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ESCAPE FROM NEW YORK: ANALYZING THE STATE'S RELATIVE INTERESTS IN PROSCRIBING THE WITHDRAWAL OF LIFE SUPPORT AND PHYSICIAN-ASSISTED SUICIDE*

This Note argues that states cannot consistently prohibit physician assisted suicide for terminally ill patients while they continue to allow the withdrawal of life support for even non-terminal patients. All of the state interests identified by the Supreme Court in rejecting a right to assisted suicide are implicated to a higher degree by withdrawal of life support. The primary reason for this difference is that withdrawal of life support often involves incompetent patients and surrogate decision making while assisted suicide by definition requires a competent patient choosing to hasten her death.

* * *

INTRODUCTION

"In New York, as in most States, it is a crime to aid another to commit or attempt suicide, but patients may refuse even lifesaving medical treatment."¹ In *Vacco v. Quill*, the Supreme Court held that New York's legalization of the latter practice while it continues to prohibit physician-assisted suicide (PAS) does not "violate[] the Equal Protection Clause of the Fourteenth Amendment."²

The validity of this decision is becoming increasingly important in the face of legal challenges by the federal government to Oregon's Death with Dignity Act,³ which legalized physician-assisted suicide.⁴ Recently, Attorney General John Ashcroft appealed the District Court's rejection of his attempt to nullify Oregon's law to the Ninth Circuit Court of Appeals, and "Congress has twice considered preempting the Oregon law."⁵

* I would like to thank Professor Donald Tortorice for his valuable assistance in helping me to write and refine this Note.

¹ *Vacco v. Quill*, 521 U.S. 793, 796-97 (1997). Under Oregon law, physician-assisted suicide involves a physician prescribing a lethal dose of drugs to a competent, terminally ill patient who will self-administer the drugs. Withdrawal of life support involves a physician or his assistant removing life-sustaining treatment from a patient who is sometimes incompetent or not suffering from a terminal illness.

² *Id.* at 797.

³ OR. REV. STAT. §§ 127.800-127.897 (2001).

⁴ Oregon is presently the only state where PAS is legal.

⁵ Lindsay F. Wiley, *Ashcroft Appeals Assisted Suicide Decision*, PAIN & L., May 24, 2002, at http://www.painandthelaw.org/palliative/ashcroft_053002.php. Congress tried "once in 1998 with the Lethal Drug Abuse and Prevention Act and again in 1999 with the Pain Relief Promotion Act of 1999. The second bill passed the House but failed to reach a vote in the Senate." *Id.*

If any of these attempts to nullify state law are successful, no states will be allowed to legalize PAS, even by popular vote. In light of this possibility, it becomes essential to reconsider the validity of the Supreme Court's decision on different grounds.

In order to reach its decision in *Vacco*, the Supreme Court had to go through two levels of analysis.⁶ First, it had to determine whether New York had committed a facial violation of the Equal Protection Clause. Under the Clause, "[s]tates must treat like cases alike but may treat unlike cases accordingly."⁷ The Court held that New York was merely adhering to the latter principle "[b]y permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide."⁸

According to the Court, "[t]he distinction comports with fundamental legal principles of causation and intent."⁹ Even if this distinction is *legally* tenable, the State must still "satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end."¹⁰

To avoid violating the Equal Protection Clause, then, the State must have rational reasons for its inconsistent treatment of withdrawal of life support and PAS based on their disparate effects on identified state interests. Each section of this Note will challenge a purported state interest in distinguishing between PAS and the withdrawal of life support.¹¹

Section One will analyze the State's "interests in protecting the integrity and ethics of the medical profession."¹² First, it will argue that the public perceives no meaningful distinction between a physician terminating life support and prescribing a lethal dose of drugs to a terminally ill patient. Further, patients are primarily concerned with life being extended artificially by advanced technology and with physicians being unresponsive to their requests because of the implicit rationing of

⁶ *Vacco*, 521 U.S. at 798.

⁷ *Id.* at 799.

⁸ *Id.* at 808.

⁹ *Id.* at 801. While this contention is highly suspect, this Note will assume the distinction is valid and only question the second prong of the Court's analysis. *But cf. infra* Section II.C.

¹⁰ *Vacco*, 521 U.S. at 809.

¹¹ On the same day the Court decided *Vacco*, it also decided *Washington v. Glucksberg*, 521 U.S. 702 (1997). That case involved a due process challenge to the denial of a right to PAS for terminally ill patients. In *Glucksberg*, the Court went into great detail describing the state's interest in prohibiting PAS, while in *Vacco*, the Court merely listed the state's interests and referred to its analysis in *Glucksberg*. See *Vacco*, 521 U.S. at 809 (stating that these interests "are discussed in greater detail in . . . *Glucksberg*"). Therefore, the Court's analysis of these interests will be cited to *Glucksberg*, 521 U.S. 702. Note, however, that, because the Court in *Vacco* merely referred to its analysis in *Glucksberg*, it never analyzed why the state has a greater interest in banning PAS than it does in banning the withdrawal of life support.

¹² *Glucksberg*, 521 U.S. at 731.

“managed care.” Finally, the withdrawal of life support actually involves a much more active role for the physician in causing her patient’s death than does PAS.

Section Two will consider the State’s “unqualified interest in the preservation of human life.”¹³ Initially, it will determine that the State’s interest is more about limiting what one human can do to another than about preserving the “sanctity” of life. To the extent that “sanctity” is important, however, the withdrawal of life support is allowed even for non-terminal individuals while only terminally ill patients may request PAS in Oregon. Finally, because physicians primarily withdraw life support from unconscious patients, a surrogate must often make the choice between life and death. Because surrogate decision making is inaccurate, and because it sometimes leads to a court determining whether the patient’s quality of life is low enough to justify death, the withdrawal of life support substantially implicates the “sanctity” of life. Conversely, PAS always involves a lucid patient making the ultimate decision on her own.

Section Three will analyze the State’s “interest in protecting vulnerable groups — including the poor, the elderly, and disabled persons — from abuse, neglect, and mistakes.”¹⁴ It will begin by noting that initial reports on Oregon’s Death with Dignity Act have revealed no evidence of any exploitation of any of the above groups. It will then argue that, because patients on life support are often unconscious and require greater resources than other terminal patients, they are more likely to be subject to exploitation.

Finally, Section Four will look at the State’s “fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia.”¹⁵ First, the argument for a legal slippery slope is untenable in light of the Court’s own line-drawing in *Vacco*. Second, the Court’s analogy to the Dutch system of “de-criminalized” euthanasia and PAS is inapplicable to a legalized, regulated scheme of PAS, such as that found in Oregon. Finally, to the extent the Netherlands does serve as a harbinger of a slippery slope, it should serve to caution against legalization of withdrawal of life support, not legalization of PAS.

Admittedly, the State has a low burden to meet in proving that its disproportionate treatment of withdrawal of life support and PAS bears some rational relationship to a legitimate end. On the other hand, the Court in *Vacco* provided no analysis as to why the state interests it analyzed in *Glucksberg* applied to any greater extent to PAS than to withdrawal of life support. When properly analyzed, it becomes clear that each identified state interest is implicated to a greater degree by withdrawal of life support than by PAS. Consequently, the State has no rational basis for its disproportionate treatment of the two acts, and states banning PAS are violating the Equal Protection Clause of the United States Constitution.

¹³ *Id.* at 728 (quoting *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 282 (1990)).

¹⁴ *Glucksberg*, 521 U.S. at 731.

¹⁵ *Id.* at 732.

I. PROTECTING THE INTEGRITY OF THE MEDICAL PROFESSION

A. Introduction

According to the Court, "[t]he State . . . has an interest in protecting the integrity and ethics of the medical profession."¹⁶ First, "the American Medical Association, like many other medical and physicians' groups has concluded that '[p]hysician-assisted physician-assisted suicide is fundamentally incompatible with the physician's role as healer.'"¹⁷ Further, "physician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."¹⁸ More perniciously, "[t]he patients' trust in the doctor's whole-hearted devotion to his best interests will be hard to sustain" if PAS is legalized.¹⁹

There are serious flaws with the Court's arguments no matter how they are construed. To begin, the Supreme Court's reliance on the American Medical Association's Code of Ethics is misguided. The AMA's "policy regarding PAS was not made binding upon its members."²⁰ Second, despite the AMA's "advisory" view, there is growing "evidence that a significant number of physicians support the practice of hastening death in particular situations."²¹

Second, "the notion that physicians are solely engaged in healing and

¹⁶ *Glucksberg*, 521 U.S. at 731.

¹⁷ *Id.* (quoting AM. MED. ASS'N, CODE OF MEDICAL ETHICS § 2.211 (1994)) (alteration in original).

¹⁸ *Glucksberg*, 521 U.S. at 731.

¹⁹ *Id.* (quoting *Assisted Suicide in the United States: Hearing Before the House Comm. on the Judiciary*, 104th Cong. 355-56 (1996) (testimony of Dr. Leon R. Kass)).

²⁰ W. Noel Keyes, *The Choice of Participation by Physicians in Capital Punishment*, 22 WHITTIER L. REV. 809, 814 (2001). This is in contrast to the AMA's policy prohibiting physician participation in executions, a policy that was made binding upon its members. *See id.* at 809 & n.2. In contrast, the American Medical Women's Association (AMWA) supports physician participation in PAS. *See* Position Paper, Am. Med. Women's Ass'n, Position Statement on Physician Assisted Suicide (Nov. 1997) ("AMWA supports the right of physicians to engage in practice wherein they may provide a patient with, but not administer, a lethal dose of medication and/or medical knowledge, so that the patient can, without further assistance, end his/her life."), available at http://www.amwa-doc.org/publications/Position_Papers/suicide.htm.

