

1997

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### Recommended Citation

Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 Fordham Urb. L.J. 817 (1997).

Available at: <https://ir.lawnet.fordham.edu/ulj/vol24/iss4/14>

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# PHYSICIAN-ASSISTED SUICIDE: A COMMON LAW ROADMAP FOR STATE COURTS

Alan Meisel\*

## Introduction

Public debate about physician-assisted suicide<sup>1</sup> has been raging for a decade. Although the exploits of Jack Kevorkian have probably been the best known factor in making this issue a matter of widespread public discussion, the groundwork had begun to be laid a few years earlier by an article in the *Journal of the American Medical Association* in which a physician anonymously (and perhaps fictitiously) claimed to have acceded to a patient's request to end her life by means of a lethal overdose.<sup>2</sup> This debate probably would have continued without Dr. Kevorkian's activities, or the publicity surrounding them, because of the publication of a self-help guide to suicide, *Final Exit*,<sup>3</sup> and an article in the *New England Journal of Medicine* by Dr. Timothy Quill in which he described having provided a terminally ill patient with a lethal

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1. Like it or not, the terms "assisted suicide" and "physician-assisted suicide" are probably here to stay. The problem with this terminology is that it prejudices the conclusion and it makes the practice illicit because of the long-standing pejorative connotations associated with the word "suicide." Traditionally the term "suicide" has been used to apply to self-killing by a physically healthy person for some purpose other than ending the pain and/or suffering arising from terminal illness. It is preferable in the context of a person with terminal illness who seeks to end his pain and/or suffering by ending his life, with the assistance of another, as "actively hastening death."

Aid-in-dying can take two forms. This phrase encompasses both actively and passively hastening death. Passively hastening death consists of withholding or withdrawing life-sustaining medical treatment. See *infra* notes 30-32 and the accompanying text. Actively hastening death includes two distinct practices, assisted suicide and active euthanasia (or mercy killing). When assisted suicide is practiced, a person provides a terminally ill patient with a means for that patient to end his own life, which is administered by the patient. When active euthanasia is practiced, the other person not only *provides*, but also *administers* the instrumentality of death.

2. *A Piece of My Mind; It's Over, Debbie*, 259 JAMA 272 (1988).

3. DEREK HUMPHRY, *FINAL EXIT* (1991).

overdose of medication which she self-administered.<sup>4</sup> The crowning events in this debate were the decisions by two federal courts of appeal holding unconstitutional the New York and Washington state statutes making assisted suicide a crime, and the United States Supreme Court's subsequent reversals.<sup>5</sup>

The reaction to these developments by opponents of actively hastening death have consisted of a variety of apocalyptic predictions about how the legalization of physician-assisted suicide will make the United States resemble Nazi Germany. The opposition to the legalization of physician-assisted suicide is deep and broad, but, ironically, the support for legalization is too. A variety of public opinion polls report that support for physician-assisted suicide hovers around the seventy-five percent mark.<sup>6</sup> Some polls of phy-

4. Timothy E. Quill, *A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991).

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

6. Since 1947, the National Opinion Research Center has asked the question, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end a patient's life by some painless means if the patient and his family request it?" The affirmative answers to this question have consistently risen, from 37 percent in 1947 to 75 percent in 1996. However, the phrasing of this question could reasonably include passively hastening death as well as actively hastening death.

Other nationwide polls since 1993 that actually refer to legalizing assisted suicide or approving the practices of Dr. Kevorkian show a gradually increasing trend, in which support for physician-assisted suicide has risen from the low to mid 40 percent range to the mid to high 50 percent range. See Louis Harris & Assoc., Survey Conducted Dec. 9-14, 1994, Q. 002, *available in* WESTLAW, Poll Database (indicating 58 percent of the respondents approve of Kevorkian's actions); Louis Harris & Assoc., Survey Conducted Nov. 11-15, 1993, Q. 002, *available in* WESTLAW, Poll Database (indicating 58 percent of the respondents approve of Kevorkian's actions); Hart & Teeter Res. Co., Survey Conducted June 20-25, 1996, Q. 024, *available in* WESTLAW, Poll Database ( ) (indicating 57 percent of the respondents support the legalization of physician-assisted suicide); Gallup Org., Survey Conducted Jan. 20 - Feb. 13, 1994, Q. 041, *available in* WESTLAW, Poll Database (indicating 57 percent of the respondents support the legalizing physician-assisted suicide under specific circumstances); Gallup Org., Survey Conducted Jan. 20 - Feb. 13, 1994, Q. 042, *available in* WESTLAW, Poll Database (indicating 55 percent of the respondents support legalizing euthanasia under specific circumstances); Tarrance group et al., Survey Conducted Dec. 8-10, 1993, Q. 002, *available in* WESTLAW, Poll Database (indicating 54 percent of the respondents support physician-assisted suicide); CBS News, Survey Conducted Dec. 5-7, 1993, Q. 001, *available in* WESTLAW, Poll Database (indicating 52 percent of the respondents approve of Kevorkian's actions); Wash. Post, Survey Conducted Mar. 22-26, 1996, Q. 002, *available in* WESTLAW, Poll Database (indicating 51 percent of the respondents support legalizing physician-assisted suicide); Louis Harris & Assoc., Survey Conducted Mar. 4-10, 1993, Q. 002, *available in* WESTLAW, Poll Database (indicating 50 percent of the respondents approve of Kevorkian's actions); Gallup Org., Survey Conducted Dec. 4-6, 1993, Q. 009, *available in* WESTLAW, Poll Database (indicating 47 percent of the respondents generally approve of physicians'

sicians also find significant support for the legalization of physician-assisted suicide.<sup>7</sup> However, because behavior deviates from the expression of opinion, the level of support diminished significantly when voters in three states were presented with the opportunity to legalize physician-assisted suicide. Two of these referenda were defeated by fifty-six percent to forty-four percent margins<sup>8</sup> before the Oregon Death with Dignity Act was approved by slightly more than fifty percent of the voters in 1994.<sup>9</sup>

Although the Supreme Court has upheld the constitutionality of state prohibitions on physician-assisted suicide, efforts to legalize physician-assisted suicide on state-law grounds are likely to continue. One way to legalize such action would be the enactment of referenda like Oregon's<sup>10</sup> in other states. This may occur in a few states, but will be unlikely in most because the process of placing a question on a statewide ballot is extremely cumbersome. State legislatures could also revise existing legislation prohibiting assisted suicide by creating an exception, hedged with safeguards like the Oregon statute's, for physician-assisted suicide for the terminally ill. This too seems unlikely to occur to any great extent. Physician-assisted suicide, like abortion, is just too controversial a subject for

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assisting in suicides of patients in great pain); CBS News, Survey Conducted Dec. 13-14, 1993, Q. 001, *available in* WESTLAW, Poll Database (indicating 46 percent of the respondents approve of Kevorkian's actions); Gallup Org., Survey Conducted Dec. 4-6, 1993, Q. 045, *available in* WESTLAW, Poll Database (indicating 43 percent of the respondents approve of Kevorkian's actions).

7. See, e.g., Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 *NEW ENG. J. MED.* 310, 311 (1996) (reporting that 60 percent of responding Oregon physicians supported legalization of physician-assisted suicide); Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 *NEW ENG. J. MED.* 303, 305 (1996) (reporting that only 17.2 percent of responding Michigan physicians favored legal prohibition of assisted-suicide).

8. See Diane M. Gianelli, *Euthanasia Measure Fails, But Backers Vow Renewed Push*, *AM. MED. NEWS*, Nov. 23-30, 1992, at 30 (describing California proposal to legalize euthanasia and physician-assisted suicide); Jane Gross, *Voters Turn Down Mercy Killing Idea*, *N.Y. TIMES*, Nov. 7, 1991, at A10 (nat'l ed.) (reporting on Washington state initiative to legalize administration of lethal injections by physicians to "adult patients who are in a medically terminal condition" at the patients' request). There was also a failed attempt to get an initiative to legalize physician-assisted suicide for the terminally ill on the ballot in California in 1988. See Katherine Bishop, *Backers Fail to Get Lethal Injection Bid on California Ballot*, *N.Y. TIMES*, May 18, 1988, at A23.

9. Oregon Death with Dignity Act, *OR. REV. STAT.* § 13 (1996), *implementation stayed*, *Lee v. State*, 891 F. Supp. 1439 (D. Or. 1995), *rev'd*, 107 F.3d 1382 (9th Cir.), *cert. denied sub nom. Lee v. Harclerod*, 118 S. Ct. 328 (1997).

10. See *id.*

legislatures to vote to approve regardless of individual legislators' views on the subject.

Now that the Supreme Court effectively precludes access to federal constitutional arguments for the legalization of physician-assisted suicide, the most likely avenue for legalization will be state constitutional<sup>11</sup> and common-law claims. Many of the arguments accepted by the two federal courts of appeals that struck down the New York and Washington state statutes<sup>12</sup> can be revived in this litigation. Because these contentions have been subjected to inordinate scrutiny and critique in law review articles, the multitude of briefs filed in the Supreme Court, and the Supreme Court's opinions themselves, there is no need to dwell on them here.

Despite the Supreme Court's decisions, neither the controversy nor the practice will go away.<sup>13</sup> The proper course is not to continue to prohibit physician-assisted suicide, but to legalize it and regulate it. Without legalization, it cannot be regulated. History and common sense show that continued legal prohibition will not in fact prevent actively hastening death. Indeed, the widespread public discussions of physician-assisted suicide might embolden physicians who otherwise would not have practiced it to consider doing so, and encourage physicians who practiced it infrequently and covertly to do so more frequently and openly.

This article returns to the legal basics. The efforts to legalize physician-assisted suicide slowly evolved out of twenty years of judicial and legislative efforts legalizing passively hastening death. Part I examines the development of the law legalizing passively hastening death and how this development relied significantly on distinguishing passively hastening death from actively hastening death.<sup>14</sup> Part II subjects the arguments used to legitimate passively hastening death to a traditional criminal law analysis and demon-

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11. This process has already begun in Florida. A trial court ruled that the state's ban on assisted suicide was unconstitutional, *McIver v. Krischer*, 679 So. 2d 786 (Fla. Dist. Ct. App. 1996), but the Florida Supreme Court reversed. *Krischer v. McIver*, 697 So. 2d 97 (Fla. 1997).

12. *See supra* note 5.

13. Although this article is written supporting the legalization of actively hastening death, there is no doubt that there are dangers to its legalization: dangers that the safeguards will be ignored; dangers that strict safeguards will erode, either in practice or through judicial decision, and people will kill themselves for all sorts of trivial reasons; dangers that life will be devalued; dangers that we will gradually convert a practice by the few under rare circumstances at their request into one frequently invoked *against* many. In short, dangers of the proverbial slippery slope.

14. Actively hastening death includes, but is not limited to, physician-assisted suicide.

strates their weaknesses which were simple to conceal when there was little enthusiasm for, and discussion of, the legalization of actively hastening death.

The central role of consent in legitimating passively hastening death is analyzed in Part III. Although passively hastening death technically satisfies all of the elements of the crimes of assisted suicide and homicide, it is not illegal because it is legitimated by *consent* — consent of a competent patient or consent of the surrogate of an incompetent patient. Consent is the mechanism for implementing the fundamental principle of self-determination on which the entire edifice of the law of medical decision-making at the end of life (indeed, the law of medical decision-making in general) is built.

This analysis is applied to actively hastening death in Part IV. Because there is no legally significant distinction between actively and passively hastening death, consent legitimates *actively* hastening death just as it does passively hastening death. Nonetheless, Part V explores other reasons why actively hastening death ought to be prohibited and concludes that any arguments of any substance that can be made against actively hastening death can be equally applied to passively hastening death and should, therefore, be rejected in the latter as they are in the former. Safeguards must be established to prevent abuse of actively hastening death just as they have for passively hastening death.

