is combined with the voluntary-nonvoluntary distinction, four general categories of euthanasia emerge, of which the second and third types have been the focus of discussion.

1. Voluntary passive euthanasia
2. Nonvoluntary passive euthanasia
3. Voluntary active euthanasia
4. Nonvoluntary active euthanasia

"Physician-assisted suicide" is often treated as a form of voluntary active euthanasia[14] on grounds that the voluntary choice of the patient makes the death a suicide and the physician-assistance is active rather than passive. However, the concepts of voluntary active euthanasia and physician-assisted suicide should be

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Britain, 121 ANNALS INTERNAL MED. 793 (1994); W. B. Fye, *Active Euthanasia: an Historical Survey of its Conceptual Origins and Introduction into Medical Thought*, 52 BULL. HIST. MED. 492 (1978).

12. LAW REFORM COMMISSION OF CANADA, EUTHANASIA, AIDING SUICIDE AND CESSATION OF TREATMENT (1982); John Lachs, *Active Euthanasia*, 1 J. CLINICAL ETHICS 113 (1990); Jeff McMahan, *Killing, Letting Die, and Withdrawing Aid*, 103 ETHICS 250 (1993).

13. This account is elaborated in Tom L. Beauchamp & Arnold Davidson, *The Definition of Euthanasia*, 4 J. MED. & PHIL. 294 (1979). *Contra* Michael Wreen, *The Definition of Euthanasia*, 48 PHIL. & PHENOMENOLOGICAL RES. 637 (1988).

14. *See* AMA Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229 (1992). This pronouncement seems to treat both as straightforward cases of prohibited killing.

kept distinct. "Euthanasia" does not require a *physician* to bring about the death, and "physician-assisted suicide" does not require that the person who dies be acutely suffering or that the person's condition forms the reason for the suicide or for assisting in suicide. There is also no conceptual requirement in physician-assisted suicide that the means chosen must be as painless as possible.[15]

A few courts and commentators have suggested that assisted suicide occurs when physicians authorize the withdrawal or withholding of treatment from patients at the patients' requests. They consider this suicide because the patient intends to bring about his or her death. Others see no suicidal intent in these cases, only an intention to relieve suffering.[16] This apparent disagreement often seems to turn on the precise nature of the actor's intentions.[17] In the *Cruzan* case, Justice Antonin Scalia argued, understandably, that the withdrawing or withholding of treatment does sometimes constitute suicide.[18] He apparently believes that *any* means productive of death can be arranged to the end of killing oneself (even if one is terminally ill and death is imminent, and even if the causes of death are natural). Stopping a treatment is not relevantly different from stabbing oneself with a knife if the intention to end life and the reason for putting an end to life are relevantly similar. Thus, suicidal intent could be present in any circumstance of a patient's intentional refusal of lifesaving treatment. Patients of this description who refuse treatment commit suicide, and physicians assist them in suicide, whether intentionally or not. (This point raises several questions about what a patient must intend and what a physician must intend in cases of physician-assisted suicide; but I will not explore these questions here.[19])

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15. For different approaches and a few contrasting analyses, see Glenn C. Graber & Jennifer Chassman, *Assisted Suicide is Not Voluntary Active Euthanasia, but It's Awfully Close*, 41 J. AM. GERIATRICS SOC'Y 88 (1993); James C. Maher et al., *VAE versus Assisted Suicide [Letters to the Editor]*, 41 J. AM. GERIATRICS SOC'Y 583 (1993); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119 (1994); David T. Watts & Timothy Howell, *Assisted Suicide is Not Voluntary Active Euthanasia*, 40 J. AM. GERIATRICS SOC'Y 1043 (1992); Weir, *supra* note 10.

16. On the nature and role of suicidal intent and related difficulties in analyzing the concept of suicide, see SUICIDE: THE PHILOSOPHICAL ISSUES (Margaret Pabst Battin et al. eds., 1980); Tom L. Beauchamp, *Suicide*, *in* MATTERS OF LIFE AND DEATH: NEW INTRODUCTORY ESSAYS IN MORAL PHILOSOPHY 707 (Tom Regan ed., 1993); David J. Mayo, *The Concept of Rational Suicide*, 11 J. MED. & PHIL. 143 (1986). For the principal cases and an analysis, see Martha Alys Matthews, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CAL. L. REV. 707 (1987); Meisel, *supra* note 2. Two decisions that take the view that refusals of treatment are not suicides are *In re* Conroy, 486 A.2d 1209 (N.J. 1985), and Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

17. Ronald Dworkin, *The Right to Death*, *in* NEW YORK REVIEW OF BOOKS 14 (1991); Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857 (1992).

18. Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990) (Scalia, J., concurring).

19. For some suggestive comments on these themes focused on the scope of the *right* to refuse treatment, see N. Ann Davis, *The Right to Refuse Treatment*, *in* INTENDING DEATH 109-30

Moreover, many persons who unquestionably commit suicide are suffering and seek relief from that suffering; they do not seek death as an end in itself. This makes it difficult to distinguish suicides from treatment refusals on the basis of intention. Like typical suicides, patients who refuse treatment often intend to end their lives because of their grim prospects. Surprisingly, many judicial decisions maintain that refusals of treatment that satisfy these conditions are *not* suicides. These decisions may derive from the need to legitimate various forms of assistance that physicians provide when helping patients die by withholding treatment. The reason is that without the protections afforded by these precedent cases many common forms of assistance might be legally proscribed.

Assisted suicide and voluntary active euthanasia both involve assistance in bringing about another's death, but "assisted suicide," as this term will be used here, also requires that the person whose death is brought about be the ultimate cause of his or her own death (the final relevant link in a causal chain leading to death), whereas "voluntary active euthanasia" requires that the ultimate cause of one person's death be another person's action. As we will see, when physicians assist in or administer death to their patients, the physicians' *intentions* and the *causes* of death involved can make a decisive difference to both the classification and the evaluation of their acts. However, we need first to consider how the often invoked distinction between *killing* and *letting die* plays a role in these controversies.

II. THE LANGUAGE OF "KILLING" AND "LETTING DIE"

Those who defend the view that euthanasia and physician-assisted suicide are morally prohibited typically assume that acts of killing are impermissible and that a defensible distinction exists between killing and letting die.[20] However, this distinction has been difficult to explicate,[21] and it creates both moral and conceptual confusion because the right of autonomy that underlies allowing patients to die when they refuse treatment seems, in principle, to extend to a patient's choice of suicide or euthanasia.[22] The distinction is also of less value in practical contexts and public policy than is commonly assumed.[23] The problem

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(Tom L. Beauchamp ed., 1996).

20. *See* MARGARET PABST BATTIN, LEAST WORST DEATH 15-20 (1994).

21. *See* various articles in KILLING AND LETTING DIE (Bonnie Steinbock ed., 1980); and in INTENDING DEATH (Tom L. Beauchamp ed., 1996). *See also* H. M. Malm, *Killing, Letting Die, and Simple Conflicts*, 18 PHIL. & PUB. AFF. 238 (1989); McMahan, *supra* note 12, at 250-79.

22. *See generally* Kadish, *supra* note 17; George P. Smith, II, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination*, 22 U.C. DAVIS L. REV. 275 (1989).

23. *See* Donald G. Casswell, *Rejecting Criminal Liability for Life-shortening Palliative Care*, 6 J. CONTEMP. HEALTH L. & POL'Y 127 (1990); James F. Childress, *Non-Heart-Beating Donors: Are the Distinctions Between Direct and Indirect Effects and Between Killing and Letting Die Relevant and Helpful?*, 3 KENNEDY INST. ETHICS J. 203 (1993); Lawrence O. Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*,

is illustrated by cases in which parents, surrogates, and physicians consider the forgoing of treatment for patients in instances of justified *letting die*, but critics accuse them of unjustified *killing*.[24] For example, Dr. Gregory Messenger, a dermatologist, was charged with manslaughter after he unilaterally terminated his premature (25 weeks gestation, 750 g.) son's life-support system in a Lansing, Michigan's neo-natal intensive care unit; he thought he had merely acted compassionately and allowed his son to die after a neonatologist had failed (he thought) to fulfill a promise not to resuscitate the infant.[25] Law and public policy have given physicians and parents little guidance about the permissible range of discretion in these non-life-support cases,[26] with consequent confusion about whether the act is one of killing or letting die.