²¹ *Glucksberg*, 521 U.S. at 749 n.12 (Stevens, J., concurring). One "survey published in the New England Journal of Medicine found that 56% of responding doctors in Michigan preferred legalizing assisted suicide to an explicit ban." *Id.*; *see also* UNIV. OF WASH. SCH. OF MED., ETHICS IN MEDICINE: PHYSICIAN-ASSISTED SUICIDE ("Surveys of individual physicians show that half believe that PAS is ethically justifiable in certain cases."), available at <http://eduserv.hscer.washington.edu/bioethics/topics/pas.html> (last modified Oct. 2001).

prolonging life has come into severe dispute.”²² “The public no longer (if it ever did) desires to attempt to preserve life in all instances, nor do they wish to bear the costs [that] may be required in order to do so.”²³ The majority of Americans accepts that physician participation in acts such as abortions and executions is “of benefit to both individuals and society.”²⁴ Thus, the public generally does not believe the only proper role of physicians is as healers, always extending life.

This Section will argue that the public perceives no important distinction between PAS and the withdrawal of life support. Further, patients should be more concerned with legalized withdrawal of life support and the policy of double effect than with PAS. In addition, patients are more concerned with physicians using modern technology to extend suffering and with physician abandonment than with the idea of PAS. Finally, if the ban on PAS is based on causation, the State should be more concerned with the physician’s role in causing death when he withdraws life support than when he assists in a suicide.

B. Public Perception

If the argument is that the integrity of the medical profession will be diminished in the public eye as a result of PAS, it is tenuous at best. Some have opined that, “from the perspective of the lay public, a doctor’s pulling of the plug and precipitating death may seem as much a killing as provision of a prescription for

²² Keyes, *supra* note 20, at 814. “When medical science became capable of prolonging the dying process beyond the point that most patients would wish, medical management of the dying process became a necessity. Health-care providers no longer [can] strive inexorably to extend waning human lives.” Norman L. Cantor, *Philosophy and Law: The Real Ethic of Death and Dying*, 94 MICH. L. REV. 1718, 1718 (1996).

²³ Keyes, *supra* note 20, at 814 (quoting 2 W. NOEL KEYES, *LIFE, DEATH, AND THE LAW: A SOURCEBOOK ON AUTONOMY AND RESPONSIBILITY IN MEDICAL ETHICS* 808 (1995)).

²⁴ Keyes, *supra* note 20, at 814. In the capital punishment context, the public recognizes physician participation allows executions to be performed in the most efficacious manner. In fact, many states require that a physician at least be present during the execution while other states require physicians to “insert[] intravenous lines for lethal injections” and “administer[] . . . injection drugs or their doses or types.” Stacey A. Ragon, *A Doctor’s Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA’s Code of Medical Ethics*, 20 U. DAYTON L. REV. 975, 977, 987 (1995).

Also, note that if the Court is really concerned about placing limits on human relationships, it contradicts itself to the extent it allows capital punishment. To the extent it allows physicians to participate directly in the execution of a prisoner but not even indirectly to assist in the suicide of a patient, the inconsistency becomes even more glaring. Even if the Court can maintain that withdrawal of life support is not akin to killing a patient, the same argument cannot be made for executions. If this practice is allowed, if physicians can prescribe lethal doses or morphine to patients, and if physicians can abort fetuses, one wonders how the Court can maintain that physician’s only role is as healers?

poison."²⁵

Whether there is a legal distinction between the two acts is irrelevant toward safeguarding the public perception of physicians as long as the public conflates the two acts. If the public sees no ethical distinction, "the symbolic message embodied in the distinction between killing and letting die becomes confused and hollow."²⁶

Perhaps most importantly, studies have shown that the vast majority of patients would not lose trust in their physician if she participated in PAS. In one "survey of adult patients, researchers found that 90.5% of patients would consider a physician who assisted suicides to be as trustworthy as other physicians in providing care to critically ill patients."²⁷

In fact, patients may be less trustworthy of physicians who do not participate in PAS. "[F]or some patients, it would be a physician's refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role."²⁸ This is because "[p]atients fear that when they are suffering intolerably, they will be denied the drugs that are necessary to end their suffering."²⁹ Presently, the American public is more concerned that modern medical technology will artificially extend lives than with the prospect of legalized PAS. Primarily, "[t]he public seems to fear the dying process now because it believes doctors' efforts will prolong, not relieve suffering."³⁰

It has even been argued that "it is clear . . . trust cannot survive in the present context surrounding dying."³¹ Some doubt that "the public [can] place much faith in a process that involves . . . 'long, drawn out months to years of increasingly complicated illness that can require an array of specialists, confusing choices, false

²⁵ Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 155 (2000); see also Stephen A. Newman, *Euthanasia: Orchestrating "The Last Syllable of . . . Time,"* 53 U. PITT. L. REV. 153, 166 (1991) ("[I]n the modern medical setting, these terms and distinctions are ephemeral. The concept of natural death in the hospital has lost its meaning.").

²⁶ Cantor & Thomas, *supra* note 25, at 155.

²⁷ David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443 n.43 (1997) [hereinafter Orentlicher, *Legalization*] (citing Mark A. Graber et al., *Patients' Views About Physician Assisted Suicide and Euthanasia*, 11 J. GEN. INTERNAL MED. 71, 73 (1996)) (studying 228 patients at a single university-based family practice program); see also UNIV. OF WASH. SCH. OF MED., *supra* note 21 ("Surveys of patients and members of the general public find that the vast majority think that PAS is ethically justifiable in certain cases . . .").

²⁸ *Glucksberg*, 521 U.S. at 748 (Stevens, J., concurring); see also S.D. Block & J.A. Billings, *Patient Request to Hasten Death*, 154 ARCHIVES INTERNAL MED. 2039, 2045 (1994).

²⁹ Orentlicher, *Legalization*, *supra* note 27, at 452.

³⁰ Newman, *supra* note 25, at 171.

³¹ *Id.* at 172.

hopes, loss of control and dignity, misery and pain.”³² When we “[a]dd to this enormous costs and the propensity of certain doctors to block out others’ suffering, to avoid contact with the dying, and to neglect available measures for pain relief, . . . the picture of an ailing doctor-patient relationship becomes complete.”³³

The primary concerns of patients with terminal illnesses are “doctor neglect and abandonment.”³⁴ “[T]he present system fosters [these maladies] by allowing an inordinate amount of suffering to continue for months, leading many caregivers to simply block it out.”³⁵ When the physician cannot assist in the suicide of a patient in great suffering, it is often difficult for her to face the patient, and avoidance is often the only possible response. “By avoiding the hopeless patient and the family, the doctor learns to live with the brutality of prolonged suffering by disregarding it.”³⁶ Worse, “[a] doctor’s refusal to hasten death ‘may be experienced by the [dying] patient as an abandonment, a rejection, or an expression of inappropriate paternalistic authority.’”³⁷

As Justice O’Connor suggested in her concurring opinion in *Glucksberg*, there is another choice for physicians. Under the principle of double effect, the physician may presently prescribe amounts of morphine to patients that they know will hasten death as long as her primary “intent” is to alleviate the patient’s pain.³⁸ This practice appears more dangerous than the legalization of PAS for two reasons.

First, under double effect, there are no safeguards. As long as the physician claims she intended to treat her patient’s pain, she will avoid liability notwithstanding questions of consent. Second, because the physician’s intent and not the consent of the patient is controlling, a decision resulting from a meaningful doctor-patient relationship is not a mandatory prerequisite to suicide. Under double effect, a physician’s unilateral decision to end life is just as valid as a bilateral decision between doctor and patient.

Further, physicians often use double effect to hasten death after they have withdrawn life support from a patient.³⁹ When a physician withdraws life support, the patient will not often die quickly. Thus, physicians must administer morphine

³² *Id.* (quoting *Should Physicians Perform Euthanasia?*, AM. MED. NEWS, Jan. 7, 1991, at 12).

³³ Newman, *supra* note 25, at 171.

³⁴ *Id.* at 176.

³⁵ *Id.*

³⁶ *Id.*

³⁷ *Washington v. Glucksberg*, 521 U.S. 702, 748 (1997) (Stevens, J., concurring) (quoting Block & Billings, *supra* note 28) (alteration in original).

³⁸ See *Glucksberg*, 521 U.S. at 736–37 (1997) (O’Connor, J., concurring) (“[A] patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.”).

³⁹ See *infra* note 54 and accompanying text.

to hasten the dying process.⁴⁰ If the physician "intended" to cause her patient's death, however, she would be practicing euthanasia. It would appear this thinly veiled and unregulated practice could weaken the doctor-patient relationship.

Presently, then, there are several pernicious alternatives available to physicians and patients. Because PAS is illegal, a patient may be forced to suffer through terrible pain.⁴¹ A sympathetic physician may be able to end this patient's life through double effect, but there are no safeguards protecting this decision. Finally, in lieu of physician participation, the patient may attempt to take her own life or have a family member cause her death. It is unlikely under any of these alternatives that the physician and patient could have any meaningful discussion about the patient's desire to die or regulating the dying process.