### **I. The Consensus about Forgoing Life-sustaining Treatment and the Bright Line Between Actively and Passively Hastening Death**

Hastening the death of a dying person is not a new phenomenon. Historical accounts are widespread and are not limited to ancient stories about the practices of our barbarian forebears. There is plenty of evidence that aid-in-dying has been practiced continually

throughout modern history by physicians<sup>15</sup> and nonphysicians alike.<sup>16</sup>

Some forms of physician aid-in-dying have been accepted in American law for the past two decades. The celebrated *In re Quinlan*<sup>17</sup> case, decided in 1976, marked the first step in the legalization of physician aid-in-dying. *Quinlan* has more than 100 progeny in half the states,<sup>18</sup> and has spawned a variety of legislative enactments<sup>19</sup> that recognize the legal right to "passively" hasten death. Passively hastening death includes refusal of treatment, termination of life support, forgoing treatment, or withholding and withdrawing treatment, and variants on these terms.

This agglomeration of case and statutory law comprises a well-accepted legal consensus from which it is reasonable to infer how the case law on passively hastening death will develop in the states

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15. See, e.g., Ezekiel J. Emanuel, *Euthanasia—Historical, Ethical, and Empiric Perspectives*, 154 ARCHIVES INTERNAL MED. 1890 (1994); see also *Compassion in Dying v. Washington*, 79 F.3d 790, 828 (9th Cir. 1996) ("[D]octors have been discreetly helping terminally ill patients hasten their deaths for decades and probably centuries, while acknowledging privately that there was no other medical purpose to their actions. They have done so with the tacit approval of a substantial percentage of both the public and the medical profession."), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

16. See, e.g., Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Law*, 15 LAW, MED. & HEALTH CARE 231 (1987).

17. 355 A.2d 647 (N.J.), *cert. denied sub nom.* *Garger v. New Jersey*, 429 U.S. 922 (1976).

18. See 1 ALAN MEISEL, *THE RIGHT TO DIE* § 1.7 (2d ed. 1995 & Supp. 1997) [hereinafter 1 MEISEL].

19. There are several types of such statutes. The most widespread and best known are advance directive statutes creating a mechanism for competent individuals to make medical decisions after they lose decision-making capacity either by giving directions about what treatment they do or do not want (living will statutes) or designating someone to make decisions for them (health care power of attorney statutes). See generally 2 *id.*, chs. 10-12. Surrogate decision-making (or family decision-making) statutes authorize particular individuals to make health care decisions for patients who lack decision-making capacity and have not appointed a proxy through a health care power of attorney. See *id.* ch. 14. Do-not-resuscitate statutes either authorize physicians to write orders not to withhold cardiopulmonary resuscitation from a patient who suffers a cardiac arrest or authorize patients to execute a request for cardiopulmonary resuscitation to be withheld. See *id.* §§ 9.7 - 9.30. A small number of states have enacted statutes authorizing physicians to provide patients with adequate medication for pain relief. See *id.* § 8.7 (Supp. 1997) (Table 8-1) (collecting statutes). From a purely legal perspective, these statutes are largely superfluous because they implement rights that have their foundations in constitutional or common-law principles. However, as a practical matter, their restatement in positive law may assist in alleviating physicians' anxieties about the existence of these rights and thus may make them more willing to effectuate them.

that have not yet had an authoritative appellate case.<sup>20</sup> This consensus rests on three fundamental points: (1) there is a legal right of autonomy or self-determination which vests in competent individuals the right to refuse medical treatment, even if death results; (2) persons who have lost decision-making capacity have a right to have their families decide to withhold or withdraw medical treatment, even if death results;<sup>21</sup> and (3) there is a bright line between the refusal of treatment that results in death and more "active" means of hastening death.

*Quinlan*, and the consensus that has evolved from it, acknowledge a clear awareness of the distinction between passively and actively hastening death. Courts and legislatures are mindful of this distinction and have taken special pains to distinguish the two forms of hastening death. In fact, it is fair to say that this distinction has been the bedrock of the consensus. Without this distinction, it is doubtful that *Quinlan* would have been decided as it was or that the legal consensus about forgoing life-sustaining treatment would have evolved.

Opponents of the legalization of physician-assisted suicide object that *Quinlan* and its progeny are different because the current movement is for the legalization of *actively* hastening death.<sup>22</sup> Regardless of terminology, the common feature is that life-sustaining medical treatment is either stopped or not started. In actuality,

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20. I have discussed this consensus at some length in 1 MEISEL, *supra* note 18, §§ 2.2 - 2.5, at 38-54, and in Alan Meisel, *The Legal Consensus about Forgoing Life-Sustaining Treatment: Its Status and Its Prospects*, 2 KENNEDY INSTITUTE ETHICS J. 309 (1992).

21. It is generally recognized that close family members of patients who lack decision-making capacity have the common-law authority to act as surrogate for the patient and to make decisions about life-sustaining medical treatment on the basis of the substituted judgment standard. However, a small number of states reject this principle. New York does in all situations. See *In re Westchester County Medical Ctr. ex rel O'Connor*, 531 N.E.2d 607 (N.Y. 1988). Missouri does, at least with respect to feeding tubes. See *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director*, 497 U.S. 261 (1990); *but cf. In re Warren*, 858 S.W.2d 263 (Mo. Ct. App. 1993) (holding of *Cruzan* applicable only to decisions to forgo artificial nutrition and hydration). Michigan rejects it if the patient is not terminally ill or permanently unconscious. See *Martin v. Martin*, 538 N.W.2d 399 (Mich. 1995). Maine rejects substituted judgment by name, see *In re Swan*, 569 A.2d 1202 (Me. 1990), but appears to apply it in fact. See 1 MEISEL, *supra* note 18, § 7.5, at 364-66.

22. See *supra* note 9. The current debate focuses on, and the two Supreme Court cases deal exclusively with, physician-assisted suicide. Even if one believes that there is no morally or legally significant difference between assisted suicide and active euthanasia, there are reasons why one might support physician-assisted suicide but not active euthanasia by doctors. For example, because the agency of death must be administered by the patient in physician-assisted suicide, there is a greater assurance that the patient is mentally competent.



there never was a bright legal, logical or moral line between the two; the distinction was never more than semantic.

Only a few judges have been willing to acknowledge this, the best known of whom is Justice Scalia. In *Cruzan v. Director*,<sup>23</sup> he devoted a substantial part of his concurring opinion to arguing that there was no constitutional right to passively hasten death because it was the equivalent of killing and the states had the constitutional authority to prohibit such conduct if they so chose. Many illustrations could be plucked from his opinion, but one should suffice:

Starving oneself to death [his characterization of forgoing artificial nutrition and hydration procedures] is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to "pu[t] an end to his own existence."<sup>24</sup>

Yet, for two decades courts created and maintained the fiction, with little, if any, in-depth analysis,<sup>25</sup> that there is a difference, a determinative difference, between passively and actively hastening death.

Doing this has served primarily a practical political purpose: making passively hastening death acceptable to courts, to legislatures, to the medical profession and to the public. If the withholding or withdrawal of life-sustaining medical treatment were to be viewed as "killing" a patient, it would have been far more difficult, and probably impossible, for the practice of passively hastening death ever to have achieved legitimacy. As proponents embarked

23. *Cruzan v. Director*, 497 U.S. 261 (1990).

24. *Id.* at 296-97, quoting 4 Blackstone, Commentaries \*189. See also *Mack v. Mack*, 618 A.2d 744, 774 (Md. 1993) (Chasanow, J., concurring and dissenting) ("I do not, however, subscribe to the passive euthanasia implication" of the majority opinion.); *Brophy v. New Eng. Sinai Hosp., Inc.*, 497 N.E.2d 626, 640 (Mass. 1986) (Nolan, J., dissenting) ("court today has indorsed euthanasia"); *id.* at 644-45 (O'Connor, J., dissenting); *In re Grant*, 747 P.2d 445, 458 (Wash. 1987) (forgoing artificial nutrition and hydration "is pure, unadorned euthanasia") (Andersen, J., concurring in part and dissenting in part).

25. Even the Supreme Court's discussion in *Vacco* of the purported differences between actively and passively hastening death is superficial. In the end, the Court is content to conclude:

Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

*Vacco*, 117 S. Ct. at 2302.

on the legitimation of passively hastening death, courts recognized that making and emphasizing the distinction between passively and actively hastening death met a symbolic, and perhaps real, need to preserve the fundamental societal prohibition of killing innocent human beings.

Synonyms for actively hastening death, such as suicide, assisted suicide, active euthanasia, and mercy killing, have deeply negative connotations. They would have been like Typhoid Mary to the development of the law of end-of-life decision-making. No one wanted to associate with these terms for fear of becoming tainted. Thus, courts that wanted to recognize a right of both competent and incompetent individuals to be free of unwanted medical treatment realistically appraised the situation and determined that the best way to establish this right was to conceptualize, compartmentalize, and package the "right to die" to make it more acceptable. The most fundamental way in which courts did this was to proclaim not merely a significant difference, but a legally determinative difference between actively and passively hastening death, even if such a difference did not exist. This was accomplished by concluding that passively hastening death does not meet the requirements of the criminal offenses of homicide or assisted suicide, but actively hastening death does.

## II. Purported Distinctions between Passively and Actively Hastening Death

The primary motivation for seeking judicial review in end-of-life decision-making cases is the fear of liability arising from forgoing life-sustaining treatment.<sup>26</sup> Although the opinions of the appellate courts allude to the fear of both civil and criminal liability, the major concern has been with criminal liability. It has been asserted that forgoing life-sustaining treatment would constitute some form of criminal homicide<sup>27</sup> in the case of patients lacking decision-making capacity, and aiding, assisting, or abetting suicide<sup>28</sup> in the case

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26. See 2 MEISEL, *THE RIGHT TO DIE* § 17.24, at 431 n.445 (2d ed. 1995) (collecting cases) [hereinafter 2 MEISEL].

27. See, e.g., *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Ct. App. 1983); *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633, 641 (Mich. Ct. App. 1992); *In re Quinlan*, 355 A.2d 647, 669 (N.J. 1976); *Eichner v. Dillon*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (1981); *Grace Plaza of Great Neck, Inc. v. Elbaum*, 82 N.Y.2d 10, 29, 623 N.E.2d 513, 517, 603 N.Y.S.2d 386, 390 (1993) (Hancock, J., concurring); *In re Colyer*, 660 P.2d 738, 751 (Wash. 1983).

28. See, e.g., *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987); *Bouvia v. Superior Court (Glenchur)*, 225 Cal. Rptr. 297 (Ct. App. 1986); *Satz v. Perlmutter*, 362 So. 2d

of competent patients. The possibility of liability for conspiracy or accessory liability has also lurked in the background of the cases.

Beginning with *Quinlan*,<sup>29</sup> the courts have steadfastly hewed to the position that forgoing life-sustaining treatment does *not* subject the participants—either those who make the decision or those who actually withhold or withdraw the treatment—to criminal liability. In so doing, judges have not merely legitimated the forgoing of life-sustaining treatment, they have also endeavored to distinguish passively hastening death from actively hastening death, and to condemn the latter.

The courts have achieved this dual effort by employing three stratagems,<sup>30</sup> sometimes alone and sometimes in combination. The fundamental idea is that passively hastening death is not a crime because (1) death results from an omission rather than an act, (2) the intent necessary to support a crime is lacking, and/or (3) the omission is not the cause of the patient's death. Each of these stratagems, in effect, negates an essential element of a crime: act, intent, or causation. In addition, a small number of courts have taken a fourth tack and concluded that there is no criminal liability because the patient has a legal right to refuse treatment.<sup>31</sup>

## A. Act and Omission

### 1. *The Traditional Explanation*

The first method of avoiding criminal liability when life-sustaining medical treatment is forgone begins with the assertion that forgoing treatment is an omission, not an act. The locution sometimes used is that when treatment is forgone, the patient is allowed to die; no one is killing him.<sup>32</sup> In the case of a competent patient, it

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160 (Fla. Dist. Ct. App. 1978); *In re Farrell*, 529 A.2d 404 (N.J. 1987); *In re Quinlan*, 355 A.2d 647 (N.J. 1976); *In re Eichner*, 102 Misc.2d 184, 423 N.Y.S.2d 580 (Sup. Ct. Nassau County 1979).