Ordinary language, law, and traditional medical ethics give us no clear answer whether such cases are correctly described as "killing" or as "letting die." "Killing" does not entail either a wrongful act, a crime, or an intentional action. For example, persons are killed in accidental automobile collisions, even when the other driver was not at fault. In ordinary language, *killing* represents a set of related ideas whose central condition is causal action that brings about another's death (when existing conditions would otherwise have sustained the life). *Letting die* represents another family of ideas whose central condition is intentional avoidance of causal intervention so that disease, system failure, or injury causes death (when existing conditions would, without medical intervention, not have sustained the life). Law, medicine, ethics, and ordinary language all recognize that some forms of letting die constitute killing. As the Supreme Court of Washington put it, "the killing of a human being [can occur] by the act, procurement, or omission of another."[27] Killing by omission (or by abatement of treatment) and killing by commission also cannot be distinguished by intention, as both can be intentional.

If we are to retain some distinction between killing and letting die and use it to distinguish appropriate from inappropriate physician behavior, we need more precise meanings for these notions.[28] For example, the term "killing" could be

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21 J. L. MED. & ETHICS 94 (1993); Susan Kowalski, *Assisted Suicide: Where do Nurses Draw the Line?*, 14 NURSING & HEALTH CARE 70 (1993).

24. The classic case is presented *In re Treatment and Care of Infant Doe* (an Indiana case held in Monroe County Circuit Court). Contrast the conceptual argument in Bart Gruzalski, *Killing by Letting Die*, 90 MIND 91 (1981).

25. Howard Brody, *Messenger Case: Lessons and Reflections*, 5 ETHICS-IN-FORMATION 8 (1995); John Roberts, *Doctor Charged for Switching Off His Baby's Ventilator*, 309 BRIT. MED. J. 430 (1994); *Man Acquitted in Son's Death*, N.Y. TIMES, Feb. 4, 1995, at 10. In February 1995, Dr. Messenger was cleared by a jury in a lower court of manslaughter charges brought in 1994. For similar cases, see 17 LAW, MED. & HEALTH CARE 294-406 (1989) (a special issue devoted to the Linares case); *see also* Fred Barbash & Christina Russell, *The Demise of 'Infant . . .': Permitted Death Gives Life to an Old Debate*, WASH. POST, April 17, 1982.

26. Brody, *supra* note 25.

27. *In re* Colyer, 660 P.2d 738, 751 (Wash. 1983).

28. *See generally* Raanan Gillon, *Acts and Omissions, Killing and Letting Die*, 292 BRIT.

defined so that it is restricted entirely to circumstances in which one person *intentionally and unjustifiably* causes the death of another human being—a usage that limits and reconstructs the ordinary meaning of the term.[29] The term "killing" would then be morally loaded in such a way that *justified* acts of arranging for death in medicine logically could not be instances of killing; they would necessarily be cases of letting die. Under this *stipulative* definition of "killing," physicians do not kill when they justifiably remove a life-sustaining treatment in accordance with a patient's refusal of treatment, and patients do not kill themselves when they justifiably forgo treatment. However, this stipulative move to redefine "killing" evades rather than resolves the moral and conceptual problems.

In Parts I and II of this Article, I have been dealing with conceptual problems that surround terms and distinctions such as "euthanasia" and "physician-assisted suicide," "active" and "passive," and "killing" and "letting die." I have only touched the surface of these problems, though some will be discussed later. It deserves notice at this point that in many complex cases the elements of these notions are so intertwined as to almost defy neat classification of the case as falling under one or more of these terms, even when they are combined in expressions such as "voluntary active euthanasia." A case in point is the following:

> A bright, alert, elderly man with several different life-threatening illnesses sought counseling for what he hoped would be an approach to euthanasia. . . . A "new" symptom [suddenly] precipitated the possibility of major surgery, albeit with an awareness on all sides of the poor prognosis. Nonetheless, the patient pushed for the surgery, which resulted in his death. The patient achieved his wish by seducing his medical caregivers to unwittingly expedite his demise.[30]

This and many other complicated cases create doubt that a comprehensive and morally neutral analysis consistent with law and ordinary usage will be developed for the terms "killing" and "letting die." Nonetheless, I will start with the neutral assumption that the term "killing" refers only to certain acts of causing death and these acts are neither justified nor unjustified.

III. Problems in the Justification of Killing and Letting Die

If "killing" is justified under some conditions (for example, in cases of self-defense), the justifiability of any *particular* killing is an open question and we cannot assert without examining particular cases and justifications that a case of killing is morally worse than a case of letting die. That is, to correctly apply the

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MED. J. 126 (1986); McMahan, *supra* note 12.

29. For straightforward usages of "killing" as a moral notion entailing culpability, see Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 52; C. Everett Koop, *The Challenge of Definition*, HASTINGS CENTER REP., Jan.-Feb. 1989, Special Supplement 2.

30. Nathan Schnaper, *Surgery or Assisted Suicide*, 114 ANNALS INTERNAL MED. 995 (1991).

label "killing" or the label "letting die" to a set of events will not, by itself, determine whether an action is acceptable or unacceptable.[31] Killing will in most cases be worse that letting die, but such judgments will be contingent on the cases and cannot be reached through the meaning of the terms "killing" and "letting die." A particular act of killing, such as a callous murder, will generally be morally worse than a particular act of letting die, such as forgoing treatment for a dying and comatose patient; but some acts of letting die such as not resuscitating a patient who could easily be saved, but who has refused treatment because of a series of mistaken assumptions, also will be morally worse than particular acts of killing, such as mercy killing at the request of a seriously ill and suffering patient.

Nothing about killing or letting die, then, entails judgment about the wrongness or rightness of either type of action, or about the acceptability of the intentions of an actor who performs the actions. Rightness and wrongness depend on the justification underlying the action. Any judgment that an act of killing or letting die is justified or unjustified requires that something be known about the actor's intention or motive (whether it is benevolent or malicious, for example), about the patient's refusal of treatment or request of assistance, about the balance of benefits over burdens to the patient, and about the consequences of the act.

Some writers have tried to address these problems of justification through an account of the cause of death and causal responsibility for death.[32] They construe the forgoing of treatment as letting die, rather than killing, if and only if an underlying disease, system failure, or injury is the cause of death. Medical technology, in this account, merely delays the natural course of an underlying condition. When the technology is removed, a natural death occurs, because natural conditions do what they would have done if the technology had never been initiated.[33] The patient's affliction becomes the proximate cause of death, not the physician's, surrogate's, or patient's action, thus, neither homicide nor assisted suicide occurs. By contrast, killing occurs when an act of a person causes death: One acts appropriately in many cases of intentionally allowing a person to die (one is not the cause of death at all), but inappropriately when they intentionally kill.

To make this argument complete and plausible, I believe it must be added that the forgoing of treatment that allows a person to die must be a *justified* forgoing. The *justification of forgoing treatment* then becomes the centerpiece issue rather than the *causation of death* (that is, the particular causal route to death). What, then, justifies a forgoing of treatment?

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31. *Cf.* James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975). *See also* JAMES RACHELS, THE END OF LIFE: EUTHANASIA AND MORALITY (1986); Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 10.

32. *See In re* Estate of Greenspan, 558 N.E.2d 1194, 1203 (Ill. 1990); *In re* Conroy, 486 A.2d 1209, 1222-23 (N.J. Sup. Ct. 1985); *In re* Conroy, 464 A.2d 303 (N.J. Super. Ct. App. Div. 1983); *see also* BY NO EXTRAORDINARY MEANS pt. V, at 227 (Joanne Lynn ed., 1986); Daniel Callahan, *Vital Distinctions, Mortal Questions: Debating Euthanasia and Health Care Costs*, 115 COMMONWEAL 397 (1988).

33. Compare the general account in DANIEL CALLAHAN, THE TROUBLED DREAM OF LIFE ch. 2 (1993).

The mere fact that a natural cause will, if released, bring about death is not in itself sufficient to justify not treating someone. To see why, consider the following example: A disaffected employee of a hospital maliciously detaches a patient from a respirator. This detachment of the patient from the respirator is causally no different than the detachments by physicians that allow patients to die. The disaffected employee and the physician do not differ causally when they detach the respirator and allow someone to die. Therefore, some features in the circumstance other than forgoing treatment, disconnecting the respirator, and the presence of disease or injury must be considered to arrive at moral and legal conclusions about justifiable actions.