In contrast, allowing PAS may have the potential to "foster a deeper dimension to some doctor-patient relationships."⁴² Legalization of PAS "moves it into the arena for open discussion and consideration."⁴³ Consequently, "a process of conversation, explanation and negotiation may ensue between doctors and patients requesting help in ending life."⁴⁴ It is nearly universally accepted that "[d]ying is one of life's most profound experiences. To share this . . . with another who is willing to understand and acknowledge this type of suffering, and to act on it, surely must create one of the most trusted bonds that can be possible."⁴⁵

At the very least, "[f]or doctors who have longstanding relationships with their patients, . . . who are attentive to their patient's individual needs, . . . heeding a patient's desire to assist in her suicide would not serve to harm the physician-patient relationship."⁴⁶ Finally, the Court's "traditional view of the physician's role" is simply inapplicable in an age where "physicians are already involved in making decisions that hasten the death of terminally ill patients — through termination of life support, withholding of medical treatment, and terminal sedation"⁴⁷

C. Causation

Some argue that PAS is unacceptable because it forces the physician to become the cause of death, as opposed to the underlying illness, when life support is

⁴⁰ See *infra* note 54 and accompanying text.

⁴¹ Of course, even if PAS were legal, many terminally ill patients would still choose to live, and this choice would not be foreclosed by legalization of PAS.

⁴² Newman, *supra* note 25, at 171.

⁴³ *Id.* Currently, however, "[m]aking the practice illegal discourages discussion. One must be very sure of others' reactions before confiding in them. The useful deliberation that comes from sharing ideas and perspectives is thereby lost." *Id.* at 177.

⁴⁴ *Id.* at 172.

⁴⁵ *Id.* (quoting *Should Physicians Perform Euthanasia?*, *supra* note 32).

⁴⁶ *Washington v. Glucksberg*, 521 U.S. 702, 748 (1997) (Stevens, J., concurring).

⁴⁷ *Id.*

withdrawn. Ironically, however, "if causation were really the issue, assisted suicide would be less problematic morally than withdrawal of treatment."⁴⁸ The physician has an alternated causal role in the patient's death under PAS because the physician merely prescribes a "lethal dose of a drug."⁴⁹ "[B]ecause the patient must *self-administer* the drug, the patient brings about his or her own death."⁵⁰

In fact, the physician's act of prescribing the drug is not even always temporally close to the death of the patient. Often, a physician's lethal prescription will not be used until "a few weeks or months later in a suicide,"⁵¹ if it is used at all.⁵² Consequently, a physician practicing PAS would have "a more attenuated role in the patient's death than the physician whose discontinuation of a ventilator leads to death in minutes."⁵³

Furthermore, other factors that normally accompany the withdrawal of life support make the physician partake in an even more active role in causing death. "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."⁵⁴

⁴⁸ Orentlicher, *Legalization*, *supra* note 27, at 448.

⁴⁹ *Id.*

⁵⁰ *Id.* (emphasis added).

⁵¹ *Id.*

⁵² According to the data reported from Oregon in the first year of its Death With Dignity Act, "23 people received [lethal] prescriptions, 15 of whom used them in hastening death . . ." Andrew I. Batavia, *So Far So Good: Observations on the First Year of Oregon's Death with Dignity Act*, 6 PSYCHOL. PUB. POL'Y & L. 291, 293 (2000). The data also dispels the fear that the Act would be overutilized, creating a suicide problem. Instead, "only an extremely small percentage of people (.05% or 5 people in 10,000) who died in Oregon received assistance under the Act." *Id.*

⁵³ Orentlicher, *Legalization*, *supra* note 27, at 448. "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." *Quill v. Vacco*, 80 F.3d 716, 729 (1996), *rev'd*, 521 U.S. 793 (1997).

⁵⁴ *Quill*, 80 F.3d at 729. The court concluded that, as a result of these accompanying actions, "[t]he ending of life by these means is nothing more nor less than assisted suicide." Actually, the court was more generous than it needed to be toward withdrawal of life support in this characterization. Because the physician never administers the drugs under PAS, her involvement is actually more attenuated than when drugs must be directly administered.

Furthermore, when the physician administers lethal drugs after withdrawing life support, the argument that the physician did not intend to kill the patient dissipates. The combination of these two acts reveals that the physician intends, through the entire process, to hasten her patient's death.

Imagine an ordinary citizen claiming she merely intended to treat her husband's insomnia after administering a lethal dose of sleeping pills to him. Those who oppose PAS could counter that the law should treat physicians differently from ordinary citizens because of their disparate levels of medical knowledge. In reality, however, physicians should be more culpable than ordinary citizens. An ordinary citizen might honestly have believed she

II. PRESERVING THE SANCTITY OF LIFE

A. Introduction: The Court's Two Prong Approach

The Court has found that the State “has an ‘unqualified interest in the preservation of human life.’”⁵⁵ Despite this language, the Court made it clear that this interest does not involve traditional sanctity of life considerations. Instead, the Court found that, “[w]hile suicide is no longer prohibited or penalized, the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships.”⁵⁶

This appears to be the first prong of the Court’s “sanctity of life” argument. As stated before, however, this is not a literal sanctity argument. Instead, the state interest actually appears to be the interest in not allowing individuals to assist in the deaths of other individuals. As such, the interest truly is in placing ‘limits on human relationships’ as opposed to protecting the underlying life itself.⁵⁷

The second prong of the interest appears to be preserving the State’s interest in “properly declin[ing] to make judgments about the ‘quality’ of life that a particular individual may enjoy.”⁵⁸ By remaining neutral on such issues, the State can consistently maintain the proposition “that all persons’ lives, from beginning to end, regardless of physical or mental condition, are under full protection of the law.”⁵⁹

This Section will first analyze why the State’s interest in preserving the sanctity of life is not really about sanctity at all. Second, because PAS is limited to the

was merely treating her spouse’s pain in administering a lethal dosage of medication. In contrast, if anyone should know exactly how much medication can be prescribed without leading to death, it would be a physician. It is thus disingenuous to say the doctor administering a lethal dose of morphine does not intend to kill her patient.

⁵⁵ *Washington v. Glucksberg*, 521 U.S. 702, 728 (1997) (quoting *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 282 (1990)). Note that the Court takes this interest directly from its decision in *Cruzan*, a case dealing with the withdrawal of life support. The Court in *Vacco* never explained why this interest applies with any greater force to PAS than to withdrawal of life support.

⁵⁶ *Glucksberg*, 521 U.S. at 728.

⁵⁷ Of course, the Court did later recognize that “suicide is a serious public-health problem, especially among persons in otherwise vulnerable groups.” *Id.* at 730. While at first glance this appears to be a strict sanctity of life concern, it is in fact a concern over depression and various heteronomous factors influencing a patient’s decision to end his life. As such, these arguments will be considered *infra* in Section IV. See also Note, *Physician Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2024 (1992) (“Suicide is not a crime in any state, and state officials cannot take custody of a person who exhibits suicidal intentions unless the person is certifiably mentally ill. Thus, the crucial issue is the legality of the physician’s act.”).

⁵⁸ *Glucksberg*, 521 U.S. at 729 (quoting *Cruzan*, 497 U.S. at 282).

⁵⁹ *Glucksberg*, 521 U.S. at 729; see also *United States v. Rutherford*, 442 U.S. 544, 558 (1979).

terminally ill, it actually coincides with greater limits on human relationships than does the withdrawal of life support. Finally, because of surrogate decision making in the withdrawal of life support, these limits are implicated to an even greater degree when withdrawal of life support is allowed.

B. Why the Sanctity of Life is Not About 'Sanctity'

If the State had a valid interest in preserving the 'sanctity' of life, it could not reasonably draw a distinction between withdrawal of life support and PAS. According to the Court, "[t]he distinction comports with fundamental legal principles of causation and intent."⁶⁰ Whether a physician intends to kill a patient by withdrawing life support or whether he is the legal cause of that death is irrelevant to the principle of 'sanctity' of life.

The physician who pulls the plug knows his act will result in the death of his patient, and yet he does nothing to preserve that life. Not only does society fail to intervene, but the Court also explicitly authorizes the act. If the purpose of the sanctity of life is to preserve all lives without contingency, it is certainly violated when this withdrawal is allowed.⁶¹

C. Closeness to Death as a Limit Upon PAS and Withdrawal of Life Support

Under the Court's first prong of reasoning, limits must be placed on human relationships.⁶² Under PAS, there is more of a limit than under withdrawal of life support because, under the Oregon Death with Dignity Act, only an adult "suffering from a terminal disease"⁶³ may be a candidate for PAS. Earlier in the Act, a terminal disease is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months."⁶⁴ This limitation appears to reinforce the principle that "the state's interest [in preserving life] lessens as the potential for life diminishes."⁶⁵

In contrast, New York has held that life-sustaining treatment may be withdrawn even from patients without terminal diseases. In fact, New York has held that "[p]hysicians can withdraw life-sustaining treatment even when there is a good

⁶⁰ *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

⁶¹ The Court can attempt to distinguish its interest by labeling PAS as suicide while holding withdrawal of life support allows a *natural* death. Linguistics and reasoning aside, the fact remains that, in either case, a physician stands by when he knows his inaction will result in a patient's death.

⁶² See *supra* notes 56–57 and accompanying text.

⁶³ OR. REV. STAT. § 2.01 (1997).

⁶⁴ *Id.* § 1.01.

⁶⁵ *Quill v. Vacco*, 80 F.3d 716, 729 (1996) (citing *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1976)), *rev'd*, 521 U.S. 801 (1997).

possibility of significant improvement in the patient's condition."⁶⁶

Opponents of PAS can still argue that, by only allowing those with terminal illnesses to qualify for PAS, the State is implicitly assuming these individuals have a lower quality of life than others, implicating the second prong of the State's interest in preserving the sanctity of life. To a degree, this analysis is misguided. By legalizing PAS, the State makes no determination on the patient's quality of life. Instead, it merely recognizes that individuals with terminal illnesses have a heightened liberty interest in deciding for themselves whether to end their lives that can trump the State's interest in preserving the sanctity of life.⁶⁷

Whatever merit remains in the opposition's argument dissipates when viewed in the context of the Court's decision. Once again, according to the Court, "[s]uicide is not a crime in any state."⁶⁸ By legalizing PAS, then, the State would not be giving any license to the terminally ill to take their own lives that other individuals do not currently hold. The only issue would be whether the terminally ill should have the additional right of physician assistance. While this clearly raises questions about implicating the integrity of the medical profession (which have already been addressed), it raises no additional questions about devaluing the quality of life of a terminally ill patient.