29. 355 A.2d 647 (N.J. 1976).

30. The Supreme Court used these same stratagems in *Vacco v. Quill*, 117 S. Ct. 2293 (1997), to explain why there is a rational distinction between New York's statutory ban on assisted suicide and its case law permitting the forgoing of life-sustaining treatment.

31. See, e.g., *Cruzan*, 497 U.S. at 277 n.6.

32. See, e.g., *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985). See generally PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 64-66 (1983) [hereinafter PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT]. The Supreme Court took this position in *Vacco v. Quill*:

This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In *Cruzan v. Director, Mo.*

is maintained that the patient is not committing suicide but merely omitting treatment.<sup>33</sup> These arguments are founded on the assumption that acts are culpable but omissions are not. Thus, passively hastening death by forgoing life-sustaining treatment is not culpable, but actively hastening death is.

## 2. *Difficulties with the Traditional Explanation*

There are at least three problems with this approach, any one of which is fatal.

### a. *Liability for Omissions*

The most general flaw with the traditional explanation is that this assertion about the nature of criminal liability is flat-out wrong; liability may be imposed for an omission.<sup>34</sup> Although it is well accepted black-letter law, both in criminal law<sup>35</sup> and the civil law of torts,<sup>36</sup> that an omission to act is not culpable, this is merely a general rule or presumption that can be overcome by showing that the party who omitted to act was under a duty to do so.

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Dept. of Health, 497 U.S. 261, 278, 110 S. Ct. 2841, 2851, 111 L. Ed. 2d 224 (1990), we concluded that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions,” and we assumed the existence of such a right for purposes of that case, *id.* at 279, 110 S. Ct. at 2851-2852. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract “right to hasten death,” 80 F.3d at 727-728, but on well established, traditional rights to bodily integrity and freedom from unwanted touching, *Cruzan*, 497 U.S. at 278-279, 110 S. Ct. at 2851-52; *id.* 287-288, 110 S. Ct. at 2856-2857 (O’Connor, J., concurring). In fact, we observed that “the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.” *Id.* at 280, 110 S. Ct. at 2852. *Cruzan* therefore provides no support for the notion that refusing life-sustaining medical treatment is “nothing more nor less than suicide.”

*Vacco*, 117 S. Ct. at 2301.

33. See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978).

34. See *Compassion in Dying v. Washington*, 79 F.3d 790, 822 (9th Cir. 1996) (“The first distinction — the line between commission and omission — is a distinction without a difference now that patients are permitted not only to decline all medical treatment, but to instruct their doctors to *terminate* whatever treatment, artificial or otherwise, they are receiving.”), *rev’d sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997). See generally WAYNE R. LAFAVE & AUSTIN W. SCOTT, JR., *SUBSTANTIVE CRIMINAL LAW* § 3.3, at 202-03 (2d ed. 1986).

35. See *id.* § 3.3, at 203-07. See generally MODEL PENAL CODE § 2.01 commentary at 222-24 (1985).

36. See generally W. PAGE KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* § 56, at 375 (5th ed. 1984).

There are various ways to show an individual had a duty to act. In the context of life-sustaining medical treatment, one can look for a duty established by contract or by the actor's voluntarily undertaking to act on behalf of the victim. In the present context, the two are essentially indistinguishable: the doctor-patient relationship is generally agreed to be contractual in nature; and although as a general rule a physician has no obligation to treat a patient,<sup>37</sup> once there is an agreement to do so, a duty arises to continue to provide treatment until the relationship is terminated in any one of a number of legally acceptable ways.<sup>38</sup>

This does not mean that the physician is legally obligated to treat the patient until the patient dies despite the physician's efforts. In end-of-life decision-making cases, a physician is excused from the obligation to provide treatment either by the patient's consent for the physician to forgo treatment or, if the patient lacks decision-making capacity, by the permission of a person legally authorized to act on the patient's behalf.

*b. Forgoing Treatment May Be Accomplished by an Act*

The second problem with the argument that forgoing life-sustaining treatment is not criminally culpable because it is an omission rather than an act is that sometimes "forgoing" treatment is accomplished by an act, not by an omission. There are two ways in which treatment may be forgone. "Withholding" treatment is readily and uncontroversially denominated an omission. The one almost universally involved in the reported cases, however, is "withdrawing" treatment.<sup>39</sup>

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37. This general rule is undergoing a slow process of erosion. *See, e.g.*, Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(b) (1994) (requiring hospitals to evaluate and stabilize an emergency condition before transferring a patient to another hospital); 42 U.S.C. § 1395dd(d)(1)(B) (1994) (subjecting physicians who negligently violate EMTALA to potential civil monetary penalties). *But see, e.g.*, *Vickers v. Nash Gen. Hosp., Inc.*, 875 F. Supp. 313, 315 (E.D.N.C. 1995), *aff'd*, 78 F.3d 139 (4th Cir. 1996) (holding that EMTALA does not create a private right of action against violating physicians, as it does against hospitals). *See also* *Sharrow v. Bailey*, 910 F. Supp. 187, 192 (M.D. Pa. 1995) (holding that a physician's professional office was a place of "public accommodation" for purposes of the Americans with Disabilities Act); *Woolfolk v. Duncan*, 872 F. Supp. 1381, 1391 (E.D. Pa. 1995).

38. Controversy also rages over termination of the doctor-patient relationship in end-of-life cases when the doctor seeks to terminate the relationship — or, more specifically, the treatment — against the wishes of the patient's family. This issue is generally discussed under the label of "futility." *See generally* 2 MEISEL *supra* note 26, at ch. 19.

39. The reason that litigated cases almost exclusively involve withdrawing, rather than withholding, is because it is so much easier to disavow *psychological* responsibil-

Withdrawing treatment ordinarily requires the physician, or someone under the physician's authority and acting at the physician's direction, to *do* something to stop treatment, such as removing ventilatory support or a feeding tube. That being the case, someone performs an act which leads to the patient's death.<sup>40</sup>

*c. Difficulty in Distinguishing Between Act and Omission*

A third problem with the traditional explanation is the difficulty in characterizing behavior as either an act or an omission. The New Jersey Supreme Court addressed this problem in *In re Conroy*:<sup>41</sup>

Characterizing conduct as active or passive is often an elusive notion, even outside the context of medical decision-making.

Saint Anselm of Canterbury was fond of citing the trickiness of the distinction between "to do" (*facere*) and "not to do" (*non facere*). In answer to the question "What's he doing?" we

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ity for forgoing treatment by not initiating a treatment than by stopping a treatment that is already in progress. Cases of withholding are less likely to reach a physician's discomfort level, and, thus, to elicit a refusal to forgo treatment which then forces the patient's family to seek judicial permission to overturn that refusal. In addition, withholding less clearly presents a decision point than withdrawing.

40. See *Compassion in Dying v. Washington*, 79 F.3d 790, 822 (9th Cir. 1996) ("In disconnecting a respirator, or authorizing its disconnection, a doctor is unquestionably committing an act; he is taking an *active* role in bringing about the patient's death. In fact, there can be no doubt that in such instances the doctor intends that, as the result of his action, the patient will die an earlier death than he otherwise would."), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997). See also PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 73-74 (physicians have great difficulty stopping treatment than not starting because withdrawing treatment already in progress "seems to them to constitute killing the patient. By contrast, not starting a therapy seems acceptable, supposedly because it involves an omission rather than an action."). Indeed, it is arguable that physician-assisted suicide is more passive than withdrawing treatment. As contemplated by the only statute to legalize physician-assisted suicide, the Oregon Death with Dignity Act, *supra* note 9, the physician's conduct would be to write a prescription. On an active-passive scale, this is arguably more passive than the more common form of "withdrawing" treatment, namely removing a patient from a ventilator. See *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996) ("Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.").

41. 486 A.2d 1209 (N.J. 1985).

say "He's just sitting there" (positive), really meaning something negative: "He's not doing anything at all." . . .

The distinction is particularly nebulous, however, in the context of decisions whether to withhold or withdraw life-sustaining treatment.<sup>42</sup>

That the very same treatment can be forgone either by withholding (omitting to act) or by withdrawing (acting) strongly suggests that the legal consequences should not depend on such slim semantic differences having no practical difference between them.

Take the case of a patient who is being kept alive by a feeding tube, as has so often been the situation in litigated cases.<sup>43</sup> When a decision is made to forgo tube-feeding, there are two general ways to accomplish it: one is to take the feeding tube out; the other is to leave it in place but not introduce any further fluids or nourishment through the tube.<sup>44</sup> Is death achieved by an act or by an omission? More fundamentally, should legal culpability turn on such hair-splitting distinctions that have no practical differences?<sup>45</sup> Thus, as the New Jersey Supreme Court concluded, "'merely determining whether what was done involved a fatal act or omission does not establish whether it was morally acceptable. . . . [In fact, a]ctive steps to terminate life-sustaining interventions may be permitted, indeed required, by the patient's authority to forgo therapy even when such steps lead to death.'"<sup>46</sup>

Similar scenarios can be sketched for other common forms of life support. A ventilator could be turned off and the tube removed from the patient. This seems to be an act, and, thus, would be legally culpable as long as the other elements of a crime could be proved. Instead, the patient could be left on the ventilator and the

42. *Id.* at 1234 (citations omitted); see also PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 74.

43. See 1 MEISEL, *supra* note 18, § 9.39, at 607-08 (Table 9-2) (collecting cases).

44. There are possible logical variations on this though they may not be clinically feasible. For example, one could decide not to introduce additional fluid or nourishment when the current supply runs out, or one could decide to leave the feeding tube in place but cut off the supply of fluids and/or nourishment rather than waiting for the current supply to be depleted.

45. "In a case like that of Claire Conroy, for example, would a physician who discontinued nasogastric feeding be actively causing her death by removing her primary source of nutrients; or would he merely be omitting to continue the artificial form of treatment, thus passively allowing her medical condition, which includes her inability to swallow, to take its natural course?" *Conroy*, 486 A.2d at 1234, citing PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 65-66.

46. *Conroy*, 486 A.2d at 1234, (quoting PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 67, 72).

gases not properly adjusted or replenished when they run out. Death, by this latter course, would result from an omission, and it would not be culpable.

Consider a patient being kept alive by antibiotics administered through an intravenous drip. Does the patient's death result from an act or an omission if the drip is not replenished when the current bag of solution containing the antibiotics is finished? It appears to be an omission which is not culpable, but the physician or nurse who turns off the drip before it is fully depleted commits an act which is legally blameworthy. *Ceteribus paribus*, should the "stopping" of one be legally blameworthy but the "not starting" of the other be legally nonculpable?<sup>47</sup>

The question of whether there is a legally determinative distinction between withholding and withdrawing life-sustaining medical treatment has arisen countless times since the *Quinlan* case.<sup>48</sup> The courts have uniformly concluded that it makes no difference whether life-sustaining medical treatment is forgone by withholding or by withdrawing treatment. Both are legally permissible forms of forgoing life-sustaining medical treatment. That one involves an act and the other involves an omission is deemed to be of no legal significance.<sup>49</sup>

While this precludes liability for passively hastening death by the withdrawal of treatment, it creates another problem. By equating withdrawing with withholding, withdrawal attains the same legal status as omissions. But the reason why some acts (those involved in passively hastening death) are still considered omissions while others (those involved in actively hastening death) are not is never

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47. See PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 74 ("Even when a clear distinction can be drawn between withdrawing and withholding, insofar as the distinction is merely an instance of the acting-omitting distinction it lacks moral significance.").