Just as the employee killed a patient, physicians who do the same thing also kill their patients, *unless* we introduce a condition about the justifiability of one person (the physician) forgoing treatment and the unjustifiability of the other person "forgoing" treatment. Without some distinguishing and justifying feature in the circumstances that renders their discontinuations of treatment justified, physicians cannot justifiably say, "We do not kill our patients, only the underlying diseases and injuries do," any more than the disaffected employee can say, "It was the disease, not me, that killed him." An account of killing and letting die restricted to forgoing treatment, disconnecting machines, and disease-caused death leads to the conclusion that either the employee did not kill the patient or that physicians always kill their patients when they die from such forgoing of treatment. To solve this problem we must provide a more plausible account of justified forgoing of treatment and justified actions that cause death.

To this end, we need an evaluative framework to determine which causal interventions and outcomes make a difference and what difference they make. The framework, rather than the bare causal facts, will point us to the *relevance* of the causal facts and will determine how we can and cannot properly make ascriptions of responsibility, culpability, liability, and the like.

IV. Problems in the Causation of Death

I have argued that whether an act is justified cannot be determined by the fact that it is a killing and that an independent justification is necessary. Many will resist this conclusion on grounds that killing and causing death are intrinsically unjustified acts.[34] In this Part, I will concentrate on this problem as an issue of causation (of death) and liability.

Causation in the law, unlike causation in other fields of causal inquiry, is structured to identify *causal responsibility* for an outcome. The "cause of death" in law assigns responsibility for death; the "cause of death" in science identifies causal facts as determined by causal laws. In law one could not assess causal responsibility for negative outcomes without a preexisting system of duties. Without an assigned duty, no causal responsibility exists; we could even say that in law no *causation* exists by human agents without an assignment of duties.

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34. *Cf.* Richard Doerflinger, *Assisted Suicide: Pro-choice or Anti-life?*, Hastings Center Rep., Jan.-Feb. 1989, Special Supplement 16.

Therefore, if a physician has no duty to treat, forbearing to treat does not breach a duty and does *not cause death.* Authorized withdrawal of treatment is not an affirmative act:[35] It is not providing treatment when there is no legal duty to provide treatment. Indeed, there is a legal duty not to provide treatment. The physician's forbearance is not causally connected to the death. When no duty to treat exists, then preexisting disease, system failure, or injury is the proximate cause, and the physician escapes liability.[36] If a physician does have a duty to treat, omission of treatment breaches the duty and *causes death.*

This structuring of duties rests on evaluative judgments about permissible conduct, and these *value* judgments often control what appear to be *factual* judgments about the cause of death. That is, value judgments about justified and unjustified actions, rather than factual judgments, control judgments about what constitutes "killing" and how it differs from letting die; causal judgments do not determine what constitutes killing and letting die.[37] "Killing" thus functions more as an *evaluative* category than a *causal* category.[38]

This approach to causation helps to alleviate the fears of health professionals concerning legal liability, but it is neither the only way to think about causation nor an adequate account of the physician's duties. Here is an alternative way to think about causation:[39] In many cases a patient's death cannot plausibly be attributed entirely to natural causes; the intentional action of a physician, a patient, or both plays a central role. The patient's decision or the physician's action are causal factors that determine how and when death will occur. They may not be *proximate* causes under law,[40] but they are causes nonetheless. As Lawrence Gostin explains, "Withholding or withdrawing life sustaining treatment, such as abating technological nutrition, hydration or respiration, will cause death as surely

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35. Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983).

36. *In re* Estate of Greenspan, 558 N.E.2d at 1203.

37. Causal judgments are often structured through various forms of evaluative judgment (as well as by causal explanation) in both law and morals. *See* H. L. A. HART & A. M. HONORÉ, CAUSATION IN THE LAW (1959); Samuel Gorovitz, *Causal Judgments and Causal Explanations*, 62 J. PHIL. 695 (1965).

38. For an example of one author who straightforwardly uses "killing" as a moral notion entailing culpability, see Daniel Callahan, *When Self-Determination Runs Amok*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 52.

39. *See* Dan W. Brock, *Forgoing Life-Sustaining Food and Water: Is it Killing?*, *in* BY NO EXTRAORDINARY MEANS 118 (Joanne Lynn ed., 1986); Raymond G. Frey, *Intention, Foresight, and Killing*, *in* INTENDING DEATH 72 (Tom L. Beauchamp ed., 1996); Raymond J. Devettere, *The Imprecise Language of Euthanasia and Causing Death*, 1 J. CLINICAL ETHICS 268 (1990); Kenneth F. Schaffner, *Recognizing the Tragic Choice: Food, Water, and the Right to Assisted Suicide II*, 16 CRITICAL CARE MED. 1063 (1988). These writers have variously used a but-for theory of causation, a contributory theory of causation, and an account of singular causal judgments to fill out their accounts.

40. From the law's perspective, these conditions might be viewed as incidental causes or conditions of the superior or controlling cause that qualifies as the proximate cause.

as a lethal injection."[41]

To exploit an example used by Chief Justice Rehnquist and Justice Scalia in the *Cruzan* case, when feeding tubes were removed from Nancy Cruzan and death occurred a few days later, it was implausible to argue that the cause of death for this comatose person was the injury sustained years before in an automobile accident.[42] The injury sustained in the accident was the motivating factor and perhaps the justifying reason for the action of removing the medical technology that sustains life, but was it the cause of the death that came to Nancy Cruzan? Even if it was *a* cause, was it the sole cause?[43]

The actions of physicians are in many (certainly not all) cases necessary parts of the sufficient conditions of death at the time and in the way the death occurs.[44] To withhold nutrition and hydration so that a patient dies is a necessary part of a sufficient condition of death at the time and in the way the death occurs. If the patient is suffering from conditions such as severe brain damage, cancer, or quadriplegia, these conditions are neither necessary nor sufficient conditions of death. They are not the cause of death as it occurs and when it occurs. If physicians are not legally responsible for their participation in this process, it is only because they are protected by a network of duties that does not require them to act and prevent the death, not because they have no causal role in the outcome. If this network of duties were to be altered, causal responsibility for outcomes would be correlatively altered.

To appreciate this point, consider an *unintentional* and *unjustified* action. Suppose a physician *mistakenly* removes a respirator from a quadriplegic patient who wanted to continue living and could have continued living for many years. We could not reasonably say, "The physician did not cause the patient's death; he only allowed the patient to die." By "letting" this patient die, he failed to discharge a duty and caused the patient's death. It would be preposterous in this case for the physician to protest a legal indictment by saying, "*I* did not kill him; the disease killed him. I merely allowed him to die." Except for being unintentional, this physician's act is the same act that a physician performs, intentionally and at the request of a patient or patient's family, in a standard case of "letting die." What the physician does is *causally* no different than what anyone would do if he or she removed a patient's life-support.

Generally, the motives of patients and physicians are proper, and both moral and legal justification exists for the action. Whether the motive is evil or noble, the act remains one of causing death. Courts have occasionally followed this path of reasoning and extended it to proximate causation and causal responsibility. For example, the Superior Court of New Jersey, Appellate Division, held in the *Conroy* case that removing the nasogastric tube from 84-year-old Claire Conroy would not be merely forgoing treatment. The court believed that her physicians

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41. Gostin, *supra* note 23.

42. Cruzan v. Missouri Dep't of Health, 497 U.S. 261 (1990).

43. *See* Edward R. Grant & Cathleen A. Cleaver, *A Line Less Reasonable:* Cruzan *and the Looming Debate over Active Euthanasia*, 2 MD. J. CONTEMP. LEGAL ISSUES 99 (1991).

44. Brock, *supra* note 39; Schaffner, *supra* note 39.

were proposing to *dehydrate and starve* Conroy, which would constitute killing her. The court explained that the patient "would have been actively killed by independent means," a result the court held to be euthanasia.[45]

The Supreme Court of New Jersey later overturned this lower court ruling. It followed the dominant view in law and medicine that natural causes are responsible for the patient's death under these circumstances.[46] But was the lower court entirely wrong with its view of causation? Is the matter clear and settled? Are natural causes the *only* morally relevant type of causes? Are both natural causes and human causes at work in these cases?

In some difficult and controversial circumstances, both physician intervention *and* a relevant causal condition of disease, system failure, or injury are present. In a few cases, multiple causal conditions may be relevant, each forming an independent causal sequence sufficient to bring about death. That is, any one of several distinct sequences of causally linked events may be sufficient to cause death. To isolate a single event that causes death may not be possible because our concepts of causation in law and elsewhere are not sufficiently precise to allow us to isolate "the cause."[47]

In law, some of the problems regarding causation and killing can be eradicated through a determinate scheme of duties in which physicians or surrogates do not have a duty to provide or to continue the treatment. If no duty to treat exists, then questions of legal causation and liability do not arise. Would this strategy require that we altogether dispense with the language of "killing" and "letting die" in medical contexts, framing the issues exclusively in the language of optional and obligatory treatments? If so, the thesis would be unsatisfactory, because physicians can both kill and let die. All that the argument thus far forces us to reconsider is the precise foundation for determinations that physicians let die and kill. The foundation is simpler for letting die than many have thought, as we will now see.