⁶⁶ Orentlicher, *Legalization*, *supra* note 27, at 453 (citing *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990)). In *Nicoleau*, the court recognized the right of an adult Jehovah's Witness to "refuse[] to consent to blood transfusions prior to delivery of her baby" and "after losing a substantial amount of blood following the Cesarean birth of [her] child." *Nicoleau*, 551 N.E.2d at 77, 78.

While the decision involved a Jehovah's Witness, the court did not limit its decision to a right to the free exercise of religion. Instead, the court recognized that "[t]he citizens of this State have long had the right to make their own medical care choices without regard to their physical condition or status as parents." *Id.* at 84.

In Oregon, the same dichotomy exists. "Assisted suicide may be less susceptible to abuse because, by law in Oregon, it is limited to terminally ill persons, while treatment can be withdrawn from any person, regardless of prognosis." David Orentlicher, *The Implementation of Oregon's Death With Dignity Act*, 6 PSYCHOL. PUB. POL'Y & L. 489, 493 n.23 (2000) [hereinafter Orentlicher, *Implementation*].

Of course, most courts have extended a right to refuse medical treatment to an amalgam of circumstances where the patient's condition could not be described as incurable and irreversible. Now, "[a]uthorization to withhold or withdraw life support . . . extends to the most basic forms of medical intervention including blood transfusions, artificial nutrition, and chemotherapy." Cantor, *supra* note 22, at 1721.

⁶⁷ Of course, it could still legitimately be argued that the state implicitly judges the quality of life of terminally ill patients by placing them in this position.

⁶⁸ See *supra* text accompanying note 56.

D. Surrogates

1. The Invalidity of Surrogate Decision-Making

With PAS, it is always the patient who consents to ending her life.⁶⁹ With the withdrawal of life support, however, it is often not the patient who decides to end her own life. When the patient is unconscious or unable to give voluntary consent, either a surrogate or a physician must decide whether to end the patient's life. Based on this fact alone, there is less of a limit on human relationships with withdrawal of life support than with PAS.

There are two models under which surrogates make decisions regarding the withdrawal of life support for unconscious patients. The first of these is the substituted judgment standard, where the "surrogate decisionmaker attempts to establish, with as much accuracy as possible, what decision the patient would make if he were competent to do so."⁷⁰ The second is the best-interests standard, where the "surrogate decisionmaker chooses for the incompetent patient which medical procedures would be in the patient's best interests."⁷¹

Surrogate decision making in withdrawal of life support cases is especially troublesome because "[t]he empirical data indicate[s] . . . that surrogates do a poor job of carrying out patients' wishes."⁷² In fact, "[t]hese studies consistently demonstrate that the potential surrogates' predictions do not reach a statistically significant degree of agreement with the choices of the individual."⁷³ "This holds

⁶⁹ Critics can legitimately argue that external pressures may influence this decision, but it is still the patient who ultimately makes the determination.

⁷⁰ *In re Estate of Longeway*, 549 N.E.2d 292, 299 (1989).

⁷¹ *Id.* Under this standard, the surrogate looks at certain determinative factors such as degree of suffering and quality of life in arriving at her decision. An initially identifiable "problem with the best-interests test is that it lets another make a determination of a patient's quality of life, thereby undermining the foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands." *Id.*

⁷² David Orentlicher, *Trends In Health Care Decision Making: The Limits Of Legislation* 53 MD. L. REV. 1255, 1278 (1994) (citing Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis*, 267 J. AM. MED. ASS'N 2067, 2069 (1992)) [hereinafter Orentlicher, *Limits*]. These studies "examined the accuracy of surrogate decisionmakers by presenting individuals with hypothetical scenarios and asking them to indicate their treatment preference for each scenario. Potential surrogates are simultaneously asked to predict the preferences of the individual." Orentlicher, *Limits, supra*, at 2069.

While the main focus of placing limits on human relationships is to prevent individuals from having to decide whether other individuals should die, a tertiary focus is to prevent individuals from wrongly concluding other individuals want to die.

⁷³ *Id.* "The empirical studies . . . do suggest that proxies are not much better than chance at predicting patients' preference during incompetence." *Id.* at 1278, n.147 (quoting Emanuel & Emanuel, *supra* note 72, at 2069).

true even when individuals chose people that they would feel most comfortable with as surrogate decisionmakers."⁷⁴

This failure on the part of surrogates results from three distinct factors. "First, most people do not engage in meaningful discussions of their treatment preferences with close family members or friends."⁷⁵ As a result, "potential surrogates are not likely to have a good sense of the person's preferences."⁷⁶ Thus, when surrogates act under the substituted judgment standard, they are often forced to make decisions based on circumstantial and incomplete evidence of the patient's beliefs and values.

Unfortunately, surrogates may be no better off using the best-interests standard. This is true because "potential surrogates tend to underestimate the quality of life of the people for whom they will be making medical decisions."⁷⁷ Consequently, surrogates "may conclude that treatment is not desired even when it is."⁷⁸

Under either standard, "surrogates may be reluctant to authorize the withholding of life-sustaining treatment for a family member and thus mistakenly predict a person's treatment preferences."⁷⁹ Surrogates' choices can be prejudiced by factors such as "[t]he psychological stress of feeling responsible for another person's death."⁸⁰

Overall, then, "some factors drive surrogates toward deciding on less treatment than that which is desired by patients, while others drive them toward deciding on more than is desired."⁸¹ Unfortunately, these "opposing tendencies generally do not cancel each other out."⁸² Instead, they "serve to increase the chance of a mismatch, causing some patients to receive excessive care and others to receive inadequate care."⁸³

When it is the physician who is deciding whether life support will be withdrawn, similar problems of consent are present. This is so because studies have shown "physicians often overr[i]de living wills when they disagree[] with the wisdom of the patients' choices."⁸⁴ "[I]n many cases," however, the patient's preferences do

⁷⁴ Orentlicher, *Limits*, *supra* note 72, at 1278 (citing Jan Hare et al., *Agreement Between Patients and Their Self-Selected Surrogates on Difficult Medical Decisions*, 152 ARCHIVES INTERNAL MED. 1049, 1052 (1992)).

⁷⁵ Orentlicher, *Limits*, *supra* note 72, at 1278.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ *Id.* at 1279.

⁷⁹ *Id.* "Close family members may have a strong feeling . . . that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading." *Id.* at 1280, n.158 (quoting *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 286 (1990)).

⁸⁰ Orentlicher, *Limits*, *supra* note 72, at 1280.

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ *Id.* at 1283. "[P]hysicians probably overrode patients preferences a majority of the time

not even come into play because, "when the patient [is] transferred from the nursing home to a hospital, the patient's living will [does] not accompany the patient and [is] therefore not incorporated into the patient's hospital chart."⁸⁵

Still, even when the patient is accompanied by her living will, there is no guarantee her preference will be honored. "In some cases . . . physicians provide[] undesired treatment because they [feel] that the treatment [is] appropriate. In other cases, they [withhold] desired treatment because they believe[] that the treatment [will] not benefit the patient."⁸⁶

2. Surrogate Decision-Making and the Quality of Life

Because surrogates, and sometimes the courts, are forced to consider the patient's quality of life in making a withdrawal decision, the withdrawal of life support also implicates the second prong of the state's interest. In *In re Beth Israel Medical Center*,⁸⁷ "[a] New York court established twelve factors to determine the best interests of an incompetent individual, including age, degree of pain and suffering, degree of disability and dependency, *quality of life*, views of the individual's family members and physician, and type of care required if life is prolonged."⁸⁸

When it is simply a surrogate such as a family member or physician making the decision to terminate life support under this standard, the State does remain neutral on the patient's quality of life although someone other than the patient must judge the worth of his life.⁸⁹ In some cases, however, the decision to end life does not end with the surrogate. In these jurisdictions, "the intervention of a judge" is required to determine whether the surrogate's decision was proper.⁹⁰ Practically, when courts must make this decision, the State is deciding on the quality of life of the patient. Legally, "[t]hat the action of state courts and judicial officers in their official capacities is to be regarded as action of the State within the meaning of the Fourteenth Amendment, is a proposition which has long been established by

when there was a disagreement between the patient and physician." *Id.* at 1282-83.

⁸⁵ *Id.*

⁸⁶ *Id.* at 1283 (citation omitted).

⁸⁷ 519 N.Y.S.2d 511 (N.Y. Gen. Term 1987).

⁸⁸ Teresa Harvey Paredes, *The Killing Words? How the New Quality-of-Life Ethic Affects People with Severe Disabilities*, 46 SMUL. REV. 805, 830 (1993) (citing *In re Beth Israel*, 519 N.Y.S.2d 511 (N.Y. Gen. Term 1987)) (emphasis added) (footnotes omitted). Also note the degree to which this analysis diametrically opposes the state interest "that all persons' lives, from beginning to end, regardless of physical or mental condition, [be] under the full protection of the law." *Washington v. Glucksberg*, 521 U.S. 702, 729 (1997). By including age and degree of disability as factors, it is clear that not all individuals are treated equally under the law.

⁸⁹ Further, when the views of family members and physicians are part of a calculus, another limit on human relationships is removed.