48. See, e.g., *Cruzan v. Director*, 497 U.S. 261, 270 (1990).

49. See, e.g., *Barber v. Superior Court*, 195 Cal. Rptr. 484, 490 (Ct. App. 1983) ("Even though these life support devices are, to a degree, 'self-propelled,' each pulsation of the respirator or each drop of fluid introduced into the patient's body by intravenous feeding devices is comparable to a manually administered injection or item of medication. Hence 'disconnecting' of the mechanical devices is comparable to withholding the manually administered injection or medication."); *Conroy*, 486 A.2d at 1233-34 ("[W]e reject the distinction that some have made between actively hastening death by terminating treatment and passively allowing a person to die of a disease as one of limited use in a legal analysis of such a decision-making situation. . . . For a similar reason, we also reject any distinction between withholding and withdrawing life-sustaining treatment."). See also PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 73-77.



satisfactorily explained.<sup>50</sup> Thus, it seems that not all acts are created equal. When the issue is the legitimacy of forgoing treatment, acts (withdrawing treatment) and omissions (withholding treatment) are equivalent. But when an act involves the introduction of some lethal substance into the patient's body, that act is traditionally deemed culpable.<sup>51</sup>

## B. Intent

### 1. *The Traditional Explanation*

Some courts have distinguished actively from passively hastening death on the basis of their having a different intent, and they have justified nonliability for the latter on the absence of the kind of intent necessary to constitute a crime. According to conventional reasoning, in cases of genuine suicide, the individual's intent is to bring about his death. By contrast, forgoing life-sustaining treatment does not constitute suicide because the patient's wish is not to end life. Indeed, the patient is said to have no specific intent to die.<sup>52</sup>

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50. Even the Supreme Court, in *Vacco*, did not engage in any serious analysis. It was content to rest its conclusion that there is a difference between the two forms of hastening death on the fact that the "distinction [is] widely recognized and endorsed in the medical profession and in our legal traditions. . . ." *Vacco v. Quill*, 117 S. Ct. 2293, 2298 (1997). The Court also noted that "[t]he American Medical Association emphasizes the 'fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment.' American Medical Association, Council on Ethical and Judicial Affairs, Physician-Assisted Suicide, 10 ISSUES IN LAW & MEDICINE 91, 93 (1994)." *Id.* at 2298 n.6.

51. See Part III, *supra*, for a discussion of the distinction between causing death and allowing death to occur naturally.

52. See, e.g., *McConnell v. Beverly Enter.-Conn., Inc.*, 553 A.2d 596, 608 (Conn. 1989) ("Suicide requires a specific intent to die which courts have found absent in persons who have refused extraordinary methods of medical care."). The source of this reasoning is the dictum in *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 427 n.11 (Mass. 1977), that "refusing medical treatment . . . does not necessarily constitute suicide since . . . in refusing treatment the patient may not have the specific intent to die . . ." This has even been said to be the case when the patient was not terminally ill and when treatment could return her to *status quo ante*. See *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 228 n.2, 551 N.E.2d 77, 82 n.2, 551 N.Y.S.2d 876, 881 n.2 (1990).

In *Vacco*, the Supreme Court subscribed to a variant on this explanation:

[A] physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them. . . . Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.

*Vacco*, 117 S. Ct. at 2298-99.

Rather, in forgoing life-sustaining treatment, the patient's intent is said to be the relief of suffering.<sup>53</sup> Under this explanation, because death from forgoing life-sustaining treatment is not suicide, the physician has not aided suicide and is not subject to criminal liability.<sup>54</sup> By contrast, actively hastening death is said to be quite different because the intent is unabashedly to cause the patient's death.

## 2. *Difficulties with the Traditional Explanation: The Nature of Criminal Intent*

On closer analysis, the intent-based explanations of why there is no liability for a patient's death from forgoing treatment and the purported distinction between passively and actively hastening death are unsupportable.<sup>55</sup> The courts in right-to-die cases have been content to substitute platitudes about intent for analysis. They have utterly failed to examine the conventional meanings of intent in criminal law. Had they done so, they might have concluded that when death is passively hastened, it is hard to avoid the conclusion that criminal intent exists.<sup>56</sup>

For there to be criminal liability, there must be proof of a requisite mental element, traditionally referred to as *mens rea*, malice, or scienter.<sup>57</sup> This requirement in modern American criminal law, as exemplified by the Model Penal Code, has been replaced by the concept of culpability. Under the Model Penal Code, the general requirement of culpability is established by proof that the actor acted "purposely, knowingly, recklessly or negligently, as the law may require, with respect to each material element of the of-

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53. See, e.g., *In re Conroy*, 486 A.2d 1209, 1224 & *passim* (N.J. 1985) ("[P]eople who refuse life-sustaining medical treatment may not harbor a specific intent to die . . . rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering. . ."). But see *Cruzan v. Director*, 497 U.S. 261, 295 (1990) (Scalia, J., concurring) ("Suicide was not excused [at common law] even when committed 'to avoid those ills which [persons] had not the fortitude to endure,'" (quoting 4 W. Blackstone, Commentaries \*189)).

54. A similar argument can be made for nonliability for homicide when the patient lacks decision-making capacity and the decision to forgo life-sustaining treatment is made by a legally authorized surrogate.

55. See *Compassion in Dying*, 79 F.3d at 823 ("[G]iven current medical practices and current medical ethics, it is not possible to distinguish prohibited from permissible medical conduct on the basis of whether the medication provided by the doctor will cause the patient's death.").

56. See *id.* at 822 ("[T]here can be no doubt that in [disconnecting a respirator, or authorizing its disconnection,] the doctor intends that, as the result of his action, the patient will die an earlier death than he otherwise would.").

57. See MODEL PENAL CODE § 2.02 commentary at 230.

fense.”<sup>58</sup> To convict a person of murder, there must be proof that the actor acted “purposely or knowingly.”<sup>59</sup>

The courts have taken the position that when life-sustaining medical treatment is forgone, the physician’s purpose was to relieve suffering. Therefore, in passively hastening death there is no liability for assisted suicide, homicide, or related crimes because the actor’s purpose was not to cause death. This explanation, however, suffers from two defects. First, it overlooks the fact that culpability (or mens rea) may be established in other ways. Second, it confuses intent with motive.

### *a. Establishing Culpability*

Culpability need not be proved exclusively by demonstrating that the actor’s purpose was to cause death. An alternative is to prove that the actor acted “knowingly.”<sup>60</sup> That is, one may be criminally liable, even absent a purpose to cause death, if one knew that one’s conduct would cause death.<sup>61</sup>

The assertion that the intent was to relieve suffering is certainly credible in end-of-life decisions. That it is credible, however, does not negate the existence of another intent — the intent to cause death. No reason exists in law or in fact why an actor cannot possess and be driven to action simultaneously by two intents, espe-

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58. *Id.* § 2.02(1).

59. *Id.* § 210.2(1)(a).

60. This requirement is akin to “constructive intent” in tort law.

61. “A person acts knowingly . . . when . . . he is aware that it is practically certain that his conduct will cause such a result.” MODEL PENAL CODE § 2.02(b)(ii). *See also* LAFAYE & SCOTT, *supra* note 34, § 3.5(f), at 225. *But see* Compassion in Dying, 79 F.3d at 858 (Kleinfeld, J., dissenting) (“Knowledge of an undesired consequence does not imply that the actor intends that consequence. A physician who administers pain medication with the purpose of relieving pain, doing his best to avert death, is no murderer, despite his knowledge that as the necessary dosage rises, it will produce the undesired consequence of death.”).

Some courts and legislatures approach this matter somewhat differently, but with the same general result. They say that one is taken to intend the natural and probable consequences of one’s actions. *See generally* 1 Charles E. Torcia, Wharton’s Criminal Law § 26, at 148 (15th ed. 1993). Thus, even if it is not one’s purpose to cause death and one does not know that one’s actions will cause death, criminal liability should be imposed if the death was the natural and probable consequence of one’s conduct. This is similar to, if not the same as, saying that the standard for establishing what the actor knew is an objective, rather than a subjective, one. That is, one cannot escape liability by claiming one did not know that one’s action would cause death. By holding one responsible for intending the natural and probable consequences of one’s actions, we are really saying that the actor should have known that death would result. Either way, it is impossible to maintain that when a physician withholds or withdraws life-sustaining medical treatment, the intent was not to bring about the patient’s death.

cially when those intents are complementary. The existence of a nonblameworthy intent (the intent to relieve suffering) certainly does not eliminate the possibility of the actor's simultaneously possessing a blameworthy intent (the intent to cause death), nor in law does the existence of the former somehow cancel the effect of the latter.

*b. Avoiding Culpability by the Use of Double Effect*

One possible way to avoid this trap is to claim that the actor's intent was to relieve suffering but acknowledge that this intent can only be accomplished by causing death; that is, death is the unintended consequence of another, intended consequence.<sup>62</sup> This is the reasoning used to explain and validate the so-called doctrine of double effect<sup>63</sup> in end-of-life decision-making. This doctrine is employed to legitimate the decades',<sup>64</sup> if not centuries', old practice of using medication for the relief of pain and anxiety in terminally ill patients, even if the patient dies from the medication. Such medications, given in adequate doses to be effective,<sup>65</sup> are capable of killing the patient because of their depressing effect on respiration.<sup>66</sup> Thus, a physician who gives a patient an analgesic or seda-

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62. See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978) (competent patient suffering from amyotrophic lateral sclerosis who requested that his ventilator support be withdrawn "really wants to live, but do so, God and Mother Nature willing, under his own power. This basic wish to live, plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment being classed as attempted suicide.").

63. The doctrine of double effect holds that it is morally acceptable to cause an otherwise unacceptable result if that result is the unintended consequence of a legitimate act. The classic example of the application of the principle of double effect in the right-to-die context is the administration by a physician of a pain-killing medication to a terminally ill patient suffering from intractable pain, which, though not intended to be lethal, in fact turns out to be lethal. In such a case, the physician's intent is said to be the relief of the patient's suffering, which is a morally and legally acceptable practice (as long as the drug is legal). See generally William E. May, *Double Effect*, in 1 *ENCYCLOPEDIA OF BIOETHICS* 316-19 (Warren T. Reich ed., rev. ed. 1995); DAVID F. KELLY, *THE EMERGENCE OF ROMAN CATHOLIC MEDICAL ETHICS IN NORTH AMERICA: AN HISTORICAL - METHODOLOGICAL - BIBLIOGRAPHICAL STUDY* (1979).

64. See *Compassion in Dying v. Washington*, 79 F.3d 790, 823 (9th Cir. 1996) ("As part of the tradition of administering comfort care, doctors have been supplying the causal agent of patients' deaths for decades."), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

65. The adequacy of the dosage is especially important for patients who may have developed a tolerance to ordinary dosages of the medication and no longer obtain relief at such levels.

66. See, e.g., David R. Sussman, *Sometimes There's Only One Way to End a Patient's Pain*, *AM. MED. NEWS*, Jan. 11, 1993, at 29 (describing author's treatment of

tive adequate to relieve the patient's symptoms might actively hasten the patient's death. By applying the doctrine of double effect, however, as long as the physician's primary purpose in prescribing the medication is to manage the patient's pain or suffering, the unintended result of the patient's death should not expose the physician to criminal liability.<sup>67</sup>

Although the doctrine of double effect is well accepted by medical ethicists and physicians to justify giving a patient possibly lethal doses of medication to relieve serious pain and/or anxiety,<sup>68</sup> this mode of justification has received scant attention from the courts.<sup>69</sup> Perhaps this is because the logic of this doctrine<sup>70</sup> skirts the edges

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terminally ill cancer patient with morphine for unremitting pain, with the patient eventually succumbing to the morphine).

67. See generally PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 77-82. But see *Foster v. Tourtellotte*, 704 F.2d 1109 (9th Cir. 1983) (hospital refused to honor competent patient's request to disconnect the respirator and administer requested medication because sedation might hasten patient's death, possibly making the hospital liable for aiding suicide). In *Vacco*, the Supreme Court expressed agreement with this argument: "[W]hen a doctor provides aggressive palliative care . . . , painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, 'must, necessarily and indubitably, intend primarily that the patient be made dead.'" *Vacco v. Quill*, 117 S. Ct. 2293, 2298 (1997) (citation omitted).