V. Valid Refusals as the Justificatory Basis of Letting Die

The conceptual conditions of "letting die" are also the justifying conditions of letting die. A commonly held view is that "letting die" is to be defined as a matter of "ceasing useless treatments" after which patients die.[48] This account is highly misleading, but also revealing.

Consider what justifies a physician's act of forgoing treatment. The physician's forgoing is warranted by an *authoritative refusal of treatment* by a

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45. *In re* Conroy, 464 A.2d 303 (N.J. Super. Ct. App. Div. 1983).

46. *In re* Conroy, 485 A.2d 1209, 1224-25 (N.J. 1985).

47. Devettere, *supra* note 39; Schaffner, *supra* note 39; Benjamin Freedman, *The Titration of Death: A New Sin*, 1 J. Clinical Ethics 275 (1990).

48. Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988). It is sometimes added, as a condition, that the patients must be dependent on life-support systems. *See* Ronald E. Cranford, *The Physician's Role in Killing and the Intentional Withdrawal of Treatment*, in Intending Death 160 (Tom L. Beauchamp ed., 1996).

patient or authorized surrogate. It would be both immoral and illegal for the physician not to forgo treatment in the face of a competent, authoritative refusal. The presence of a competent, authoritative refusal of treatment is what places the physician's act into the category of letting die, rather than killing, and makes the same act by a nonphysician one of killing rather than letting die (a competent, authoritative refusal of treatment is typically absent when nonphysicians perform the same action). "Ceasing useless treatment" is neither conceptually nor morally the proper way to state the situation; "validly refused treatment" is the heart of the conceptual matter and the moral matter.

A similar claim about refusal of treatment has been defended by James L. Bernat, Bernard Gert, and R. Peter Mogielnicki.[49] They suggest that the type of action—killing or letting die—depends on whether a valid refusal warrants the forgoing of treatment, rather than the validity of the forgoing depending on whether it is an act of letting die. This suggestion is illuminating. Traditionally the distinction between killing and letting die was thought to be the first question to be decided, and it was thought that the distinction should be accounted for either in terms of *intention* (whether a person intends someone's death) or *causation* (whether a person causes someone's death).[50] The patient-refusal hypothesis provides a third way. It demotes causation and intention in importance and ascribes a pivotal role to *valid refusal.*

A refusal is valid if a patient or authorized decisionmaker autonomously refuses a proposed treatment. This account of a valid refusal is part of a larger account of the limits of the physician's authority, duties, and moral responsibilities. The physician has a duty to follow an appropriate refusal. This duty allows us to say that the physician's action of withholding or withdrawing does not cause death in the legal framework of proximate causation. The close connection between causation, duty, and causal responsibility is again apparent. Those who have looked to some of the nonlegal accounts of causation (outlined in Part IV) to determine whether physicians cause death have been looking in the wrong place if the point is to distinguish between killing and letting die; and physicians who have been worried about killing their patients have been thinking about causation in the wrong way. Although the physician's withdrawal of a treatment is a necessary part of a sufficient condition of the death as it occurs, the physician does not cause death in the relevant sense of "cause." The physician does not cause death because there is no duty to treat in the face of a valid refusal; and therefore the patient's preexisting condition becomes the proximate cause of death.

This theory gives meaning to the pivotal terms "killing" and "letting die" in

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49. BERNARD GERT, MORALITY: A NEW JUSTIFICATION OF THE MORAL RULES 294 (1988) [hereinafter GERT, MORALITY]; James L. Bernat, Bernard Gert & R. Peter Mogielnicki, *Patient Refusal of Hydration and Nutrition*, 153 ARCHIVES INTERNAL MED. 2723 (1993) [hereinafter Bernat et al.]; Bernard Gert et al., *Distinguishing between Patients' Refusals and Requests*, HASTINGS CENTER REP., July-Aug. 1994, at 13.

50. *See* Baruch Brody, *Withdrawal of Treatment versus Killing of Patients*, *in* INTENDING DEATH 90-103 (Tom L. Beauchamp ed., 1996).

a way that potentially protects the conventional moral thesis in law and medicine that it is justifiable to allow a patient to die and unjustifiable to kill a patient. Valid refusals warrant letting die, and forgoing treatment or active intervention to bring about death in the absence of a valid refusal exposes the physician to a charge of unjustified killing. Still to be considered is whether this thesis begs the central moral question by assuming, without argument, that only letting die is justified. An alternative, and my preference, is to frame acts of killing so that they can be justified on grounds that are strikingly similar to the justification of acts of letting die.

VI. Valid Requests as the Justificatory Basis of Killing

If the justification of the physician's actions is determined by a valid authorization, must the notion of a valid *authorization* be confined to a valid *refusal*? Can a valid *request* be as authoritative as a valid *refusal*?

The primary justification advanced in both law and morals for requirements that competent informed refusals be honored is the right of self-determination. The principle of self-determination in recent legal literature is the functional equivalent of the moral principle of respect for autonomy.[51] A major concern of the law is to prescribe the precise duties that devolve upon physicians in order that rights of autonomy be protected. In the last two decades it has become clear that a valid refusal of treatment obligates the physician to forgo treatment, even if it is a refusal of hydration and nutrition or a life-support system that will result in death.[52] Whenever valid refusals occur, it is never a moral offense to comply with the refusal, and how the death occurs from the refusal is irrelevant.[53]

By not categorizing the withholding or the withdrawing of a validly refused medical treatment as "killing," we have signaled our acceptance of the physician's nontreatment even when treatment is medically indicated. Had we judged withholding and withdrawing treatment morally unacceptable when competent persons refuse treatment, we would have categorized such conduct by physicians

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51. The classic origins of this principle for medical contexts is Schloendorff v. Society of New York Hospitals, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."). Despite such strong rights language, all courts passing on the issue have ruled that a patient's right to self-determination, as protected by the legal doctrine of informed refusal and informed consent, is not absolute in the sense of always validly overriding every competing claim. Several legally justified exceptions are recognized. In general, legal duties and rights, like moral duties and rights, have no more than prima facie value. A prima facie legal duty such as the duty to obtain informed consent is therefore not always an *actual* duty. Valid exceptions are admitted in both law and ethics if promotion of the best interests of society or of the individual demands them, but many proposed exceptions and justifications are highly controversial.

52. MEISEL, *supra* note 2; Meisel, *supra* note 2; Weir & Gostin, *supra* note 2.

53. For a compelling case of death by seizure after refusal of seizure-preventing medication, see Stephanie Cate, *Death by Choice*, 91 AM. J. NURSING 32 (1991).

as killing (perhaps mercy killing, but still killing). Similarly, had we found moral grounds not to accept refusals by competent persons, we might have chosen not to categorize such conduct as forgoing life-sustaining treatment, and instead have categorized it as suicide.

Valid refusals now have extraordinary power in law and morals, but the same will be true of valid requests if we come to view competent requests as having the same authorizing power in medicine as competent refusals. Bernat, Gert, and Mogielnicki argue that a request for assistance in dying by a competent patient does not have the same authority and obligatory force in law and morals as a valid refusal and, therefore, does not, in the same way justify an action of physician-assisted suicide or voluntary active euthanasia. Conventional medical ethics, such as the doctrines still espoused by the American Medical Association, would take their conclusion and use it to support the additional conclusion that physicians are obligated not to honor patients' requests for either euthanasia or physician-assisted suicide. However, this conclusion does not appear to be the one that Bernat, Gert, and Mogielnicki embrace. They write cryptically as follows:

> Physicians should honor patients' requests or refuse to honor them based upon their own carefully considered professional judgment about the legal, moral, and medical appropriateness of doing so. A common example of the exercise of this freedom is physicians' refusal to prescribe requested narcotics in situations in which they judge narcotics to be inappropriate.[54]

These authors have argued convincingly that patients' requests do not obligate physicians in the way patients' refusals do. They thus leave the door open to the *justifiability* of honoring requests by patients for euthanasia or physician-assisted suicide, even though physicians are not *obligated* to honor the request. Surprisingly, they neither explain this position nor explore its implications.[55] This disregard of the problem is particularly striking in light of their overall argument, which appears to deny any real need for physician-assisted death and appears to support, rather than reject, the traditional medical ethics position of opposition to all forms of killing. Gert, Bernat, and Mogielnicki argue:

> [T]here are often strong moral and legal reasons against [honoring patient requests for death], *because* honoring such requests is killing or assisting suicide. Recognition of the distinction between refusals and requests is an important reason for preferring patient refusal of food and fluids to voluntary active euthanasia or physician-assisted suicide as a method for determining the timing of one's death.[56]

They also defend a legal statute with the following language: "The physician shall

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54. Gert et al., *supra* note 49.