⁹⁰ *In re Estate of Longeway*, 549 N.E.2d 292, 300 (1989).

decisions of" the Supreme Court.⁹¹

III. PROTECTING THE POOR, THE ELDERLY, AND THE DISABLED FROM EXPLOITATION

A. Introduction

The Supreme Court found that "the State has an interest in protecting vulnerable groups — including the poor, the elderly, and disabled persons — from abuse, neglect, and mistakes."⁹² This interest recognizes "the real risk of subtle coercion and undue influence in end-of-life decisions."⁹³ The Court found that "[a]n insidious bias against the handicapped — again coupled with a cost-saving mentality — makes them especially in need of . . . statutory protection."⁹⁴

To begin, even by the Court's own analysis, there is no reason to distinguish PAS from withdrawal of life support. The Court merely applied its analysis of the risk of coercion from *Cruzan*, a case concerning the withdrawal of life support, to PAS.⁹⁵ By the Court's own analysis, then, a petitioner seeking to hasten his death should be required to meet certain standards to have her wish fulfilled, but she should not be prohibited from ending her life.⁹⁶ Further, the Court never presented any independent evidence as to why PAS should present any risks to vulnerable groups.⁹⁷

This Section will argue that the initial reports on Oregon's Death With Dignity Act have shown no evidence of the exploitation of vulnerable groups. Second, reasons will be presented as to why the poor, the elderly, and the disabled are more

⁹¹ *Shelley v. Kraemer*, 334 U.S. 1, 14 (1948) (finding the requisite state action when a court enforced a private, racially-restrictive covenant).

⁹² *Glucksberg*, 521 U.S. at 731.

⁹³ *Id.* at 732 (citing *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 281 (1990)).

⁹⁴ *Glucksberg*, 521 U.S. at 732 (quoting *Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9th Cir. 1995)). "If physician-assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end-of-life health-care costs." *Glucksberg*, 521 U.S. at 732.

⁹⁵ See *Cruzan*, 497 U.S. at 261.

⁹⁶ "[W]e should respond to the risk of noncompliance with assisted suicide regulations in the same way that we respond to the risk of noncompliance with treatment withdrawal regulations, unless there is some other reason to treat the two practices differently." Orentlicher, *Implementation*, *supra* note 66, at 500. In fact, because the patient herself is making the choice rather than a surrogate, arguably, PAS may require fewer safeguards than those required for the withdrawal of life support.

⁹⁷ In challenging the Appellate Court's characterization of this risk as "ludicrous on its face," the *Glucksberg* Court merely responded by citing *Cruzan*. Under an Equal Protection analysis, this actually weakens the Court's argument. Because the Court did not expound on this analysis in *Vacco*, it is left with no support.

susceptible to exploitation through withdrawal of life support than through PAS.

B. Oregon's Death With Dignity Act and Vulnerable Groups

In Oregon, the initial report⁹⁸ on its Death With Dignity Act "shows no indication of exploitation of vulnerable populations."⁹⁹ In fact, "preliminary data from Oregon suggest that such abuse is not occurring" for any of the vulnerable groups identified by the Court.¹⁰⁰

"[O]f the people who requested information and considered assisted suicide, over half were men, all were Caucasian, and none had a disability (except for functional limitations secondary to their primary condition)."¹⁰¹ More significantly, "[t]he Health Division Report found that the control patients studied did not differ statistically from the patients who received prescriptions with respect to age, education, or insurance status and similarly concluded that there is no evidence to support concerns that physician-assisted suicide was forced on any members of these groups."¹⁰²

This Report shows that there is not even a correlation between wealth, age, or disability and whether a patient participated in PAS.¹⁰³ These numbers support the conclusion that the Court's inclusion of the above groups was nothing more than a "blanket characterization[]." ¹⁰⁴ They further support those who "have concluded that those individuals who are in fact vulnerable should and will be protected by the safeguards of the law."¹⁰⁵

One of the safeguards of the law is that, before a patient can receive assistance, "[t]he patient must make one written request and two oral requests to his or her physician, and the two oral requests must be separated by at least 15 days."¹⁰⁶ Before a patient can receive his prescription, "[t]he physician and a consultant must confirm the diagnosis of a terminal condition, determine that the patient is competent to make the decision, and refer the patient to counseling if either believes the patient's judgment is impaired by depression or another psychiatric or psychological disorder."¹⁰⁷ Finally, "[t]he physician must also inform that patient

⁹⁸ Arthur E. Chin et al., *Legalized Physician-Assisted Suicide in Oregon — The First Year's Experience*, 340 NEW ENG. J. MED. 577 (1999).

⁹⁹ Cantor & Thomas, *supra* note 25, at 162.

¹⁰⁰ Batavia, *supra* note 52, at 295.

¹⁰¹ *Id.*

¹⁰² *Id.* at 295–96.

¹⁰³ Of course, to prove its theory, the Court would have to determine that the higher burden of causation was met and not simply that the two variables coincide.

¹⁰⁴ Batavia, *supra* note 52, at 295.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 294.

¹⁰⁷ *Id.*

of all feasible alternatives, including hospice, palliative care, and aggressive pain control."¹⁰⁸

As an even further precaution, "the Oregon State Assembly recently amended the Death with Dignity Act to provide that 'No person shall qualify under the provisions of [the Act] solely because of age or disability.'"¹⁰⁹ The presence of this additional safeguard, in addition to the success of the Oregon Death With Dignity Act, suggests that a legalized, regulated system of PAS should and can be effective in protecting potentially vulnerable groups.

Of course, Oregon is not the only state where PAS occurs. Even in these other states, without the safeguards of Oregon, "evidence grows that underground euthanasia occurs at a significant rate without any indications of exploitation of vulnerable populations."¹¹⁰ Still, underground euthanasia and PAS lack the protective safeguards of a regulated and legalized scheme such as that in Oregon. "[T]he problem with an underground practice of assisted suicide is that there are no second opinions, and nobody looking out for the best interests of the patients if they are weak and susceptible to suggestion."¹¹¹ When "we restrict euthanasia to the realm of covert action, we thereby run added risks of mistake and abuse."¹¹²

At a minimum, "[t]he patient who asks to be allowed to die by removal from a ventilator is at least as likely as a patient who requests a prescription for lethal drugs to be making the request because of undue influence, financial pressure, clinical depression, or inadequately treated pain."¹¹³ Furthermore, "these extraneous pressures would also potentially impact in a disproportionate manner on vulnerable populations such as the elderly, the poor, and the disabled."¹¹⁴

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* at 296 (quoting 1999 Or. Laws 423, § 2 (codified at OR. REV. STAT. § 127.805 (2001))).

¹¹⁰ Cantor & Thomas, *supra* note 25, at 164 n.292; *see also* Washington v. Glucksberg, 521 U.S. 702, 749 n.12 (1997) (Stevens, J., concurring) (citing a study finding "that 12% of physicians polled in Washington State reported that they had been asked by their terminally ill patients for prescriptions to hasten death, and that, in the year prior to the study, 24% of those physicians had complied with such requests"); *id.* (citing a report finding that "18% of responding Michigan oncologists reported active participation in assisted suicide").

¹¹¹ Kim C. Arestad, *Vacco v. Quill and the Debate Over Physician-Assisted Suicide: Is the Right to Die Protected by the Fourteenth Amendment?*, 15 N.Y.L. SCH. J. HUM. RTS. 511, 550 n.283 (1999) (citing Alexandra Dylan Lowe, *Facing the Final Exit*, A.B.A.J., Sept. 1997, at 52).

¹¹² Newman, *supra* note 25, at 177; *see also* George D. Lundberg, 'It's Over Debby' and the Euthanasia Debate, 259 J. AM. MED. ASS'N 2142 (1988).

¹¹³ Cantor & Thomas, *supra* note 25, at 161 (quoting LANCE K. STELL, PHYSICIAN ASSISTED SUICIDE 225, 247 (Margaret P. Battin et al. eds., 1988)).

¹¹⁴ *Id.*

C. The Poor

There is at least a cognizable argument that poor individuals could be at a heightened risk of persuasion from other family members and physicians to terminate life support.¹¹⁵ This is because “[p]atients dependent on ventilators or dialysis consume more resources than patients who are not so dependent, and patients can live many more years, even decades, while being sustained on artificial life supports.”¹¹⁶ Thus, “resource constraints are even more likely to cause premature withdrawals of life-sustaining treatment”¹¹⁷ than they are to cause PAS.

These “premature withdrawals” can come about because “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.”¹¹⁸ More remotely yet more perniciously, “[p]hysicians [could] subtly or heavy-handedly pressure patients into forgoing life-sustaining treatment by telling them that it is useless, painful, and expensive.”¹¹⁹

In fact, there is even evidence that this “implicit rationing” is already occurring. More than one source has commented that “physicians routinely engage in the practice of consciously making clinical compromises that result in some potentially beneficial treatment being withheld from their patients for financial reasons.”¹²⁰

¹¹⁵ Alternatively, when the patient is unconscious, these pressures can directly influence the surrogate making the final determination between life and death.

¹¹⁶ Orentlicher, *Legalization*, *supra* note 27, at 460. For instance, “[w]hen the United States Supreme Court was deciding whether to permit the withdrawal of Nancy Cruzan’s feeding tube, the costs of her care were reported to be more than \$130,000 per year, and she survived nearly eight years in her persistent vegetative state before her treatment was discontinued.” Cantor & Thomas, *supra* note 25, at 161 (quoting STELL, *supra* note 113, at 247).

¹¹⁷ *Id.*

¹¹⁸ Alan Meisel, *Physician-Assisted Suicide: A Common Law Roadmap for State Courts*, 24 FORDHAM URB. L.J. 817, 855 (1997).