68. See *Compassion in Dying*, 79 F.3d at 823 ("Physicians routinely and openly provide medication to terminally ill patients with the knowledge that it will have a 'double effect' — reduce the patient's pain and hasten his death. Such medical treatment is accepted by the medical profession as meeting its highest ethical standards."), citing Council on Ethical & Judicial Affairs, American Med. Ass'n, *Decisions Near the End of Life*, 267 JAMA 2229, 2231 (1992) ("[T]he administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life."). See also COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS § 2.20, at 37 (1994) ("Physicians have an obligation to relieve pain and suffering . . . of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death."):

69. See, e.g., *Compassion in Dying*, 79 F.3d at 823; *DeGrella v. Elston*, 858 S.W.2d 698, 715 (Ky. 1993) (Wintersheimer, J. dissenting); *Brophy v. New Eng. Sinai Hosp., Inc.*, 497 N.E.2d 626, 640 (Mass. 1986) (Nolan, J. dissenting); *Hobbins v. Attorney Gen.*, 518 N.W.2d 487, 495 n.1 (Mich. Ct. App. 1994) (Shelton, J. concurring & dissenting); *In re Quinlan*, 355 A.2d 647, 658 (N.J. 1976). The few courts that have approved of double effect have done so in the context of termination of life support. See *infra* note 73.

70. A study reports that in a sample of 44 patients from whom life support was withheld or withdrawn, 75 percent were given sedation and analgesia. The reasons for giving the medications were to relieve pain, anxiety, and air hunger from the termination of ventilatory support, to comfort families who witnessed the dying, and to hasten death. William C. Wilson, et al., *Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Critically Ill Patients*, 267 JAMA 949 (1992). However, "[i]n no instance was hastening death cited

of accepted principles of intent and causation in criminal (and tort) law. If courts were seriously to challenge the doctrine of double effect, the result might be quite the opposite of promoting the humane practice of medicine.

*c. Confusion of Motive and Intent*

Another difficulty with the argument that forgoing life-sustaining treatment does not implicate criminal liability because the actor's intent is not blameworthy is that it confuses intent with motive.<sup>71</sup> "Intent' is the word commonly used to describe the purpose to bring about stated physical consequences; the more remote objective which inspires the act and the intent is called 'motive.'"<sup>72</sup>

If a patient's suffering or own evaluation of his quality of life is such that he wishes to end his life, then it is correct to say that his motive, *i.e.*, what motivates him to end his life or to authorize another to do so, is to relieve suffering. His legally relevant intent, however, is to die because that is the consequence he seeks to achieve. A physician may also be motivated to end a patient's suffering, and the patient's surrogate may authorize the physician to forgo life-sustaining treatment motivated by the same concern, but the intent, as far as the law is concerned, is still to bring about the patient's death. Thus, although we might not wish to call a death resulting from forgoing life-sustaining treatment a suicide or homi-

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as the only reason for ordering drugs. . . ." *id.* at 951, doubtlessly because if it were, the chances of criminal prosecution would be significantly increased.

71. *See, e.g.,* Satz v. Perlmutter, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978) ("The testimony of Mr. Perlmutter . . . is that he really wants to live, but do so, God and Mother Nature willing, under his own power. This basic wish to live, plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment being classed as attempted suicide."). In *Vacco*, the Supreme Court also overlooked, or succumbed to, the confusion of intent with motive. The Court quoted approvingly an example given in a dissenting opinion in the *Compassion in Dying* case of the use of intent or purpose to distinguish between two acts that may have the same result. In that case, Judge Kleinfelt wrote that "When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death. . . . His purpose, though, was to . . . liberate Europe from the Nazis." *Vacco*, 117 S. Ct. at 2299 (quoting *Compassion in Dying v. Washington*, 79 F.3d 790, 858 (9th Cir. 1996) (Kleinfelt, J., dissenting)). Nice rhetoric though it may be, the difficulty is that conventional legal analysis would say that the liberation of Europe was the general's motive. However, because he knew with substantial certainty that soldiers would die, there was legal intent that they die. He was not guilty of homicide, however, because the action was taken in the legitimate prosecution of military affairs.

72. KEETON ET AL., *supra* note 36, § 8, at 35. *See also* LAFAYE & SCOTT, *supra* note 34, § 3.6 (a), at 228 ("One who intentionally kills another human being is guilty of murder, though . . . his motive is the worthy one of terminating the victim's sufferings even from an incurable and painful disease.").

cide, it is hard to see how this result can be achieved simply by saying that the intent to bring about death is absent.

*d. Equivalent Intent in Actively and Passively Hastening Death*

A final problem with the effort to distinguish passively and actively hastening death on the basis of differential intent is that whatever one can say about intent in the former is true about the latter as well. If we assume that all of the above arguments about intent are incorrect (*i.e.*, when treatment is forgone, there is no intent in law to cause death but rather the legally relevant intent is to relieve suffering, which is insufficient to support criminal liability) then precisely the same can be said of intent in actively hastening death. If we believe that forgoing life-sustaining treatment involves only an intent to relieve suffering and not to cause death, then when a patient takes an overdose of medication (either provided by a physician or obtained by some other means), the patient is merely intending to relieve suffering. Death is the incidental by-product of this effort, as it is in forgoing treatment. Thus, the patient's death is not a suicide and the physician who provides the patient with the means of "relieving suffering," or who administers a lethal medication to the patient at the patient's request to relieve suffering, is not assisting suicide nor committing homicide.

Phrasing the analysis in this way helps illustrate the hollowness of this argument. In both actively and passively hastening death, the clear intent — or at least the intent with which law traditionally is concerned — is to bring about death. The motive for doing so in both cases may be the relief of suffering, but motive is not necessary to establish liability.<sup>73</sup>

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73. See *Glucksberg*, 117 S. Ct. at 2310 n.15 (Stevens, J., concurring in the judgment) ("The purpose of terminal sedation is to ease the suffering of the patient and comply with her wishes . . . . This same intent . . . may exist when a doctor complies with a patient's request for lethal medication to hasten her death . . . . If a doctor prescribes lethal drugs to be self-administered by the patient, it is not at all clear that the physician's intent is that the patient "be made dead". . . .).

Motive is not necessarily irrelevant in a criminal prosecution, and evidence of it may be admissible under certain circumstances. See generally 1 TORCIA, *supra* note 61, § 89, at 610-13. However, for present purposes what is important is that "the law is settled that motive is irrelevant to a determination of whether a killing amounts to murder . . ." *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Ct. App. 1983). See generally ROLLIN MORRIS PERKINS & RONALD N. BOYCE, *CRIMINAL LAW* § 9, at 928 (3d ed. 1982); LAFAYE & SCOTT, *supra* note 34, § 3.6(a), at 227-28.

## C. Causation

### 1. *The Traditional Explanation*

The third stratagem used by courts to avoid characterizing the passive hastening of death as unlawful killing is to claim that when life-sustaining medical treatment is withheld or withdrawn, death results from natural causes, not from the behavior of those caring for the patient. Death results from the fact that the patient's underlying illness or injury, for which treatment was being provided or was proposed, prevents the patient from breathing (when ventilatory support is forgone), taking nourishment (when tube-feeding is forgone), ridding the body of wastes (when renal dialysis is forgone), or fighting infections (when antibiotics are forgone).<sup>74</sup> By saying that the patient dies a natural death or that nature is taking its course, Mother Nature, who is beyond prosecution, is made the causal agent of death rather than the health care professionals who withhold or withdraw treatment.<sup>75</sup>

Essentially what the courts have done in right-to-die cases is revive the long-discredited "cause/condition" distinction. Although they have not used this terminology, the courts are concluding that forgoing life-sustaining treatment is not the *cause* of death, but

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74. See, e.g., *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633, 641 (Mich. Ct. App. 1992) ("[D]iscontinuance of life-support measures merely allows the patient's injury or illness to take its natural and inevitable course."). See also *Kevorkian v. Thompson*, 947 F. Supp 1152, 1172 (E.D. Mich. 1997), quoting *People v. Kevorkian*, 527 N.W.2d 714, 728 (Mich. 1994) ("[W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention. Put another way, suicide frustrates the natural course by introducing an outside agent to accelerate death, whereas the refusal or withdrawal of life-sustaining medical treatment allows nature to proceed, i.e., death occurs because of the underlying condition."). In *Vacco*, the Supreme Court adopted this formulation: "[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology . . ." *Vacco*, 117 S. Ct. at 2298.

75. See, e.g., *Perlmutter*, 362 So. 2d at 162-63 ("As to suicide, the facts here unarguably reveal that Mr. Perlmutter would die, but for the respirator. The disconnecting of it, far from causing his unnatural death by means of a "death producing agent" in fact will merely result in his death, if at all, from natural causes [citation omitted]. . . . Mr. Perlmutter . . . really wants to live, but do so, God and Mother Nature willing, under his own power. This basic wish to live, plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment being classed as attempted suicide."); see also PRESIDENT'S COMM'N, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 32, at 38. This stratagem overlaps with both the "omission" and "intent" stratagem. When there is an omission to treat, it is said that a patient, who is dependent for his existence on medical treatment, is not "killed" but inevitably dies a "natural death" and similarly that the intent is not to bring about death but to relieve suffering.



merely a necessary *condition* for death to occur. As such, it is not blameworthy under the traditional rules of criminal liability. In so concluding, however, they are conveniently overlooking well-established rules of criminal liability routinely applied in other contexts.<sup>76</sup>

By contrast, it is said that when a physician engages in conduct that *actively* hastens death, it is the physician's conduct which is the cause of death.<sup>77</sup> Certainly causation is clearer in instances of actively hastening death than in passively hastening death, but this does not end the inquiry. It merely means that there must be a deeper probing into the latter, which courts have been steadfastly disinclined to do.

## 2. *Difficulties with the Traditional Explanation*

Further inquiry demonstrates that causation-based efforts to find a difference between passively and actively hastening death do not wash.<sup>78</sup>

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76. See generally LAFAYE & SCOTT, *supra* note 34, § 3.3(d), at 209-10. As Prosser explains, "Many courts have sought to distinguish between the active 'cause' of the harm and the existing 'conditions' upon which that cause operated. If the defendant has created only a passive, static condition which made the damage possible, the defendant is said not to be liable." KEETON, ET AL., *supra* note 36, § 42, at 277. In applying this reasoning to end-of-life decision-making, one would say that the doctor merely creates a "passive, static condition" when life-sustaining medical treatment is stopped allowing the true causal agent, the patient's condition, to operate. Prosser adds, "[c]ause' and 'condition' still find occasional mention in the decisions; but the distinction is now almost entirely discredited." *Id.* at 278.

77. See, e.g., *Vacco*, 117 S. Ct. at 2298 ("[I]f a patient ingests lethal medication prescribed by a physician, he is killed by that medication.").

78. See *Compassion in Dying v. Washington*, 79 F.3d 790, 822-23 (9th Cir. 1996) (citations omitted):

[D]rawing a distinction on the basis of whether the patient's death results from an underlying disease no longer has any legitimacy. While the distinction may once have seemed tenable, at least from a metaphysical standpoint, it was not based on a valid or practical legal foundation and was therefore quickly abandoned. When Nancy Cruzan's feeding and hydration tube was removed, she did not die of an underlying disease. Rather, she was allowed to starve to death. In fact, Ms. Cruzan was not even terminally ill at the time, but had a life expectancy of 30 years. Similarly, when a doctor provides a conscious patient with medication to ease his discomfort while he starves himself to death—a practice that is not only legal but has been urged as an alternative to assisted suicide the patient does not die of any underlying ailment. To the contrary, the doctor is helping the patient end his life by providing medication that makes it possible for the patient to achieve suicide by starvation.