55. The position was not even mentioned in Gert, Bernat, and Mogielnicki's first article. Bernat et al., *supra* note 49. The position appears in a single sentence in the second article, Gert et al., *supra* note 49, at 13.

56. Gert et al., *supra* note 49, at 14 (emphasis added).

not provide [pain] medication for the purpose of hastening the time of death."[57] Moreover, the authors state that they "agree with the conclusions" of the American Medical Association's report of the Council on Ethical and Judicial Affairs, which absolutely proscribes the honoring of requests for euthanasia or physician-assisted suicide.[58]

The above quotation from Gert, Bernat, and Mogielnicki contains the seeds of the correct moral position, but the position remains to be expounded and defended. The present author's view, which is clearly inconsistent with the AMA report, is summarized by the following:

> (1) Physicians are both morally and legally required to honor refusals that will lead to death;
> (2) Physicians are not legally required to honor requests other than those for abatement of treatment that will lead to death (only a "request" that is actually a refusal of treatment);
> (3) Whether physicians are either morally permitted or morally required[59] to honor requests for direct assistance that will lead to death depends on the nature of the request, the nature of the patient-physician relationship, and the nature of the physician's prior commitments.[60]

The first two have already been sufficiently explored, but the third needs explanation and defense.

Although the third thesis perpetuates use of the term "request," this language does not adequately capture the nuances of many circumstances in which patients and physicians make decisions about euthanasia and physician-assisted suicide.[61] In the clearest cases of justified compliance with requests, the patient and the physician discuss the patient's best interest. The major assumption is that the physician will not abandon the patient or resist what they jointly determine serves the patient's best interests, even if that determination is death. The justifiability of the physician's role in assisting with a patient's death in such circumstances is in part contingent on the nature of the physician's relationship with the patient and the values at work in their relationship.[62] A physician with a broad set of

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57. *Id.* at 15.

58. *Id.* at 13 (citing Council on Ethical and Judicial Affairs, American Medical Association, *Decision Near the End of Life*, 267 JAMA 2229 (1992)).

59. For a strong thesis stating that in certain cases ordinary medical practitioners are duty-bound to assist patients in bringing about death, see Malcolm Parker, *Moral Intuition, Good Deaths and Ordinary Medical Practitioners*, 16 JAMA 28 (1990).

60. *See* Timothy E. Quill, *Doctor, I Want to Die. Will You Help Me?*, 270 JAMA 870, 872 (1993).

61. *See, e.g.*, Bernard M. Dickens, *When Terminally Ill Patients Request Death: Assisted Suicide Before Canadian Courts*, 10 J. PALLIATIVE CARE 52 (1994); K. M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-assisted Suicide*, 6 J. PAIN & SYMPTOM MGMT. 289 (1991); Frederick M. Maynard, *Responding to Requests for Ventilator Removal from Patients with Quadriplegia*, 154 W. J. MED. 617 (1991).

62. *See* Nancy Jecker, *Giving Death a Hand: When the Dying and the Doctor Stand in a*

professional commitments to help patients die has made a moral commitment[63] that differs from the commitment made by a physician who draws the line in opposition to all forms of euthanasia and assistance in suicide.[64]

In some cases, patients in a close relationship with a physician *both* decline a possible treatment *and* request an accelerated death in order to lessen pain or suffering. In these cases, the refusal and the request are combined as parts of a single plan. If the physician agrees with the plan, assisted suicide or active euthanasia grows out of the close patient-physician relationship established by the two parties. In the context of such a relationship it would not be surprising if some physicians preferred active euthanasia to the form of physician-assisted suicide envisaged in Oregon, which allows prescribing drugs for suicide, but does not allow providing aid to patients at the point when they most need the care, comfort, and reassurance that a good physician can provide. How society is to judge the quality of such relationships (and whether it should judge them at all) is an unsettled matter, but it is beyond reasonable doubt that at least some patients and physicians have established this type of relationship.

When patients make reasonable requests for assistance in dying, physicians cannot escape responsibility for their decisions by refraining from helping their patients die. No physician can say, "I am not responsible for the result of my decision when I choose not to act on a patient's request." There has long been a vague sense in the medical and legal communities that if only the physician lets nature take its course, then the physician is not responsible for the resulting death. This account is misleading. A physician is always responsible for the decision taken and for the consequences of any action or inaction. The physician who complies with a patient's request is responsible in the same way a physician who refuses to comply with a request is responsible for his or her decisions.

Physicians who reject requests by patients cannot magically relocate responsibility by transferring it to the patient's disease. The only relevant matter is whether the physician has an adequate justification for the chosen course of action. Physicians have a responsibility to act in the best interests of their patients, and they cannot, without adequate justification, avoid what a patient believes to be in his or her best interests. It is undisputed, physicians often reject courses of action requested by patients and have good reasons for doing so. The question is whether the physician, who conscientiously believes that the patient's request for assistance in dying is justified and assumes responsibility for assistance, acts in a

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Special Relationship, 39 J. AM. GERIATRICS SOC'Y 831 (1991).

63. *See* Christine K. Cassel, *Physician-assisted Suicide: Are we Asking the Right Questions?*, SECOND OPINION, Oct. 1992, at 95; Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844 (1989).

64. For such cautious approaches, see PHILIP E. DEVINE, THE ETHICS OF HOMICIDE (1978); CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); Eric D. Caine & Yeates Conwell, *Self-determined Death, the Physician, and Medical Priorities: Is There Time to Talk?*, 270 JAMA 875 (1993); Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 NEW ENG. J. MED. 1110 (1991); Edmund Pellegrino, *Compassion Needs Reason Too*, 270 JAMA 874 (1993).

morally justifiable manner in complying with the request even when it is not legally justifiable.

Bernat, Gert, and Mogielnicki might object that I am confusing moral duties to honor refusals with nonrequired moral ideals of honoring requests. They apparently regard physicians who honor the patient's assisted suicide requests as exceeding professional duties by acting on personal and optional moral ideals. This classification of the physician's commitments as a moral ideal is sensible, but the distinction can also be misleading without further qualification, for two reasons. First, professional obligations do not coincide with moral obligations applicable to all persons. Second, acting in accordance with one's sense of moral integrity is not easily distinguished from acting pursuant to obligations, especially in professional life.

The complex interplay of impartial obligations, professional duties, moral ideals, and virtues become difficult for a physician to untangle both in the abstract and the specific. The commitments of physician Timothy Quill, discussed in detail below, provide a case in point. He argues that there is an obligation for a physician to be compassionate, and he thinks the obligation knows no clear boundaries in the territory of patients' requests and physicians' responses. Indeed, he views a professional's obligation to be compassionate as the justification for honoring a patient's requests.[65] Another physician might reasonably argue that there is a moral obligation to help dying patients die in the most humane manner. Under this perspective, if assisting in suicide is the most humane manner, then it is obligatory not because of an ideal of assistance but because of a fundamental moral obligation of humane treatment.

Another relevant consideration, as Gert has argued,[66] is that moral ideals sometimes legitimately override moral duties when they conflict. Even if there is a moral duty to obey the law and the law prohibits physician-assisted suicide and voluntary active euthanasia,[67] the physicians who *justifiably* believe that their moral ideals override all other moral duties will not be morally wrong in acting on their beliefs. This conclusion may be consistent with the position of Gert, Bernat, and Mogielnicki, but it is inconsistent with the AMA report and with every statement on the subject issued by a major professional association.[68]

VII. The Wrongness in Causing or Assisting in Death

Could assistance in someone's self-requested death be wrong, even if both the physician and the patient conscientiously believe it to be right? The only way to decide in specific cases whether killing is wrong and letting die is not wrong is to

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65. Timothy E. Quill, *Incurable Suffering*, Hastings Center Rep., Mar.-Apr. 1994, at 45.

66. Gert, Morality, *supra* note 49, ch. 8.

67. *Contra* H. Tristram Engelhardt & Michelle Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 Sw. L.J. 1003 (1982).