¹¹⁹ *Id.* While the prospect that physicians could knowingly force patients into choosing withdrawal of life support may be speculative, there is a real danger that its legalization has caused a form of tacit acceptance in the medical community leading to more subtle persuasion. According to this theory, “[p]hysicians can . . . become hardened to the plight of the terminally ill by the knowledge that forgoing life-sustaining treatment is an easy out for the physician.” *Id.*

¹²⁰ Marshall B. Kapp, *De Facto Health-Care Rationing by Age — The Law Has No Remedy*, 19 J. LEGAL MED. 323, 330 (1998); *see also id.* at 333 (finding that premature withdrawal of life support can result from physicians “responding to concerns about excessive health-care costs, especially in the light of the direct and indirect cost-containment incentives promoted by today’s pervasive managed care environments”); David A. Arsich & Peter A. Ubel, *Rationing by Any Other Name*, 336 NEW ENG. J. MED. 1668 (1997); Michael J. Stauss et al., *Rationing of Intensive Care Unit Services: An Everyday Occurrence*, 255 J. AM. MED. ASS’N 1143 (1986).

D. The Elderly

There is also a valid argument that the elderly are open for exploitation under the present scheme where surrogates can decide to withdraw life support under a substituted judgment or best interests analysis. "[S]tudies confirm that family members consistently underestimate the quality of life of elderly persons."¹²¹ Concurrently, "[p]hysicians also consistently underestimate the quality of life of elderly patients."¹²²

Because of these dual underestimations, both physicians and family members "may conclude that treatment is not desired even when it is."¹²³ On one level, in the majority of cases, this can lead to complete withdrawal of life support without the requirement of a court order.¹²⁴ On another level, physicians underestimating their patient's desire to live are often "likely to recommend less aggressive care to surrogates than the patient would desire."¹²⁵

Others have also claimed that the same "implicit rationing" mentioned above¹²⁶ "has the effect of discriminating at the bedside against patients who are elderly."¹²⁷ Of particular concern is "the apparently widespread practice of unilaterally withholding more expensive forms of medical care in the absence of, or even contrary to, the older person's or surrogate's own informed decision."¹²⁸

¹²¹ Orentlicher, *Limits*, *supra* note 72, at 1278–79 (citing Emanuel & Emanuel, *supra* note 72, at 2069).

¹²² Orentlicher, *Limits*, *supra* note 72, at 1279 (citing Richard F. Uhlmann & Robert A. Pearlman, *Perceived Quality of Life and Preferences for Life-Sustaining Treatment in Older Adults*, 151 ARCHIVES INTERNAL MED. 495 (1991); Robert A. Pearlman & Richard F. Uhlmann, *Quality of Life in Chronic Disease: Perceptions of Elderly Patients*, 43 J. GERONTOLOGY M25, M27 (1988)).

¹²³ *Id.*

¹²⁴ See *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987).

¹²⁵ Orentlicher, *Limits*, *supra* note 72, at 1279. This is especially true because "a relatively high proportion of elderly people desire intensive intervention to prolong their lives." *Id.* at 1279 n.151 (quoting Joseph G. Ouslander et al., *Health Care Decisions Among Elderly Long-Term Care Residents and Their Potential Proxies*, 149 ARCHIVES INTERNAL MED. 1367, 1371 (1989)).

¹²⁶ See *supra* notes 119–20 and accompanying text.

¹²⁷ Kapp, *supra* note 120, at 330. For instance, in one study, "almost half of the[] very old patients had some limitation placed on their care." *Id.* (quoting K.A. Hesse, *Terminal Care of the Very Old: Changes in the Way We Die*, 155 ARCHIVES INTERNAL MED. 1513, 1517 (1995)).

¹²⁸ Kapp, *supra* note 120, at 330–31. Again, this discrimination need not result from overt discrimination against the elderly. Instead, "[t]his phenomenon may occur, for example, when patient age is silently factored into individual caregivers' decisions to admit patients to the hospital, provide intensive care, terminate therapy, or initiate vigorous treatment." *Id.* at 331. One explanation for why "we spend fewer Medicare dollars on the final two years of life for a 90-year-old than for a 70-year-old . . . is that physicians are . . . less aggressive

Others have gone farther and claimed that age discrimination is the purpose, and not merely the effect, of physician's decisions. These individuals argue that

there is ample evidence in the medical sciences literature that individual bedside decisions about the distribution of health resources not infrequently are made by physicians on the basis of the patient's age, even when potential confounding variables such as prognosis and severity of illness have been controlled for in the analysis.¹²⁹

Decisions regarding withdrawal of life support and other end-of-life decisions are not immune from this discrimination. Thus, "[o]lder patients are more likely than their younger counterparts to be the recipients of Do-Not-Resuscitate (DNR) orders when all other conditions are equal."¹³⁰ In addition, "[w]hen attempted resuscitation is initiated for cardiopulmonary arrest, the elderly frequently receive shorter trials of advanced cardiac life support before death is declared."¹³¹ Finally,

in hospitalizing their oldest patients and initiating tests and treatments for them." *Id.* (quoting A.M. Kramer, *Health Care for Elderly Persons — Myths and Realities*, 332 NEW ENG. J. MED. 1027, 1028 (1995)).

¹²⁹ Kapp, *supra* note 120, at 331. "[R]ationing by age at the individual bedside may be the result of the physician's own often unconscious bias and prejudice regarding the elderly — in other words, ageism, acting alone or in combination with therapeutic miscalculations and/or financial incentives." *Id.* at 333 (footnote omitted). "[A]ge discrimination may . . . be practised at a primitive, subcortical level with aged patients being accorded substandard treatment simply through the exercise of knee-jerk responses based on blind prejudice." *Id.* (quoting Editorial, *Do Doctors Short-Change Old People?*, 342 LANCET I (1993)) (alteration and omission in original).

¹³⁰ Kapp, *supra* note 120, at 331 (citing K. Boyd et al., *The Relationship Between Age and the Use of DNR Orders in Critical Care Patients: Evidence for Age Discrimination*, 156 ARCHIVES. INTERNAL MED. 1821 (1996)).

Further note how sources arguing against such discrimination fall into the same kind of logic the Court is fearful will result if PAS is legalized. In *Glucksberg*, the Court held that [t]he State's assisted-suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. *Glucksberg*, 521 U.S. at 732.

According to one source, "[h]igher rates for DNR orders represent provider responsiveness to elderly patients' own values and preferences." K.E. Rosenfeld & N.S. Wenger, *Do-Not-Resuscitate Orders in the Elderly: Age Discrimination or Patient Preference?*, 157 ARCHIVES INTERNAL MED. 1041 (1997). This type of rationalization currently existing under a policy that allows withdrawal of life support reflects exactly the type of stigmatization the Court seeks to avoid by banning PAS. For evidence that the above rationalization is fallacious, see *supra* text accompanying note 102.

¹³¹ Kapp, *supra* note 120, at 331–32 (citing T.R. Fried et al., *The Association Between Age of Hospitalized Patients and the Delivery of Advanced Cardiac Life Support*, 11 J. GENERAL

"[a]dvanced age has been identified as an independent risk factor for discontinuation of [long term] dialysis" ¹³²

This "discrimination appears to be the most pronounced in the case of the 'oldest old.'" ¹³³ Often, "the oldest old patients are not offered aggressive care solely because of advanced age." ¹³⁴

E. The Disabled

There is also good reason to believe that, with regard to the disabled, "[t]he potential for abuse is actually greater in the case of withdrawal of life support" ¹³⁵ than in the case of PAS. As is the case for the poor and elderly, "[t]he potential for abuse is greater . . . because the person with the disability may not be conscious." ¹³⁶

When the patient is unconscious, often the court must enter into a best interests analysis to determine whether to discontinue life support. In many states, including New York, the "degree of disability and dependency" ¹³⁷ is factored into this calculation. As a result, "[i]f the decision-maker determines that life with severe mental disabilities is undesirable, or that being physically dependent is undesirable, nontreatment can be justified." ¹³⁸

When the patient is conscious, however, courts are no less reliant on factoring disability into their calculation of whether a request to have life support withdrawn should be granted. In *McKay v. Bergstedt*, ¹³⁹ the Nevada Supreme Court upheld a trial court's order granting the request of a quadriplegic patient to have his ventilator removed. "The court acknowledged that McKay was requesting the right to affirmatively hasten his death and that had McKay not been disabled, his liberty interest would not outweigh the state's interest" ¹⁴⁰

The court found that, "[i]f a competent adult is beset with an irreversible

INTERNAL MED. 257, 260 (1996)).

¹³² Kapp, *supra* note 120, at 332 (citing S. Neu & C.M. Kjellstrand, *Stopping Long Term Dialysis: An Empirical Study of Withdrawal of Life-Support Treatment*, 314 NEW ENG. J. MED. 14, 18 (1986)).

¹³³ Kapp, *supra* note 120, at 332.

¹³⁴ *Id.* at 332-33 (citing T.T. Perls & E.R. Wood, *Acute Care Costs of the Oldest Old*, 156 ARCHIVES INTERNAL MED. 754, 758 (1996)). As a result, "[i]n the acute hospital setting, less is spent per admission on persons over age 80 than on younger elderly patients." *Id.*

¹³⁵ Andrew I. Batavia, *The Relevance of Data on Physicians and Disability on the Right to Assisted Suicide*, 6 PSYCHOL. PUB. POL'Y & L. 546, 549 (2000).

¹³⁶ *Id.* at 549 n.12.

¹³⁷ Paredes, *supra* note 89, at 830 (citing *In re Beth Israel Med. Ctr.*, 519 N.Y.S.2d 511, 517 (N.Y. Gen. Term 1987)).