*Id.*

See also *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996):

a. *Sine Qua Non Test*

If a sine qua non test of causation, the primary one accepted by the Model Penal Code,<sup>79</sup> is employed to escape liability, we must be able to say “but for” the act or omission of a human, the patient would not have died. When life-sustaining treatment is withheld or withdrawn, however, this is clearly not the case. If treatment had been initiated or continued, the patient would *not* have died — at least not then and there — and it is a well-established principle that the shortening of a life, even the life of one who is close to death, is criminally culpable.<sup>80</sup>

b. *Natural and Probable Consequences Test*

Another test of causation used in the criminal law is the “natural and probable consequences” test. Under this test, an actor’s conduct is said to be the legally responsible cause of a result if the result is the natural and probable consequence of the actor’s conduct.<sup>81</sup> For example, if a patient is being maintained by some form of life support, it is because there is reasonable medical certainty that the patient will die without treatment. Therefore, if treatment is withdrawn, death is the natural and probable consequence of the withdrawal. There would be no difficulty making a prima facie showing that this test of causation is met.

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Indeed, there is nothing “natural” about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

*Id.*

79. MODEL PENAL CODE § 2.03(1)(a) (“Conduct is the cause of a result when . . . it is an antecedent but for which the result in question would not have occurred”).

80. *See, e.g., Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983) (holding where doctor intentionally caused a patient’s death, homicide is not excusable simply because the patient would have died soon anyway). *See also Washington v. Glucksberg*, 117 S. Ct. 2258, 2265 (1997) (“[T]he prohibitions against assisting suicide never contained exceptions for those who were near death.”). It is less clear that the patient would have lived when the issue is one of withholding treatment rather than withdrawing treatment. However, almost all, if not all, of the right-to-die cases involve the withdrawing of treatment. Furthermore, in the cases, actual or posited, in which withholding treatment is at issue, there is a belief on the part of the health care professionals that the treatment will keep the patient alive or else they would not be proposing to employ it.

81. PERKINS & BOYCE, *supra* note 73, at 812-13.

In situations in which life-sustaining medical treatment is withheld rather than withdrawn, it may be more difficult to establish that not initiating treatment caused the patient's death. If the treatment in question is truly "life-sustaining" treatment, *ex hypothesi*, the failure to administer it is the cause of the patient's death. These are, however, questions of fact. What is important for present purposes is that causation could be established in some situations of withholding treatment. Thus, one cannot make the blanket statement that withholding treatment could never be the legal cause of death.

*c. Other Tests: Foreseeability and Substantial Factor*

Some jurisdictions employ a test of causation in criminal law, or in some areas of criminal law, based on foreseeability. This test is not significantly different from the natural and probable consequences test,<sup>82</sup> and the analysis for present purposes is similar. Again, if a patient is being kept alive by a life-sustaining medical treatment and the entire course, or an essential ingredient, of the treatment is discontinued, it is reasonably foreseeable that the patient will die. Thus, if such treatment is terminated, this test of causation will be met, or at least a *prima facie* case will be easy to make out.

The same is true of another important test of causation used when there is more than one factual cause of the result in question, the substantial factor test. It is used more to rule out a factor as being causal than to pinpoint it as a legal cause.<sup>83</sup> Under this test, a person who terminates life support could be excluded as the legal cause of a patient's death if termination were not a substantial factor in bringing about death. In all instances of withdrawing life-sustaining treatment, however, the patient would not have died, at least not then and there, had treatment been continued. Thus, the person withdrawing treatment cannot be excluded as a legal cause of death.

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The concept of legal causation is ultimately a mix of factual and policy considerations of who should be responsible for what, and under what circumstances. Nonetheless, to deny that there is legal causation in passively hastening death, and yet to find it in actively hastening death, requires more than a mere assertion that causa-

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82. *Id.*

83. *Id.* at 799-80.

tion in the two types of hastening death is different. Factually it is different. The question is whether this fact ought to make a difference with respect to the ultimate issue of culpability. If it does, one must be able to point to important, relevant differences between passively and actively hastening death. Perhaps some exist<sup>84</sup> but they cannot be found in the realm of legal causation, as they are not in the nature of the act or intent.

#### D. Legal Right

If it is the case, as argued above, that all of the elements of homicide or assisted suicide are met when life-sustaining treatment is withheld or withdrawn, how could it be that criminal liability still does not ensue? The answer that has generally been given by *Quinlan* and its progeny<sup>85</sup> is that one or more of these elements really does *not* exist.

Some courts, however, have added a more forthright reason: there is no criminal liability for passively hastening death because "the decision and its implementation are authorized under the common law."<sup>86</sup> These courts have in effect, although not always in these terms, concluded that it does not matter whether passively hastening death is suicide when accomplished by the patient, assisted suicide when aided by another, or homicide when, at the request of the patient or surrogate, treatment is withheld or withdrawn by a physician. Rather, these courts maintain that there is no liability for passively hastening death because there is a *legal right* to have life-sustaining medical treatment withheld or withdrawn.

Of course there is no liability for doing something one has a right to do. But this truism begs the question, "Does one have a legal right to do it?" which is another way of saying, "Is it criminal?" On closer examination, what these courts seem to be saying is that although one might be able to make out a *prima facie* case of each of the elements of assisted suicide or criminal homicide when life-sustaining medical treatment is withheld or withdrawn, the conduct in question cannot constitute the basis for the imposition of crimi-

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84. See *infra* Part V.

85. See *supra* note 30 and the accompanying text.

86. *Rosebush v. Oakland County Prosecutor*, 491 N.W.2d 633, 641 (Mich. Ct. App. 1992). See also *In re Quinlan*, 355 A.2d 647, 670 (N.J. 1976); *Eichner v. Dillon*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (1981); *In re Colyer*, 660 P.2d 738, 751 (Wash. 1983).

nal liability because there is a defense based on law to such charges.<sup>87</sup>

The "law" on which the defense is based is the right to refuse medical treatment, which arises from common law, constitutions, or both.<sup>88</sup> This right is derivative of a broader common-law or constitutional "right to be let alone." In the context of medical decision-making, this right to be free from state interference is often referred to as self-determination or autonomy.<sup>89</sup> This is the counterpart of a criminal law defense of justification such as necessity or a tort law defense of privilege. More generally, it is a kind of con-

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87. Some courts have taken an analogous approach to permit doctors to administer adequate medication for relief of pain and anxiety that might accompany the termination of life support in a conscious patient even if it might kill the patient, in effect legitimating the doctrine of double effect. See *State v. McAfee*, 385 S.E.2d 651, 652 (Ga. 1989) (patient's "right to be free from pain . . . is inseparable from his right to refuse medical treatment"); *McKay v. Bergstedt*, 801 P.2d 617, 631 (Nev. 1990) ("In all cases decided by a district court in favor of the patient, the court's order shall specify that any physician or health care provider who assists the patient in receiving the benefits of his or her decision with minimal pain, shall not be subject to civil or criminal liability."). State legislatures have also begun to enact statutes explicitly authorizing the use of adequate medication for the relief of pain and in some cases defining death resulting from the administration of such medication as not being the assistance of suicide. See, e.g., Minn. Stat. Ann. § 609.215(3)(a) ("medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death," is not abetting or aiding suicide "unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death"). See generally 1 MEISEL, *supra* note 18, § 8.7, at 79 (Table 8-1) (collecting statutes).

88. The source of the right is sometimes also statutory, the most likely statutes being advance directive statutes. However, advance directive statutes were enacted not to create substantive rights but merely to provide a mechanism for individuals to implement their wishes about life-sustaining medical treatment once they lack the capacity to do so contemporaneously. Courts have consistently upheld the principle that advance directive statutes are not intended to preempt common-law or state constitutional rights to make advance directives and to have them enforced because these rights exist independent of the statutes. See, e.g., *Camp v. White*, 510 So. 2d 166 (Ala. 1987); *Bouvia v. Superior Court (Glenchur)*, 225 Cal. Rptr. 297, 302 (Ct. App. 1986); *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Ct. App. 1984); *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983); *McConnell v. Beverly Enter.-Conn., Inc.*, 553 A.2d 596, 605 & n.15 (Conn. 1989); *Browning v. Herbert*, 568 So. 2d 4 (Fla. 1990); *Corbett v. D'Alessandro*, 487 So. 2d 368, 370 (Fla. Dist. Ct. App. 1986); *DeGrella v. Elston*, 858 S.W.2d 698, 706-07 (Ky. 1993); *In re Gardner*, 534 A.2d 947, 952 (Me. 1987); *In re Myers*, 610 N.E.2d 663, 668 (Prob. Ct. Summit County, Ohio 1993); *In re Grant*, 747 P.2d 445 (Wash. 1987), *modified*, 757 P.2d 534 (Wash. 1988); *L.W. v. L.E. Phillips Career Dev. Ctr.*, 482 N.W.2d 60, 68 ("[T]he stated legislative policy is to leave the decision, if not declared by the patient, to be determined as a matter of common law. . ."). See generally Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 Wis. L. Rev. 737, 796-97; 2 MEISEL, *supra* note 26, §§ 10.10-10.16.

89. See, e.g., *Thor v. Superior Court*, 855 P.2d 375, 380 (Cal. 1993) ("[T]he long-standing importance in our Anglo-American legal tradition of personal autonomy and the right of self-determination.").

fession-and-avoidance defense in which the defendant in effect admits that there is proof beyond a reasonable doubt of the elements of the offense yet seeks to avoid conviction by claiming that he had a right to engage in the conduct under the circumstances in question.

The same is true when a patient dies after life-sustaining medical treatment has been withheld or withdrawn. Assuming that the elements of assisted suicide or criminal homicide could be proved beyond a reasonable doubt, liability should still not be imposed because the patient (or someone acting on his behalf) had the right under the circumstances to authorize the physician to take the actions that caused the patient's death.

### III. Consent as Legitimizing Passively Hastening Death

The courts that have concluded that forgoing life-sustaining treatment is not a crime because of the patient's legal right to refuse treatment are on the right track. However, the reasoning underlying the "legal right" rationale has never been fully developed largely because the conventional wisdom about why passively hastening death is not a crime—lack of an act, lack of intent, and lack of causation—has never been seriously challenged.

After the Supreme Court's holding that the Constitution does not bar states from enacting statutes prohibiting assisted suicide,<sup>90</sup> litigation will arise in state courts seeking to assert the invalidity of these statutes on state constitutional and/or common law grounds. State courts will then be compelled to reexamine their reasoning about the noncriminality of forgoing life-sustaining medical treatment and the purported distinction between passively and actively hastening death. When they do so, they will find that their reasoning about the required act, intent, and causation comes up short. These courts will then be forced to develop more fully their claim that there is no criminal liability for passively hastening death by withholding or withdrawing life-sustaining treatment because patient's have a right to refuse treatment.<sup>91</sup>

What is it, at core, that *does* legitimate passively hastening death? One might assert that it is the patient's legal right to refuse medical treatment, but there is a deeper explanation. The right to refuse medical treatment is itself based on the more fundamental

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90. See *supra* note 5.

91. See generally *Cruzan v. Director Mo. Dept. Of Health*, 497 U.S. 261 (1990) (holding that a competent person has a constitutionally protected right to refuse unwanted medical treatment).

legal value of self-determination, which in turn is implemented through the mechanism of consent to treatment — or more precisely, informed consent.<sup>92</sup>

Consider the following example. A doctor who strongly believes that the earth's precious natural resources are being squandered is obsessed with saving electricity. At first she is content to berate her family to turn out the lights when they leave a room and substitute fluorescent for incandescent bulbs, but she eventually disconnects the electricity from her house. She then begins to introduce conservation measures at the hospital, but as at home, they have piddling results. After investigating, she discovers that a major source of electrical consumption is ventilator-dependent patients and she begins to make plans to turn off all ventilators. One evening, when she is the sole physician on duty in the hospital, she implements her plan. She achieves her goal of saving electricity, and the patients die.