68. *See infra* note 83 (listing American Medical Association, Council on Ethical and Judicial Affairs, American Geriatrics Society, Public Policy Committee, American Neurological Association, Committee on Ethical Affairs, and American Thoracic Society).

determine what *makes* death wrong. Under certain circumstances, a person is not guilty of a crime or a wrongful act merely because he or she killed someone. Legitimate defenses for killing include killing in self-defense and killing by misadventure (accidental and nonnegligent killing while engaged in a lawful act). From a moral point of view, causing a person's death is wrong *when it is wrong* not because the death is *intended* or because it is *caused,* but because an unjustified harm or loss to the person occurs.

Death is bad for a person not because death is bad in itself, but because of the deprivation of opportunities and goods that life would otherwise have afforded.[69] Therefore, what makes a physician's act of killing or assisting in death wrong, when it is wrong, is that a person is unjustifiably harmed. In other words, it is wrong if the person unjustifiably suffers a setback to interests that the person otherwise would not have experienced. In particular, the person is caused a loss of goods and the capacity to plan and choose a future. Failure to avoid causing these losses, when one could do so, is the sole source of the wrongfulness of the action.[70]

The critical question for acts of killing in medicine is whether an act of assisting persons in bringing about their deaths causes them a loss or, rather, provides a benefit. If a person chooses death and sees that event as a personal benefit, then helping that person bring about death neither harms nor wrongs the person and may provide a benefit or at least fulfill the person's last important goal. This typical aid might harm society by setting back its interests, which also might constitute a reason against *legalization.* However, this social harm does not alter conclusions about the justifiability of the *act* of helping in an individual case. Not helping persons to die can interrupt or frustrate their goals and, from their perspective, cause them harm, indignity, or despair—even if, at the same time, it protects society's interests.

VIII. The Rightness in Causing or Assisting in Death

These conclusions can now be linked to the earlier conclusions about valid refusals and valid requests. If passive allowance of death based on valid refusals does not harm or wrong persons or violate their rights, how can assisted suicide and voluntary active euthanasia harm or wrong the person who dies? In both voluntary active euthanasia and passive letting die, persons refuse to go on and seek the best means to the end of quitting life. Their judgment is that continuing life is, on balance, worse than not continuing it. The person who attempts suicide, the person who seeks active euthanasia, and the person who forgoes life-sustaining treatment to end life are identically situated except that they may select different means to end their lives.[71] Therefore, those who believe it is morally acceptable

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69. Thomas Nagel, *Death, in* Mortal Questions (1979). For criticisms and extensions, see F. M. Kamm, Morality, Mortality ch. 1 (1993).

70. *Cf.* Allen Buchanan, *Intending Death: The Structure of the Problem and Proposed Solutions, in* Intending Death 34-38 (Tom L. Beauchamp ed., 1996).

71. For the extension to suicide, see Dan W. Brock, *Death and Dying, in* Medical Ethics

to let people die when they refuse treatment, but not acceptable to take active steps to help them die when they request assistance, must give a different account of the wrongfulness of killing and letting die than I have offered.

I reiterate that the justification of assistance in bringing about death that I have offered is an extension of the justification of letting patients die. It is not an appeal to conventional ways in which acts of killing have been justified, such as the familiar justifications for killing in war, killing in self-defense, capital punishment, and the like. The irrelevance of this kind of appeal to the medical context is one reason why assistance by physicians in bringing about death has been so long resisted. My argument is simply that letting a patient die by accepting a valid refusal to continue in life is directly analogous to helping a patient die by accepting a valid request rather than forcing the patient to continue in life.

In this argument the high value we place on rights of autonomy spills over from the well recognized right to refuse, into the underexplored right to request. Killing an autonomous person against the person's desires is a clear and fundamental violation of autonomy, but killing an autonomous person in accordance with the person's desires and instructions shows a basic respect for the person's rights and autonomy. As the autonomy interest in this choice increases on the scale of interests, denial of help to the patient becomes more burdensome; and to increase the burden is to increase the harm done to the person. There is no reason why it would be wrong for a patient to make such a request, and no reason why it would be wrong for a physician to agree to the patient-recommended sequence of events. Moreover, a rejection of the patient-recommended plan is, at least from the patient's perspective, an act against the patient's best interests.

Medicine and law now seem to say to many patients, "If you were on life-sustaining treatment, you could withdraw the treatment and we could let you die. Because you are not, we can only give you palliative care until you die a natural death." This position condemns the patient to live out a life he or she does not want—a form of cruelty that violates the patient's rights and prevents discretionary discharge of the fiduciary duties of the physician. This is not to claim that physicians face large numbers of desperately ill patients. Pain management has made circumstances at least bearable for many of today's patients,[72] reducing the need for physician-assisted suicide and euthanasia and increasing the need for adequate facilities, training, and hospice programs.[73] Nonetheless, the available medical literature indicates that some patients cannot be satisfactorily relieved,[74]

329, 345 (Robert M. Veatch ed., 1989); Kadish, *supra* note 17, at 866-67.

72. Foley, *supra* note 61, at 289-97; D. E. Weissman, *Physician Assisted Suicide*, BIOETHICS BULL., 1991, at 3-4.

73. Greg A. Sachs et al., *Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia*, 43 J. AM. GERIATRICS SOC'Y 554 (1995); Joan Teno & Joanne Lynn, *Voluntary Active Euthanasia: The Individual Case and Public Policy*, 39 J. AM. GERIATRICS SOC'Y 827 (1991). For a different slant on these issues, see Cranford, *supra* note 48, at 150-61.

74. *See* Gregg A. Kasting, *The Nonnecessity of Euthanasia*, *in* PHYSICIAN-ASSISTED DEATH 25-45 (James M. Humber et al. eds., 1994); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).

and, even if they could, questions would remain about the autonomy rights of patients to pursue their own plans in life[75] and about the fact that many patients are more concerned about suffering and indignity than about pain.[76]

Current social institutions, including the medical system, have not proved adequate for patients like those who turn, in desperation, to Jack Kevorkian. His methods are far from emulable, but those who rely on him raise profound questions about the lack of a support system in medicine or elsewhere for handling their problems. Dying persons often face inadequate counseling, emotional support or information for pain control. Their condition is intolerable from their perspective, and they see their situation as without hope. To maintain that these persons act immorally by arranging for death is a harsh and unwarranted judgment.

Even if their decisions and acts are easily explained and thoroughly justified, doubt still exists as to whether it is justifiable for physicians to assist in suicide. Should we judge the physician's decision differently than the patient's? The most widely discussed case about physician-assisted suicide in recent years has been physician Timothy Quill's report of his relationship with a 45-year-old leukemia patient.[77] The patient did not let the matter rest with a refusal of chemotherapy, which offered a twenty-five percent chance of a long-term cure, and Quill prescribed the barbiturates she desired. Many believe that Quill's actions were justified because the patient was competent and informed, had an incurable condition associated with severe suffering, had a longstanding and meaningful relationship with the physician characterized by informed decisionmaking, and had a durable desire for death and repeatedly requested to die.[78] Quill has defended his views with the argument that such acts are justified not as much by the *rights of patients*, but by the physician's *compassionate response* to an exceptional circumstance of suffering in which no good alternatives remain for the patient.[79]

Nonetheless, critics have found the action by Quill morally and legally unwarranted and a breach of physician ethics.[80] Quill has acknowledged that he violated a New York State law against assisted suicide that exposed him to criminal liability and opened up the possibility of misconduct charges from the New York State Health Department. In order to protect himself and the patient's family, and to avoid a police investigation and an ambulance at the scene, he lied

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75. Helga Kuhse, *Active and Passive Euthanasia—Ten Years into the Debate*, *in* THE EUTHANASIA REVIEW 108, 117 (1986); Parker, *supra* note 59, at 28-34.

76. Weir, *supra* note 10, at 123.

77. Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991), *reprinted in* TIMOTHY QUILL, DEATH AND DIGNITY (1993). *See also* Quill v. Koppel, 870 F. Supp. 78 (S.D.N.Y. 1994).

78. Quill et al., *supra* note 74, at 1382.

79. Quill, *supra* note 77, at 693-94. *See also* Christine K. Cassel & Diane E. Meier, *Morals and Moralism in the Debate over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750 (1990).