¹³⁸ Paredes, *supra* note 89, at 830. This standard "devalue[s] a person's life on the basis of mental disability or physical dependency." *Id.*

¹³⁹ 801 P.2d 617 (Nev. 1990).

¹⁴⁰ Paredes, *supra* note 89, at 826.

condition such as quadriplegia, where life must be sustained artificially and under circumstances of total dependence, the adult's attitude or motive may be presumed not to be suicidal."¹⁴¹ "In other words," according to the court, "the desire to die is entirely rational for a person with severe physical disabilities."¹⁴²

The stigma placed upon the disabled is even more evident in the court's discussion of maintaining the integrity of the medical profession. The court argued that the medical profession's integrity was not at stake because "nontreatment is *justified* when treatment 'will do little or nothing more than delay death in a bodily environment *essentially bereft of quality*.'"¹⁴³

Bergstedt reflects the general legal trend toward classifying the disabled as especially likely candidates for withdrawal of life support. "An examination into recent court cases . . . reveals a growing number of people with disabilities are 'qualify[ing]' for such elimination, on the basis that their lives lack meaning or quality."¹⁴⁴ This classification is further compounded by physician prejudice against the disabled.¹⁴⁵

IV. PREVENTING A SLIPPERY SLOPE TO VOLUNTARY AND INVOLUNTARY EUTHANASIA

A. Introduction

The Supreme Court found that "the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia."¹⁴⁶ Euthanasia occurs when a physician, rather than the patient, administers a lethal dosage of drugs to the patient. The Court felt that "[i]f suicide is protected as a matter of constitutional right, . . . 'every man and woman in the United States must enjoy it.'"¹⁴⁷ To support this opinion, the Court followed a few interconnected logical chains.

First, "the 'decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.'"¹⁴⁸ It would then follow, according to

¹⁴¹ *Bergstedt*, 801 P.2d at 627; see also Paredes, *supra* note 89, at 826. "McKay did not want to commit suicide; he merely wanted to be freed from his 'paralytic prison from which there was no hope of release other than death.'" *Id.* (quoting *Bergstedt*, 801 P.2d at 626).

¹⁴² Paredes, *supra* note 89, at 826.

¹⁴³ *Id.* (quoting *Bergstedt*, 801 P.2d at 628) (emphasis added).

¹⁴⁴ Paredes, *supra* note 89, at 822 (alteration in original).

¹⁴⁵ See *id.* at 831 ("Doctor recommendations are too often clouded by their own negative attitude toward disabled people.").

¹⁴⁶ *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997).

¹⁴⁷ *Id.* at 733 (quoting *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996)).

¹⁴⁸ *Glucksberg*, 521 U.S. at 733 (quoting *Compassion in Dying*, 49 F.3d at 832 n.120). If

the Court, that soon surrogates would be empowered to choose PAS for an incompetent patient. Second, "in some instances, the patient may be unable to self-administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them."¹⁴⁹ Alternatively, there is the risk "that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide."¹⁵⁰

This Section will argue that the Court's claim of an inevitable slippery slope from PAS to voluntary and involuntary euthanasia is internally inconsistent with the legal dichotomy drawn by the Court in *Vacco*. Also, it will be argued that the Court's citation of the Netherlands as an example of a country plagued by PAS abuses is invalid because Dutch policy is substantively distinct from the policy in existence in Oregon.

B. The Slippery Slope as a Legal Argument

To the extent these "slippery slope" arguments are strictly legal arguments, the Court's analysis fails. The easiest place to look for where legal distinction can be drawn is in the Court's own opinion in *Vacco*. According to the Court, the state interests it identifies are sufficient to justify a continuing ban on PAS while maintaining the legality of withdrawal of life support. If there is any justification for this distinction,¹⁵¹ there should be equally valid grounds upon which the Court can distinguish between PAS and euthanasia.

The first State interest identified by the Court is the "unqualified interest in the preservation of human life."¹⁵² As previously stated, however, according to the Court, this is not really an interest in preserving the sanctity of life because "suicide is no longer prohibited or penalized."¹⁵³ Instead, "the ban . . . shores up the notion

the Court were really concerned about the decisions of surrogates, it would be more concerned with the withdrawal of life support where surrogate decision making is prevalent.

¹⁴⁹ *Glucksberg*, 521 U.S. at 733 (quoting *Compassion in Dying*, 79 F.3d at 831).

¹⁵⁰ *Glucksberg*, 521 U.S. at 733 (paraphrasing *Compassion in Dying*, 79 F.3d at 831 n.140). Of course, the Court never addressed the probability that family members are more likely to assist in a family member's suicide when a physician is not allowed to assist. It also never addressed why family members would want to assist in suicides when a medical professional is legally allowed to hasten death. Consider the (admittedly weak) analogy to abortion. Is it more likely that family members (and indeed the pregnant woman herself) engaged in "self-help" *before* or *after* the Court found a Constitutionally protected right to abortion?

¹⁵¹ And, of course, if there is not, the Court's decision in *Vacco* is constitutionally invalid.

¹⁵² *Glucksberg*, 521 U.S. at 728 (quoting *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261, 282 (1990)).

¹⁵³ *Glucksberg*, 521 U.S. at 729. Of course, this could also force the Court to prohibit capital punishment. While some may view this as an inconsistency of the proposed limitation, it is in fact another potential critique of the Court's shifting view of the role of

of limits in human relationships.”¹⁵⁴ Really, then, the interest involves the State desiring to place limits upon the “harm” one individual can inflict upon another individual.

Based upon the Court’s analysis in *Vacco*, physicians should be limited from prescribing lethal drugs to their patients, but they should not be limited from withdrawing life support from a dependent patient. If this distinction were valid, there is no reason a further distinction between PAS and euthanasia could not also be valid. The Court could simply say that the notion that no person shall be allowed to actively and directly kill another person is a limit that must be placed on all human relationships.¹⁵⁵

The second state interest is the “interest in protecting the integrity and ethics of the medical profession.”¹⁵⁶ There are two key distinctions between the physician’s role in euthanasia and PAS. First, in PAS, the patient, rather than the physician, must administer the lethal medication. Second, because of the nature of prescriptions, the patient often does not take the lethal drugs until weeks or months after the physician prescribes them.

The Court and the American Medical Association have found that, when a physician withdraws life support from a patient, she is acting within the canons of medical ethics because it is the underlying natural causes that take the patient’s life.¹⁵⁷ At the same time, both bodies have found PAS unacceptable because it places physicians in the role of killers of their patients.¹⁵⁸

If such a distinction is valid, certainly the Court could find a physician who actively kills her patient through the administration of drugs implicates the integrity of the medical profession to a higher degree than the physician who merely prescribes these drugs. Both of these arguments appear suspect, but the important point is merely that this proposed distinction is no less plausible than the Court’s current line drawing. If neither of these arguments is compelling, the Court’s distinction between withdrawal of life support and PAS is invalid to begin with and should be overturned.¹⁵⁹

physicians in the dying process.

¹⁵⁴ *Id.*

¹⁵⁵ Because the patient self-administers the lethal drugs under PAS, the physician does not directly cause death.

¹⁵⁶ *Glucksberg*, 521 U.S. at 731.

¹⁵⁷ *Vacco v. Quill*, 521 U.S. 793, 801 (1997); AM. MED. ASS’N, CODE OF MEDICAL ETHICS § 2.20 (2002).

¹⁵⁸ *Vacco*, 521 U.S. at 801; AM. MED. ASS’N, CODE OF MEDICAL ETHICS § 2.211 (2002).

¹⁵⁹ Justice Souter argues in the alternative:

The case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation,

C. The Dutch Analogy

The Court further supports its slippery slope arguments through use of the Netherlands as an analogy. "The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia . . . , 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request."¹⁶⁰ Further, "the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent."¹⁶¹

The Court's analogy is fallacious in at least two essential regards. First, until recently (and when the above statistics were reported), "[i]n Holland, assisted suicide [was] officially illegal[] but [was] typically not prosecuted under certain specified circumstances."¹⁶² In contrast, "[i]n Oregon, assisted suicide is officially

noble or not.

Glucksberg, 521 U.S. at 785 (Souter, J., concurring).

First, it should be noted that this same risk applies with greater force to the withdrawal of life support. *See supra* Section II.D. Further, it would seem likely that there is more risk that such abuses would occur when there are not guidelines that allow a physician to assist a patient in taking his own life. When PAS is illegal, it is subject to more abuse because it is practiced in a clandestine manner, often by family members, and without safeguards. *See supra* notes 106–12 and accompanying text.

¹⁶⁰ *Glucksberg*, 521 U.S. at 734.

¹⁶¹ *Id.* It should be noted that this latter practice is closely akin to the 'double effect' utilized by many physicians in the United States. In fact, in *Glucksberg*, Justice O'Connor even recognized that "a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death." *Id.* at 736–37 (O'Connor, J., concurring).

In addition, the fact that euthanasia was administered in many cases without the patient's explicit consent is not dispositive of the issue of voluntariness. "[T]he absence of a contemporaneous request does not automatically mean that the patient's death is inconsistent with the patient's wishes." Orentlicher, *Implementation*, *supra* note 66, at 500. Often, "patients had expressed their desire for euthanasia but were no longer able to communicate at the time of their death. In these cases, euthanasia may well have been exactly what the patient wanted." *Id.*

In other cases, the patient had not made a request and was unconscious when the physician performed euthanasia. In these cases, either the physician or a family member used substituted judgment or a best-interests standard. Unless the Court is arguing that withdrawal of life support performed under similar standards in "involuntary," it cannot make a similar argument with regard to euthanasia.