If one accepts the current reasoning of the courts at face value, that is, if the withdrawal of life-sustaining treatment is not a crime because it is an omission and not an act, because it does not cause the patient's death, because there is no intent to cause death, or because of some combination, then our environmentally-conscious physician has committed no crime: she has "omitted" to provide ventilation by withdrawing it; death has been "caused" by the patient's illness or injury that results in an inability to breath without a ventilator; her intent was to improve the environment, not to bring about death; death was merely the unintended consequence of legal conduct.

This is obviously not the correct conclusion. The physician's conduct is criminal beyond doubt. This example illustrates that claims can be made that on their face are the same as those presented by courts to justify the actions of physicians when ventilatory support has been withdrawn from patients but which do not deserve protection.

What distinguishes the environmentally-conscious doctor from the physicians whose proposed conduct the courts have evaluated since *Quinlan*?<sup>93</sup> One thing is motive. In conventional right-to-die cases, the physician's motive is to end suffering; whereas the environmentally-conscious doctor is motivated to save the environment. This motive is perhaps on an equal moral plane with the relief of suffering of the terminally ill, but not at all relevant to the

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92. *See id.*

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

morality of end-of-life decision-making. That, however, cannot be the determinative difference because the actor's motive is not an element in establishing criminal liability.

The answer is simple: consent. In the consensus right-to-die cases, the physician's conduct is licit because it is authorized by a patient who gives consent to that which he has the right to authorize. When patients lack decision-making capacity, the forgoing of life-sustaining treatment can still be licit because it is authorized by one who has the legal authority to speak for the patient. This is what courts mean when they say that forgoing life-sustaining treatment is not culpable because there is a "legal right" to refuse medical treatment.

The argument that a patient's consent legitimates passively hastening death comes up against the objection that consent is not a defense to a crime.<sup>94</sup> That well-accepted dictum, however, is just that: dictum. It is not a fundamental principle of law.

Opponents assert that consent is not a defense because in criminal prosecutions, unlike civil prosecutions, the interests being asserted are those of the state rather than the victim of the crime.<sup>95</sup> Thus, the consent of the victim does not absolve the actor of criminal liability, for the victim does not have the authority to absolve the actor. Only the state is able to do that. The state can absolve an actor of criminal liability in a variety of ways including decisions not to prosecute and the creation of criminal defenses such as insanity and entrapment, which recognize that a crime has been com-

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94. See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2265 (1997) (stating that the consent of a homicide victim is "wholly immaterial to the guilt of the person who cause[d] [his death]"); 3 J. STEPHEN, *A HISTORY OF THE CRIMINAL LAW OF ENGLAND* 16 (1883); 1 F. WHARTON, *CRIMINAL LAW* 451-52 (9th ed. 1885); *Martin v. Commonwealth*, 37 S.E.2d 43, 47 (Va. 1946) ("The right to life and to personal security is not only sacred in the estimation of the common law, but it is inalienable"); LAFAYETTE & SCOTT, *supra* note 34, § 5.11, at 477; 1 TORCIA, *supra* note 61, at 304-05 ("Where conduct constitutes a crime because it causes or threatens bodily harm, the law as a matter of public policy will allow a victim's consent to be effective only if the conduct, to which the consent refers, does not cause or threaten serious bodily harm or death."), citing MODEL PENAL CODE § 2.11(2)(a). See also MODEL PENAL CODE § 2.11 commentary.

95. Although the victim has been wronged, the victim must file a civil action in tort to personally right the wrong that resulted from the actor's conduct. The victim is free to bring a civil action before or after the criminal prosecution based on the same underlying conduct, or instead of a criminal prosecution, if the state chooses not to prosecute. This distinction between criminal and civil actions is not a necessary feature of law. Other legal systems permit the use of criminal sanctions for public as well as private purposes but the bifurcated system is a long-standing and well-accepted feature of the American legal system.



mitted, but provide absolution to further more important state interests.

Is this not the same situation in instances of passively hastening death? Although a *prima facie* case of assisted suicide or homicide can be made out when life-sustaining medical treatment is withheld or withdrawn, the courts have concluded that such conduct should not be prosecuted because of a superior societal interest in respecting the autonomy of the individual, which includes the individual's interest in determining for himself whether to permit or deny invasions of bodily and psychic integrity.<sup>96</sup>

Prosecution for terminating life-sustaining treatment has occurred in only one case, *Barber v. Superior Court*,<sup>97</sup> in which the physicians were absolved from liability for murder for essentially this reason. The *Barber* court concluded that there *was* legally sufficient intent or knowledge on the part of the defendant-physicians that the patient would die as a result of their actions and that their actions *were* the legal cause of the patient's death.<sup>98</sup> The court also concluded that although the physicians' conduct (the withholding of treatment) was an omission rather than an act, an omission could support criminal liability.<sup>99</sup> The three essential elements of homicide were satisfied. Nonetheless, the court held there was no criminal liability because the physicians' omission was not culpable.<sup>100</sup> There was no duty to act and, more specifically, no duty to continue to provide artificial nutrition and hydration. Of central importance is the fact that the court held that there was no duty to act because the doctors had been relieved of this duty by the consent of those having legal authority to do so — the patient's family.<sup>101</sup>

Thus, consent functions as a defense in right-to-die cases, just as other justifications are recognized as defenses under appropriate circumstances. Consent, however, is not merely a defense. To speak of it as such degrades its status in all medical decision-making. Consent is the fundamental validating property of forgoing

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96. *Washington v. Glucksberg*, 117 S. Ct. at 2265-66.

97. 195 Cal. Rptr. 484 (1983).

98. *Id.*

99. *Id.* at 490

100. *Id.*

101. *Id.* at 489, 492 ("A long line of cases, approved by the [California] Supreme Court . . . have held that where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that a competent adult patient has the legal right to refuse medical treatment. . . . [P]etitioners consulted with and relied on the decisions of the immediate family, which included the patient's wife and several of his children.").

life-sustaining treatment whether by withholding or withdrawing, whether by a competent patient or a surrogate.

#### IV. Consent as Legitimizing Actively Hastening Death

I have argued that actively and passively hastening death are on an equal footing before the law and that each ought to be treated as *prima facie* criminal because in each the elements of act, intent, and causation are met. Yet we do not treat passively hastening death as criminal when there is legally valid consent. I now want to turn to consider whether actively hastening death should be treated similarly.

Passively hastening death is criminally nonculpable, when it is, not simply because the patient (or authorized surrogate) gives consent, but because consent is given to that over which the patient has legal dominion. The substantive right implemented by giving (or withholding) consent is the right to be let alone, which includes the right to be free from unwanted invasions of one's bodily and psychic integrity.<sup>102</sup>

Opponents of legalization claim this is the fundamental distinction between passively and actively hastening death.<sup>103</sup> As the terminology itself implies, to fail to respect a patient's wish to have death passively hastened constitutes an invasion of the patient's bodily and psychic integrity; to *treat* the patient would be to *not* let

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102. See *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

103. In *Washington v. Glucksberg*, 117 S. Ct. 2258, 2270 (1997), the Supreme Court viewed the right at stake in passively hastening death as the right to be free from battery, which it found to be a long-recognized legal right. Adopting the reasoning in *Cruzan v. Director*, 497 U.S. 261 (1990), the *Glucksberg* Court explained that the assumed right to be free of unwanted medical procedures for supplying artificial nutrition and hydration "was not simply deduced from abstract concepts of personal autonomy." *Id.* Rather, "[g]iven the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions." *Id.* But see *id.* at 2306 (Stevens, J., concurring in the judgments) ("[T]he source of Nancy Cruzan's right to refuse treatment was not just a common-law rule. Rather, this right is an aspect of a far broader and more basic concept of freedom that is even older than the common law. This freedom embraces, not merely a person's right to refuse a particular kind of unwanted treatment, but also her interest in dignity, and in determining the character of the memories that will survive long after her death."); *id.* at 2311 (Breyer, J., concurring in the judgments) ("[I] would use words roughly like a 'right to die with dignity.' But irrespective of the exact words used, at its core would lie personal control over the manner of death, professional medical assistance, and the avoidance of unnecessary and severe physical suffering—combined."). That this may be the case for federal constitutional purposes does not preclude state courts from deciding otherwise on state law grounds. *Id.*

the patient alone. Actively hastening death, the argument continues, does not implicate the right to be let alone. In fact, actively hastening death, by its very nature, requires that there be some invasion of the patient's bodily and psychic integrity. Thus, the individual interests in passively and actively hastening death are not only different, they are polar opposites.

Sometimes this argument is put in terms of the difference between a negative and a positive right. A negative right is said to be involved in passively hastening death: a right to be *free from* unwanted, and thus unwarranted, interference with one's bodily integrity. By contrast, in actively hastening death, a positive right is said to be at stake; the patient is claiming entitlement against another to have something done *for* him. Positive rights are, however, strongly disfavored by the common law<sup>104</sup> and by the Constitution,<sup>105</sup> and can ordinarily be conferred only by statute. Thus, if actively hastening death is to be legalized, it must be achieved by statutory enactment.

This argument fundamentally misunderstands what is at stake in the debate about actively and passively hastening death. First, to put it somewhat concretely, dying, or as Judge Reinhardt repeatedly penned in *Compassion in Dying*, "determining the time and manner of one's own death,"<sup>106</sup> is at stake in both situations. Second, this objection to actively hastening death, and the correlative attempt to distinguish it from passively hastening death, views the underlying right in the passive cases too narrowly. What is involved is not merely a right to be free from unwanted bodily and psychic invasions, but "a right to *determine* what shall be done with [one's] body," as Cardozo put it generations ago.<sup>107</sup> The familiar locutions, such as the right to refuse treatment, are used simply because of the medical context in which the broader right has traditionally been made manifest.

Finally, the nature of the right involved in actively hastening death is not a positive right; it is just as surely a negative right as

104. KEETON ET AL, *supra* note 36, §§ 53, 56. Cf. Barber v. Superior Court, 195 Cal. Rptr. 484, 490 (Ct. App. 1983) (failure to feed infant distinguishable from doctor's termination of artificial nutrition and hydration because parent has "a clear duty to feed an otherwise healthy child"). See generally 2 MEISEL, *supra* note 26, § 19.11.

105. See, e.g., DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189 (1989); Harris v. McCrae, 448 U.S. 297 (1980); San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1 (1973). See generally 2 MEISEL, *supra* note 26, § 19.10.

106. *Compassion in Dying v. Washington*, 79 F.3d 790, 793 & *passim* (9th Cir. 1996) (en banc).

107. *Schloendorff v. Soc'y of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (emphasis added).

that implicated in the passive cases. The fundamental issue in the legalization of actively hastening death, as it is in the legalization of passively hastening death, is the preclusion of state-imposed penalization of the conduct in question. In the *Quinlan* case,<sup>108</sup> for example, Karen Quinlan's parents wanted a decree that the physicians who were being asked to terminate life-sustaining treatment would not be subject to criminal prosecution if they complied with the request. In effect, they sought a declaration that the power of the state, as manifested, through the criminal process, would not be interposed against the physician.

This is exactly what the petitioners attempting to legalize physician-assisted suicide are seeking. Proponents of physician-assisted suicide have not sought, nor should they be accorded, the right to compel physicians (or anyone else) to actively hasten death, even with a patient's consent. That would be a claim for a disfavored positive right.

An analogy to abortion helps to clarify this point. The litigation to establish the right to an abortion sought not merely an abstract right to terminate a pregnancy, but a right to terminate a pregnancy free from state imposition of penalties on the pregnant woman and the physician who performs the abortion. This would be an empty right if what had been sought and granted was merely the right of a woman to have an abortion without being subjected to criminal prosecution for so doing, but not the right of a woman to have a physician perform the operation without being subject to prosecution. Indeed, such a limited right would completely undercut the harm sought to be prevented — namely, the right not to have to subject oneself to dangerous self-performed measures to terminate a pregnancy.