80. *See* Conwell & Caine, *supra* note 64; Pellegrino, *supra* note 64, at 874-75; Peter A. Ubel, *Assisted Suicide and the Case of Dr. Quill and Diane*, 8 ISSUES IN L. & MED. 487 (1993).

to the medical examiner by reporting that a hospice patient had died of acute leukemia. Subsequently, a grand jury in Rochester, New York, where the events occurred, declined to indict Quill.[81] From the jury's perspective, Quill did nothing wrong. That is, even though he violated the law, on balance, he did nothing *morally* wrong and the moral justification overrides the legal violation.

Whether grand juries should reach such decisions is, of course, another matter, but it is not surprising that jurors accepted Quill's view that physician-assisted suicide can be a form of humane responsiveness to patients' requests and can protect vulnerable persons who have a strong relationship with a physician. Quill has insisted that physician-assisted suicide should never be substituted for comprehensive care or for helping patients resolve physical, personal, and social challenges posed by the dying process. He also believes that physicians are *obligated* to explore an incurably ill patient's informed request for help in dying and under appropriate circumstances the physicians must comply with it.[82]

If this claim and the earlier argument in this Part are sound, then the burden of justification for proscriptions of acts of voluntary active euthanasia and physician-assisted suicide rests on those who refuse or hinder assistance to competent patients who elect death, rather than on those who assist them. Associations of medical professionals in the United States seem to have improperly reversed this order of justification by placing the burden on physicians who want to assist patients.[83] Of course, the merit of this conclusion depends on how one interprets the vague and imprecise guidelines generated by these professional associations. Their guidelines might be interpreted as:

(1) policies for members of a particular professional medical association;
(2) policies for members of the medical profession generally; or
(3) public policy governing members of a profession.

Professional associations have not clarified which group their guidelines are

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81. Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 22, 1991, at A1.

82. Quill et al., *supra* note 74, at 1380-84. These authors defend physician-assisted suicide, but not voluntary active euthanasia. *See also* Quill, *supra* note 60, at 870-73; Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 NEW ENG. J. MED. 1039 (1993).

83. Council on Ethical and Judicial Affairs, American Medical Association, *Euthanasia: Report C*, *in* PROCEEDINGS OF THE HOUSE OF DELEGATES 258-60 (Chicago: American Medical Association June 1988); *see also Decisions Near the End of Life*, *supra* note 14; American Geriatrics Society, Public Policy Committee, *Voluntary Active Euthanasia*, 39 J. AM. GERIATRICS SOC'Y 826 (Aug. 1991); AMERICAN MEDICAL ASSOCIATION, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, TREATMENT DECISIONS FOR SERIOUSLY ILL NEWBORNS, REPORTS OF THE COUNCIL, No. 43, at 66-75 (Chicago: American Medical Association June 1992); American Neurological Association, Committee on Ethical Affairs, *Persistent Vegetative State: Report of the American Neurological Association Committee on Ethical Affairs*, *in* ANNALS OF NEUROLOGY 386-90 (1993); American Thoracic Society, *Withholding and Withdrawing Life-sustaining Therapy*, 115 ANNALS OF INTERNAL MED. 478-85 (1991).

intended to cover. The problem is that their policies may legitimately apply to only the first, but the associations may believe that their policies apply to all three.

IX. The Distinction Between Justifying Policies and Justifying Acts

The argument thus far suggests that physicians' acts of honoring valid refusals and acts of complying with valid requests can both be justified. Is this argument sufficient to show that *public policies*, such as Measure 16 in Oregon, are justified? It is possible, without inconsistency, to hold strong views about the justifiability of some acts of physician-assisted suicide and support public policies that prohibit these acts. One can consistently judge acts morally acceptable that one cannot support legalizing.

The resistance to physician-assisted suicide and voluntary active euthanasia has long been the wedge or slippery slope argument.[84] This argument is grounded in a cautious conception of human nature and society. The reasoning is that practices that are acceptable in one type of circumstance will, inevitably be extended to similar circumstances in which the practices are morally unacceptable. For example, even if particular acts of assistance in dying are morally justified in circumstances of a substantial patient-physician relationship, the social consequences of sanctioning practices of killing in these circumstances would inevitably be extended to cases in which serious risks of abuse in patient-physician relationships would outweigh the benefits to society.

This argument is commonly applied to public policy and to the patient-physician relationship, which is driven by cure, amelioration, and prevention of illness, pain, and disability.[85] To introduce killing into this relationship, it is argued, threatens to distort it and will eventually impair the trust and respect vital to the relationship.[86] A removal of current prohibitions could weaken the fabric of restraints and beneficial attitudes,[87] raising doubts in the patient's mind about the physician's commitment to the patient and to the provision of effective treatment.[88] The argument is not that these negative consequences will occur

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84. *Cf.* James Rachels, The End of Life: Euthanasia and Morality ch. 10 (1986); Douglas Walton, Slippery Slope Arguments (1992); Mary Warnock, The Uses of Philosophy (1992); Wibren van der Burg, *The Slippery Slope Argument*, 102 Ethics 42 (1991); Frederick Schauer, *Slippery Slopes*, 99 Harv. L. Rev. 361 (1985).

85. *See* Alan J. Weisbard & Mark Siegler, *On Killing Patients with Kindness: An Appeal for Caution*, *in* J. Arras & N. Rhoden, Ethical Issues in Modern Medicine 218 (1989); H. J. J. Leenen & Chris Ciesielski-Carlucci, *Force majeure (Legal Necessity): Justification for Active Termination of Life in the Case of Severely Handicapped Newborns after Forgoing Treatment*, 2 Cambridge Q. Healthcare Ethics 271 (1993); Alan D. Ogilvie & S. G. Potts, *Assisted Suicide for Depression: The Slippery Slope in Action?: Learning from the Dutch Experience*, 309 Brit. Med. J. 402 (1994).

86. Cassel & Meier, *supra* note 79, at 750-752; Watts & Howell, *supra* note 15, at 1043-46.

87. Raymond J. Devettere, *Slippery Slopes and Moral Reasoning*, 3 JAMA 298 (1992).

88. David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844 (1989); *see also* David Orentlicher et al., *Physician Participation in Assisted Suicide [Letters and*

immediately after legalization of physician-assisted suicide, but that they will grow incrementally over time.[89] Society might start with innocent beginnings by developing policies that carefully restrict the number of patients who qualify for assistance in suicide, but these policies will be weakened as the practice continues.[90] The next generation, having grown up with the expectation that terminally ill patients who drain medical resources opt for death, will have lost the old values that buffered patients from manipulation by this expectation.[91]

A major concern is that if active euthanasia or physician-assisted suicide were legalized, it would quickly move beyond competent patients and voluntary choice.[92] As active euthanasia grew in acceptance, the same advantages would be extended to incompetent patients who are seriously suffering but have not expressed a preference for assistance in dying.[93] Some believe that the United States Supreme Court created such small beginnings in the case of Nancy Cruzan, and that the citizens of Oregon enlarged the problem by voting to legalize physician assistance in dying.[94] The concern is that restrictions initially built into legislation will be revised over time and increase the possibilities for unjustified killing. Unscrupulous persons will learn how to abuse the system, just as they do with methods of tax evasion that operate on the margins of legitimate tax avoidance. These concerns will be escalated in importance if the medical system does not come to grips with the needs of terminally ill and vulnerable patients.[95]

Response], 263 JAMA 1197 (1990).

89. Some believe they have already so changed. *See* Charles L. Sprung, *Changing Attitudes and Practices in Forgoing Life-sustaining Treatments*, 263 JAMA 2211(1990); *see also* Peter A. Singer & Mark Siegler, *Euthanasia—A Critique*, 322 NEW ENG. J. MED. 975 (1990); Doerflinger, *supra* note 34, Special Supplement 16-19; Wanzer et al., *supra* note 63, at 844-49.

90. C. Everett Koop & Edward R. Grant, *The 'Small Beginnings' of Euthanasia: Examining the Erosion in Legal Prohibitions against Mercy-killing*, 2 NOTRE DAME J.L. ETHICS & PUB. POL'Y 585 (1986); Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 102 (1985).

91. K. Danner Clouser, *The Challenge for Future Debate on Euthanasia*, 6 J. PAIN & SYMPTOM MGMT. 310 (1991).

92. Victor G. Rosenblum & Clarke D. Forsythe, *The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing?*, 6 ISSUES IN L. & MED. 3 (1990).

93. Yale Kamisar, *Preserve Traditional Restraints*, A.B.A. J., Apr. 1993, at 43; Marjanke Spanjer, *Terminating Life of Severely Handicapped Dutch Baby*, 345 LANCET 975 (1995); Richard Tomlinson, *China Considers Voluntary Euthanasia*, 310 BRIT. MED. J. 761 (1995).