¹⁶² Batavia, *supra* note 52, at 301; *see also* Maria Angel, *Euthanasia in the Netherlands — Good News or Bad?*, 335 NEW ENG. J. MED. 1676 (1996); Paul J. van der Mass et al., *Euthanasia, Physician-Assisted Suicide and Other Medical Practices Involving the End of Life in the Netherlands, 1990–1995*, 335 NEW ENG. J. MED. 1699 (1996); Gerrit van der Wal, *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 NEW ENG. J. MED. 1706 (1996).

legal under specified circumstances and is illegal under all other circumstances.”¹⁶³

If anything, the non-prosecution policy in the Netherlands is more closely analogous to current PAS policy in all of the other United States *besides* Oregon. In every other state, PAS is officially illegal, but no physician has ever been prosecuted for assisting in a suicide. In fact, Jack Kevorkian was acquitted numerous times for assisting in suicides before he was finally convicted for euthanizing a patient.¹⁶⁴ In contrast, Oregon has legalized PAS as long as the physician complies with certain safeguards and reporting requirements. Oregon’s Death With Dignity Act explicitly legalizes PAS and places it into the public sphere for regulation and observation. To compare this to a system where PAS was not officially legalized until recently is patently unfair.¹⁶⁵

Second, “[i]n Holland, the nonprosecution policy applies in certain cases of euthanasia, as well as assisted suicide.”¹⁶⁶ “In Oregon, euthanasia . . . is illegal in *all* cases and under *all* circumstances.”¹⁶⁷ The Court was concerned with a slippery slope to both voluntary and involuntary euthanasia. With regard to the former, “the fact that euthanasia occurs in a country that condones euthanasia tells us little about what will happen in another jurisdiction that does not condone such a practice.”¹⁶⁸

The fact that involuntary euthanasia is reported in the Netherlands also is largely irrelevant. When some form of euthanasia is legalized in a jurisdiction, it is much more likely that physicians will report when they participate in euthanasia.¹⁶⁹ It therefore follows that more cases of involuntary euthanasia will be reported in such a jurisdiction.¹⁷⁰

¹⁶³ Batavia, *supra* note 52, 301.

¹⁶⁴ See Liz Townsend, *Kevorkian's Nine-Year Euthanasia Crusade Leads to Murder Conviction*, NAT’L RIGHT TO LIFE NEWS, Apr. 8, 1999 (“Jack Kevorkian finally faces jail time for killing a desperate man . . . by lethal injection, administered directly by Kevorkian and nationally televised on *60 Minutes* . . .”). Kevorkian had previously undergone three trials, which ended in acquittal, one mistrial, and various court cases” without convictions.

¹⁶⁵ Now that the Netherlands has officially legalized PAS and euthanasia, it will be interesting to see how their statistics change. It is important that these statistics be analyzed in the proper light. Many may construe any reported abuses and involuntary deaths as evidence of the flaws of legalized PAS and euthanasia. However, the relevant consideration should be whether the number of reported abuses increases or decreases from the number that currently exist under the non-prosecution policy. The change should indicate whether explicit legalization or a passive non-prosecution policy leads to more non-voluntary deaths.

¹⁶⁶ Batavia, *supra* note 52, at 301.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ By contrast, when euthanasia is categorically prohibited, physicians are faced with the choice of not reporting versus reporting and facing prosecution for their participation.

¹⁷⁰ In a jurisdiction where euthanasia is illegal, any physician reporting participation in euthanasia would be subject to prosecution. In a jurisdiction where euthanasia is not illegal, however, there is no less reason for a physician to report her participation in euthanasia than there is for her to report participation in a hysterectomy or physical exam.

The number of *reported* cases of involuntary euthanasia, however, is irrelevant. “[T]he appropriate question is whether involuntary euthanasia occurs more frequently where there is a specific law that legalizes the practice under very specific guidelines or where there is a law totally prohibiting the practice”¹⁷¹ This is a question that simply cannot be answered by comparing reported numbers among jurisdictions where physicians have entirely different motivations for reporting (or not reporting) their participation.

The fact that abuses are reported in the Netherlands, however, is relevant for one purpose. According to opponents of PAS, the statistics in Oregon are inherently unreliable because “physicians who engage in such conduct obviously would not report it.”¹⁷² The fact that numerous reports of abuse do occur in the Netherlands suggests one of two conclusions.

First, when abuses occur, they are reported, and the absence of such reports in Oregon makes it likely such abuses are not occurring. Second, because the PAS and euthanasia policies in the Netherlands are so different from the Death With Dignity Act, physicians are more likely to report abuses in the Netherlands. This means that either the analogy is invalid or that it is valid but reveals that Oregon does not suffer from a slippery slope.¹⁷³

However, even if there were the slightest risk of such a slippery slope, it would apply with at least equal force to the current right to withdrawal of life support. Arguably, “all of the ‘slippery slope’ arguments made for prohibiting assisted suicide are also arguments for prohibiting the withdrawal of life-sustaining treatment.”¹⁷⁴ In actuality, the possibility of a slippery slope is much more likely with withdrawal of life support than with legalized PAS.

Withdrawal of life support is much more akin to the involuntary euthanasia performed in the Netherlands for a few reasons. “Most importantly,” as with many cases involving withdrawal of life support, “most of the abuse in the Netherlands involves euthanasia of persons who lack decision-making capacity at the time euthanasia is performed.”¹⁷⁵ Under Oregon’s Death with Dignity Act and by definition,¹⁷⁶ an individual choosing PAS must be “capable” and must have “voluntarily expressed his or her wish to die.”¹⁷⁷

The abuses of euthanasia in the Netherlands, then “demonstrate . . . the risks of

¹⁷¹ Batavia, *supra* note 52, at 301.

¹⁷² *Id.* at 295 (citing Margot White & Daniel Callahan, *Oregon’s First Year: The Medicalization of Control*, 6 PSYCHOL. PUB. POL’Y & L. 331–41 (2000)).

¹⁷³ Because the reporting in the Netherlands was anonymous, it is likely the latter conclusion is correct, further weakening the Court’s analogy.

¹⁷⁴ Orentlicher, *Implementation*, *supra* note 66, at 493.

¹⁷⁵ Orentlicher, *Legalization*, *supra* note 27, at 461–62.

¹⁷⁶ Under PAS, the patient must be the one self-administering the drugs. In order to ingest the drugs, the patient must have a minimum of mental capacity.

¹⁷⁷ OR. REV. STAT. § 127.805 (2001).

permitting euthanasia — not assisted suicide. With a right to assisted suicide, the patient must perform the life-ending act; accordingly, persons lacking decision-making capacity would not have their lives ended by others inappropriately.”¹⁷⁸

This risk of lives ending inappropriately does exist to a substantial degree with the withdrawal of life support. Factors pushing relatives’ and physicians’ hands can include financial strain, limited resources, and under- or over-estimation of the patient’s quality of life. Potentially, “[l]ife-sustaining treatment might [even] be withdrawn from incompetent patients . . . on the basis of decisions by family members who are driven by their self-interest rather than by the wishes of the patient.”¹⁷⁹

In addition, “[s]tudies have consistently shown that physicians do not comport with ethical principles when implementing treatment withdrawals.”¹⁸⁰ In one “study of living wills, physicians overrode a patient’s treatment preference twenty-five percent of the time, and, in three-quarters of those overrides, the physician withheld treatment desired by the patient.”¹⁸¹ Again, “[w]ith a right to assisted suicide, the patient must perform the life ending act; accordingly, persons lacking decision-making capacity would not have their lives ended by others inappropriately.”¹⁸²

CONCLUSION

There is no evidence that PAS poses a more substantial threat than withdrawal of life to the state interests identified by the Court in *Vacco v. Quill*. In fact, because patients are often incompetent when they are on life support, the probability that the wishes of these patients will not be honored is higher even than that of competent patients choosing PAS.

As a result, surrogates must decide whether the patient’s life is worth living under withdrawal of life support, and thus the state’s interest in the sanctity of life is threatened. Because these decisions also frequently involve disabilities, the age of the patient, and limited resources, vulnerable groups face a potentially higher degree of exploitation. To the extent the abuses plaguing the Netherlands surround incompetent patients, the risk of a slippery slope is more pronounced when withdrawal of life support is legalized.

The only cognizable argument that applies with equal force against PAS is that

¹⁷⁸ Orentlicher, *Legalization*, *supra* note 27, at 462. “Because assisted suicide is performed by a competent patient, and life-sustaining treatment can be withdrawn from incompetent patients, it is quite possible that it is less susceptible to abuse than treatment withdrawal.” Orentlicher, *Implementation*, *supra* note 66, at 493 n.23.

¹⁷⁹ *Id.* at 493.

¹⁸⁰ Orentlicher, *Legalization*, *supra* note 27, at 461.

¹⁸¹ *Id.*; see also Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882, 884–85 (1991).

¹⁸² Orentlicher, *Legalization*, *supra* note 27, at 462.

its legalization would harm the integrity of the medical profession. However, physicians are no longer viewed solely as healers, and the principle of double effect, which can be unilateral, poses greater dangers to the physician-patient relationship than does PAS.

The Court was correct in one sense: Patients seeking withdrawal of life support and those seeking PAS are not similarly situated. Unfortunately, the Court erred in determining withdrawal of life support is the more benign of the two procedures. Instead, patients (or their surrogates) requesting that withdrawal of life support require much more external participation than do patients merely asking for a prescription they will self-administer. Because these former patients require surrogates or a court to make the decision and physicians to withdraw life support and often administer lethal drugs, there are several potential areas of abuse. Because the patient maintains control at all stages of PAS, the potential for abuse is substantially lower, and the Court's dichotomy fails to serve any legitimate ends.

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