The same is true about actively hastening death. Although some patients can actively hasten their own deaths, others (and perhaps many) cannot. The right to actively hasten death, if there is to be one, is hardly a robust one if terminally ill people are denied the right to enlist the assistance of a physician. The analogy to abortion is again useful.<sup>109</sup> A woman can perform an abortion on herself, and she might even be successful both in performing the procedure

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

109. See *Glucksberg*, 117 S. Ct. at 2288 (Souter, J., concurring in the judgment) (“Without physician assistance in abortion, the woman’s right would have too often amounted to nothing more than a right to self-mutilation, and without a physician to assist in the suicide of the dying, the patient’s right will often be confined to crude methods of causing death, most shocking and painful to the decedent’s survivors.”).

and in avoiding serious harm. Likewise, a terminally ill person can attempt to end his own life through a variety of means, but there are two kinds of risks in doing so. The first is that the effort will not succeed.<sup>110</sup> The second, more serious, risk is that the person may incur a range of physical and psychological harms in the process of not succeeding. Moreover, there are also many terminally ill people who lack the physical ability to arrange their own deaths. If they have a right to determine the time and manner of their death, this right can only be exercised with the assistance of some other person. Denying the right to assistance is to deny the underlying right.

That actively hastening death, like abortion, is a negative right, can also be discerned from some of the limitations which have been imposed on abortion to prevent its being transformed into a positive right. There are two fundamental limitations: there is no right to have the cost of an abortion paid for by the state; and a physician cannot be compelled to perform an abortion. Legalization has meant only that a physician *may* perform an abortion, not that he *must*.

In other words, there is a right to decide to have an abortion and to enlist the assistance of a willing physician, not a right to abortion, just as there should be a right to decide to actively hasten one's death with the assistance of a willing physician. The state might choose to pay for a physician to actively hasten death, just as some states have chosen to pay for abortions, but states would not be compelled to do so. These are limitations which could, and perhaps should, also be imposed on actively hastening death.

Similarly, legalization of actively hastening death would mean that physicians would be free from criminal liability, not that they would be compelled to perform this service. Throughout all of the discussions, it must not be forgotten that the fundamental interest at stake in both actively and passively hastening death is the right to decide the time and manner of one's death, and to procure the

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110. It might not succeed for a number of reasons. First, patients might not have *knowledge* of the means of ending their lives. Second, they may not have *access* to the means of doing so, especially to medications available only by prescription, which is why a robust right to actively hasten death must include the right not merely to the assistance of another person but of a physician (and a pharmacist). Third, people may have requisite knowledge and means, but not the physical ability to obtain access to the means to end their own lives. Finally, people may not have the physical ability to end their own lives, which takes us beyond assisted suicide to active euthanasia. See *Cruzan v. Director*, 497 U.S. 261 (1990).

assistance necessary to transform that right into reality, free from state interference.<sup>111</sup>

### V. Protecting Against the “Abuse” of Actively Hastening Death

Even if there is no bright line between actively and passively hastening death — both are manifestations of the fundamental right of self-determination and both are legitimated by consent—there are still arguments which can be lodged against the prima facie claim for the validity of actively hastening death. These claims must be examined to determine whether the prima facie case can be overcome. This is what the Second<sup>112</sup> and Ninth Circuits<sup>113</sup> did, albeit within a constitutional framework, and found them to be unpersuasive support for statutes criminalizing physician-assisted suicide.<sup>114</sup>

In defending against claims of unconstitutionality, opponents of physician-assisted suicide have cited a number of reasons why the state has an important interest in maintaining the criminality of this conduct. A list of these reasons could be compiled from many sources, in a number of ways. I will rely on the reasons set forth by the majority opinion in *Compassion in Dying*,<sup>115</sup> the purpose here being illustrative, not comprehensive:

1. Disadvantaged individuals, the poor, the elderly, the disabled, and minorities, will be pressured to submit to physician-assisted suicide, becoming victims rather than beneficiaries.<sup>116</sup>
2. The real problem is the “lack of universal access to medical care” resulting from misplaced national priorities.<sup>117</sup> If high

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111. See generally James E. Fleming, *Constitutional Tragedy in Dying: Responses to Some Common Arguments Against the Constitutional Right to Die*, 24 *FORDHAM URB. L.J.* 881 (1997).

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

113. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

114. In *Glucksberg*, the Supreme Court also evaluated these claims but found them to be persuasive. *But see Glucksberg*, 117 S. Ct. at 2271-2275 (Stevens, J., concurring in the judgment) (characterizing the difference in causation in actively and passively hastening death as “illusory” and observing that “the actual cause of death [in terminal sedation] is the administration of heavy doses of lethal sedatives. This same . . . causation may exist when a doctor complies with a patient’s request for lethal medication to hasten her death.”).

115. 79 F.3d 790 (9th Cir. 1996) (en banc). I had originally thought that there were many other objections to physician-assisted suicide, but a review of the legal and medical literature leads me to conclude that those discussed in *Compassion in Dying* are a fair summary of those that have been made by others.

116. *Id.* at 825; see also *Glucksberg*, 117 S. Ct. at 2273.

117. See *Compassion in Dying*, 79 F.3d at 826.

quality medical and other care were provided to the dying, they would not seek physician-assisted suicide.

3. Acceptance of physician-assisted suicide would make doctors insensitive "to the plight of terminally ill patients, and . . . they will treat requests to die in a routine and impersonal manner, rather than affording the careful, thorough, individualized attention that each request deserves."<sup>118</sup>
4. Acceptance of physician-assisted suicide would have a substantial adverse effect on the patient's "children, other family members, and loved ones."<sup>119</sup>
5. Acceptance of physician-assisted suicide would undermine "the integrity of the medical profession"<sup>120</sup> and require doctors to act "contrary to their individual principles."<sup>121</sup>
6. Acceptance of physician-assisted suicide will lead us down the slippery slope, converting a right to die into an obligation to die in which "courts will sanction putting people to death, not because they are desperately ill and want to die, but because they are deemed to pose an unjustifiable burden on society."<sup>122</sup>

The purpose here is not to attempt to refute these arguments. There is no denying the truth to these claims and they must be taken seriously. There is, however, no evidence, nor is there any abstract reason, why these arguments should be considered more compelling in the context of actively hastening death than they are in the context of passively hastening death.<sup>123</sup> Any argument that can be made against actively hastening death can be levelled with equal vigor against passively hastening death. There is no significant difference between the two that would warrant acceptance in the latter and rejection in the former.<sup>124</sup>

It will come as no surprise that patients (whether belonging to some categorically vulnerable group, or merely vulnerable because

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118. *Id.* at 826-27.

119. *Id.* at 827.

120. *Id.* at 827; *Glucksberg*, 117 S. Ct. at 2273.

121. *Compassion in Dying*, 79 F.3d at 830.

122. *Id.*; see also *Glucksberg*, 117 S. Ct. at 2274 n.23 (noting "the case for a slippery slope has been made out").

123. See *Quill v. Vacco*, 80 F.3d 716, 730 (2d Cir. 1996) ("There is no clear indication that there has been any problem in regard to the former, and there should be none as to the latter.").

124. See *Cruzan*, 497 U.S. at 2960 (Scalia, J. concurring) (noting "the irrelevance of the action-inaction distinction").

they are patients) are susceptible to pressure by physicians.<sup>125</sup> Physicians can subtly or heavy-handedly pressure patients into forgoing life-sustaining treatment by telling them that it is useless, painful, and expensive. Moreover, the lack of access to health care may cause patients to reluctantly request or accede to a suggestion that they forgo life-sustaining treatment because they cannot afford the treatment they need and want.<sup>126</sup> Physicians can also become hardened to the plight of the terminally ill by the knowledge that forgoing life-sustaining treatment is an easy out for the physician. Family members suffer either way. They experience severe loss when a terminally ill patient dies from forgoing treatment, but they also suffer if the patient is forced to continue suffering by not being allowed to forgo treatment if that is his wish. Forgoing life-sustaining treatment was once at odds with the ethics of the medical profession. One of the important factors in its acceptance by the medical community has been its legalization. Finally, predictions that terminally ill patients should be prohibited from forgoing life-sustaining treatment because it would be subject to widespread abuse have similarly proved to be untrue.

Why has the experiment in passively hastening death, begun by *Quinlan*, turned out as well as it has? The key to the answer is consent. Consent is not only the validating principle underlying passively or actively hastening death, it is also the mechanism which protects against abuse in both situations. Just as procedural and substantive protections have been developed to assure that abuse does not occur when forgoing life-sustaining treatment occurs, similar protection must be created for actively hastening death.

Work has already begun in this direction. The Oregon Death with Dignity Act,<sup>127</sup> adopted by statewide initiative in 1994, contains a set of such protections. Although they might not be totally

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125. See *Quill*, 79 F.3d at 730 (“[P]sychological pressure’ can be applied just as much upon the elderly and infirm to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death.”).

126. See *Glucksberg*, 112 S. Ct. at 2273.

127. Oregon Death with Dignity Act, OR. REV. STAT. § 13 (1996), *implementation stayed*, *Lee v. State*, 891 F. Supp. 1439 (D. Or. 1995), *rev’d*, 107 F.3d 1382 (9th Cir.), *cert. denied sub nom. Lee v. Harclerod*, 118 S. Ct. 328 (1997). See Charles H. Baron, et al., *Statute: A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. LEG. 1 (1996). See also Timothy E. Quill, et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992).



adequate,<sup>128</sup> the protections adopted in the early cases legitimating the passive hastening of death are not the ones exclusively relied on today. This concern did not prevent the legalization of forgoing life-sustaining treatment which presents essentially the same potential risks as actively hastening death. Therefore, such a concern should not be allowed to impede the development of the law concerning actively hastening death.

### Conclusion

I have attempted to show several things. First, the arguments that courts have put forth for two decades to justify the criminal nonculpability of passively hastening death are fundamentally unsound. Nonetheless, passively hastening death should not invoke criminal sanctions against those whose conduct causes it if there is legally adequate consent to the conduct and its consequences. Second, once we see that the stock arguments used to justify passively hastening death are spurious and that the true justification for its legitimacy is self-determination implemented through consent, the purported legal distinctions between actively and passively hastening death fade. Finally, although there are sound, indeed strong, arguments against the legitimation of actively hastening death, these same arguments can be made with equal force against passively hastening death. Yet, they are not made, or when made they have been rejected. In light of the virtual indistinguishability of the two practices, there are no sound legal reasons for continuing the prohibition against actively hastening death. What is critical is not the means by which death occurs but that there be adequate protections against abuse, whatever the means of hastening death.

If states decide to decriminalize assisted suicide, the job of assuring adequate safeguards remains, just as it has in the context of passively hastening death. It has taken at least a decade for the states to arrive at a consensus about the procedural and substantive contours of the right to have death passively hastened. We should expect that it will take at least as long in the case of actively hastening death. Indeed it might take longer, not because of any inherent differences between the two but because of greater public concerns, whether warranted or not, about the latter. To assure public confidence, both in passively and actively hastening death, the fo-

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128. See, e.g., Ezekiel J. Emanuel & Elisabeth Daniels, *Oregon's Physician-Assisted Suicide Law: Provisions and Problems*, 156 ARCHIVES INTERNAL MED. 825 (1996).

cus of our efforts must be on safeguards, rather than on the means by which death occurs.

Doctors have been permitted, to put it bluntly, to kill terminally ill patients for at least two decades. Despite the use of sanitizing phrases like "forgoing life-sustaining treatment," we need to recognize that this is what has been happening. Once it is understood why this has been allowed and why it has been perfectly legitimate, it is simple to see that only two choices remain: re-criminalize forgoing life-sustaining treatment or de-criminalize physician-assisted suicide. While it may have been useful, or even necessary, for courts to employ a variety of fictions to establish the right to passively hasten death, they no longer serve any useful purpose in that realm. These fictions must now be discarded so that their perpetuation does not undermine the very ends they were originally devised to promote and protect: the humane care of the dying.