94. Edward R. Grant & Cathleen A. Cleaver, *A Line Less Reasonable:* Cruzan *and the Looming Debate over Active Euthanasia*, 2 MD. J. CONTEMP. LEGAL ISSUES 99 (1991); Mark E. Haddad, Cruzan *and the Demands of Due Process*, 8 ISSUES IN L. & MED. 205 (1992); Patricia A. King, *The Authority of Families to Make Medical Decisions for Incompetent Patients after the* Cruzan *Decision*, 19 LAW MED. & HEALTH CARE 76 (1991); John N. Suhr, Cruzan v. Director, Missouri Department of Health*: A Clear and Convincing Call for Comprehensive Legislation to Protect Incompetent Patients' Rights*, 440 AM. U. L. REV. 1477 (1991).

95. George J. Annas, *Physician-Assisted Suicide—Michigan's Temporary Solution*, 328 NEW ENG. J. MED. 1573 (1993); Singer & Siegler, *supra* note 89, at 1881-83; Teno & Lynn, *supra*

Such patients could easily be lost in the system, suffer a loss of rights in the system, or be encouraged to end their lives by the system's expectations.[96] They may not desire death, but they might feel that ending their lives is a social priority or duty.[97]

Some of these arguments may rest on premises of risk of abuse rather than the slippery slope premises, but it is difficult to separate the two cleanly, and all such arguments depend on speculative predictions of a progressive erosion of moral restraints and abuses that cannot be prevented by careful public policies. If the dire consequences they predict actually will develop from the legalization of assisted suicide or voluntary active euthanasia, then these arguments rightly suggest that practices should be legally prohibited. Still, we need to ask how good the evidence is that dire consequences will occur. Is there a sufficient reason to think that we cannot maintain control over and even improve public policy?[98] Those who use predictive arguments in defense of legalization and those who use such arguments in opposition to legalization owe us a careful accounting of the basis of their predictions. Empirical predictions require empirical support, and thus far the evidence is spotty on all sides and generally analyzed in favor of a predetermined favorite outcome.[99]

These difficult empirical questions are fundamental in the current social controversy about euthanasia. The substance of the empirical problems cannot be addressed here, but it follows from the earlier argument that even if slippery slope arguments provide solid reasons against legalization, they provide no basis for the conclusion that acts of euthanasia and physician-assisted suicide are morally wrong. Slippery slope arguments conclude that patients such as Sue Rodriguez and the patrons of Jack Kevorkian cannot be helped by physicians because giving help to those individuals would open the gates to killing persons who should not be killed. All patients should be denied help, not because of anything they have done or because of any demerit in their cases, but because acts of assistance in dying would hurt others if legalized and therefore should not be tolerated under any circumstances.

There is something very right and something very wrong about this argument—right because the argument points to dangers of the most profound sort, wrong because at least some patients deserve to be helped and their physicians do nothing morally wrong by helping them. It may therefore be necessary to prohibit these acts of assistance in our public policies while acknowledging that there is nothing morally wrong with the acts other than their

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note 73, at 828-29.

96. Joanne Lynn, *The Health Care Professional's Role When Active Euthanasia Is Sought*, 4 J. PALLIATIVE CARE 100 (1988); Susan Wolf, *Holding the Line on Euthanasia*, HASTINGS CENTER REP., Jan.-Feb. 1989, Special Report 13-15; Susan Wolf, *Gender, Feminism, and Death*, *in* FEMINISM & BIOETHICS (Susan Wolf ed., 1996).

97. *See* BATTIN, *supra* note 20, chs. 3, 8.

98. *Cf.* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994).

99. *Cf.* Meier, *supra* note 4.

potentially far-reaching social consequences. This position leaves room for justified civil disobedience, moral nonconformity, or evasive noncompliance with prohibitions recommended by professional associations.[100] I see no grounds for the judgment that carefully considered acts of noncompliance and moral nonconformity in helping desperately ill patients are morally indefensible.[101]

Should we rest satisfied with a situation in which disobedience is the physician's only choice? Despite the clear importance of concerns about slippery slopes, I believe the legislation in Oregon is a promising development, although not in the form passed. Although the AMA has declared that acts of assistance in suicide by physicians are "immoral," including the acts allowed under the Oregon bill, there is reason to believe that we should welcome some version of the Oregon legislation.[102] This suggestion may seem to contradict my earlier arguments about legalization, but slippery slope arguments should not be so paralyzing that we are not open to social innovation that will help us determine whether the empirical predictions they make are correct and whether one system works better than another.[103] The Oregon legislation could be viewed as a social trial that will eventually provide a valuable perspective on both the risks and the benefits. If careful research could help us evaluate such experimental programs in upcoming years, we could learn about benefits and risks in a comprehensive, timely, and objective manner.[104] Perhaps then we can be positioned to decide on the basis of evidence whether the slippery slope argument is as slippery as some fear it could be.

CONCLUSION

Avoidance of intentionally causing the death of patients is a deep and primitive restraint encouraged by the many reservations that we have long had about killing innocent persons. Even killing non-innocents, such as combatants in war and criminals, is troublesome to many persons. Our reservations are so deep in the case of innocent parties that in the criminal law the consent and encouragement of the person killed is no defense to the most serious of charges.

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100. *Cf.* James F. Childress, *Civil Disobedience, Conscientious Objection, and Evasive Noncompliance: A Framework for the Analysis and Assessment of Illegal Actions in Health Care*, 10 J. MED. & PHIL. 63 (1985).

101. For a contrasting view that rests on a form of slippery slope argument, see CALLAHAN, *supra* note 33, ch. 3.

102. Franklin G. Miller & John C. Fletcher, *The Case for Legalized Euthanasia*, 36 PERSPECTIVES IN BIOLOGY & MED. 159 (1993); Miller et al., *supra* note 15, at 119-23.

103. *See* Maria T. CeloCruz, *Aid-in-dying: Should We Decriminalize Physician-assisted Suicide and Physician-committed Euthanasia?*, 18 AM. J. L. & MED. 369 (1992); H. Hendin & Gerald Klerman, *Physician-assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143 (1993); Henk Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. MED. ETHICS 212 (1994); Wendy N. Weigand, *Has the Time Come for Doctor Death: Should Physician-assisted Suicide be Legalized?*, 7 J. L. & HEALTH 321 (1993).

104. Miller et al., *supra* note 15, at 122.

Proscriptions of physician assistance in bringing about death have been forged in this context of assumptions about the morality of killing. To change this perspective seems not merely to change what physicians do, but to threaten our whole structure of thinking about the place of the healing professions and about prohibitions in the criminal law. To decriminalize suicide was one thing; to decriminalize killing in medicine seems quite another.[105]

This line of reasoning, appealing as it is, provides us with a good reason for abandoning the killing-letting die distinction altogether. Instead of qualifying our views against killing in order to allow physicians to kill, we will be better off if we forswear the premises that physicians kill in these circumstances and that they violate a patient's right to life. A better perspective is that physicians can benefit patients in ways other than by healing and palliation, and that patients can waive their rights to ordinary protections. Similar reasons suggest abandoning the label "suicide" in "physician-assisted suicide."[106] The idea that terminally ill patients who seek to advance the date of their death commit suicide may be correct, but the morality of the circumstance seems more obscured than clarified by use of the term "suicide." The pejorative connotations of the term may serve to limit options and pressure patients unnecessarily.

Opponents of physician-assisted suicide and voluntary active euthanasia often allege that such acts by physicians will, over time, undermine the public's trust in physicians, changing the image from healer to killer. There may be some wisdom in this prediction, but the converse may be just as likely. The seriously ill and suffering will feel abandoned by both law and medicine and will come to distrust the members of these professions, especially when physicians insist on sustaining life whatever the cost to the patient's feelings, hopes, and plans.[107] Many persons deeply fear a time of indignity and increased suffering, and feel unempowered by the system to control their own fate. I believe that we have generally underassessed the importance of patient control at the end of life while overassessing the importance of physician control.

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105. A majority of states in the United States still have statutes criminalizing physician-assisted suicide; in other states homicide statutes could be invoked for the same actions. *See* Marzen et al., *supra* note 90.

106. *See* Robert A. Sedler, *Constitutional Challenges to Bans on 'Assisted Suicide': The View from Without and Within*, 21 HASTINGS CONST. L.Q. 786 (1994).

107. Richard W. Momeyer, *Does Physician-Assisted Suicide Violate the Integrity of Medicine?*, 20 J. MED. & PHIL. 17 (1995).