TINKERING WITH THE LEGAL STATUS QUO ON PHYSICIAN ASSISTED SUICIDE: A MINIMALIST APPROACH

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I. INTRODUCTION

You believe in humanity, greatness and love,
You can't ask for anything more!
But in me, life has stopped…
I cannot go any further.
This terrible loneliness!...
One grows tired of both good and evil,
The whole world becomes boring.
Even heaven bores you
And you feel your soul die within you.
I don't want it anymore!
Here, take it![1]

In Leos Janacek's 1926 opera The Makropulos Case (setting a play by Karel Capek of the same name), Elina Makropulos, a mysterious woman who has lived for 330 years thanks to an elixir given to her by her father, finally gives up her quest to recover the formula and gain another 300 years, choosing death when she realizes that her life long ago lost what makes it recognizably human and thus worth living. Almost a century later, while the geometric progress of medical science has not yet matched the Makropulos elixir's ability to extend life, it has managed to make it possible for human life to be maintained in the face of debility that only a short time ago would have ended it. The prospect of being forced to live in pain and indignity, when life has lost its meaning, has led many to wish that they, like Elina Makropulos, had the ability to decide when death was preferable to life. Unlike Elina, whose ex-

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1. LEOS JANACEK, THE MAKROPULOS CASE, Act III (text taken from the English subtitles accompanying the DVD recording of the Salzburg Festival production (C Major Entertainment GmbH, Berlin 2012)).

istence ceased when the elixir's formula was burned, real patients in circumstances that would cause them to wish for death often need the assistance of others and the intervention of medicine to bring about the desired end.

Thus the movement to legalize physician-assisted suicide ("PAS") was born.[2] However, that movement soon encountered legal systems that were products of times in which a quick death was far more likely than a protracted and painful dying process, and which were shaped directly by religious views that saw any suicide as sinful and harmful to the patient's chances for eternal life in the hereafter. Calls for recognizing a legal right based on one or another founding document or fundamental doctrine ensued, and have been dealt with in varying ways by courts and legislatures throughout the developed world. Although the United States Supreme Court has found that there is not a generalized constitutional right to PAS,[3] and there has not been a snowballing of sentiment for recognition of a right to PAS,[4] polling data and the periodic commencement of both state legislative efforts and litigation indicate that the issue is still remarkably salient in the public mind.[5] In addition, both the fragmentation of the *Glucksberg* Court's plurality and concurring opinions and the more recent case of *Lawrence v. Texas*[6] have raised doubts about whether the Su-

2. In this paper, "PAS" refers to situations in which an affirmative act by a physician, made at the request of the patient or her surrogate, and constituting something other than the withholding or withdrawal of medical treatment, is required to bring about the patient's death, whether or not another intervening act by the patient or another person is required to bring about that death (e.g. ingesting pills prescribed by the physician).

3. Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

4. Since *Glucksberg*, only the U.S. states of Oregon, Washington and Montana have recognized or created a right to PAS under state law. In Europe, only the Netherlands, Switzerland, Luxembourg and Belgium have done so.

5. *See, e.g.*, Assemb. 3328, 2012 Leg., 215th Sess. (N.J. 2012); *see also* Nancy Reardon Stewart, *Stoughton Rep Re-Files Right-to-Die Legislation*, PATRIOTLEDGER.COM (Mar. 16, 2001, 6:00 AM), http://www.patriotledger.com/news/x32326775/Stoughton-rep-re-files-right-to-die-legislation; *Strong Public Support for Right to Die*, PEW RES. CTR. (Jan. 5, 2006), http://www.people-press.org/2006/01/05/strong-public-support-for-right-to-die/; Susie Steimle, *Debate over Right to Die Returns to Vermont Statehouse*, WCAX.COM (Mar. 13, 2013, 3:39 PM), http://www.wcax.com/story/17149142/debate-over-the-right-to-die-returns-to-vt-statehouse.

6. 539 U.S. 558 (2003).

preme Court has not moved in the intervening years to a more favorable view of end-of-life rights, including PAS.[7]

This paper takes the position that, while there may well be a cognizable *moral* right to PAS, recognition of a fundamental *legal* right to PAS is unwise because such recognition would itself create moral problems not now present in end-of-life scenarios. In doing so, I also review evidence that indicates that, under present practice in at least U.S. states in which it remains legally proscribed, PAS is available to patients in need of it, and I argue that this imperfect *status quo* is preferable to the various means of creating a legal right. I note, however, that the *status quo* has the undesirable effect of putting compassionate physicians at legal risk for providing PAS in cases in which it is morally acceptable, and therefore consider a number of ways in which that exposure has been or could be limited without going so far as to recognize a right to PAS.

II. THE ETHICAL CASE AGAINST PAS, AND THE STATUS OF U.S. LAW REFLECTING IT

A. The Moral Landscape

The ethical case for legalizing PAS has long rested on two foundational pillars: 1) that there are a number of patients who, either because they are suffering intractable pain from a terminal illness for which there is no hope of recovery or because they find the helplessness and dependence incident to modern medical care at the end of life an affront to their conception of personhood, have made a competent and informed decision that death is preferable to continued life; and 2) that the ethical precept valuing individual autonomy compels us to prioritize, for such patients, this choice over the potentially competing interests of the state, society or other persons.[8] As a starting point for this discussion, I recognize that whatever the objections to one or another of these bases, there

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7. *See infra* pp. 11-13; Yale Kamisar, *Can Glucksberg Survive Lawrence? Another Look at the End of Life and Personal Autonomy*, 24 ISSUES L. & MED. 95 (2008).

8. *See* J. David Velleman, *Against the Right to Die*, 17 J. MED. & PHIL. 665, 666 (1992). *See generally* TOM L. BEAUCHAMP & ROBERT M. VEATCH, ETHICAL ISSUES IN DEATH AND DYING (2d ed. 1996).

exists a class of patients for whom in ethical terms PAS should be available, however limited its number may be.[9]

Nevertheless, does the acknowledgement that some circumstances compel recognition of a moral right necessarily lead to the need to create a legal right? Put another way, is the creation of a legal right the best way to implement the moral right acknowledged above, or would it be a case of the cure being worse than the disease?

A number of commentators have offered persuasive arguments that in fact the cure *would* be worse than the disease. Among the most eloquent of these have been Yale Kamisar and Ezekiel Emanuel from the standpoints of law and public policy, and J. David Velleman from the standpoint of moral philosophy.[10] Kamisar, in a 1997 lecture,[11] places opponents of PAS into three camps: those who believe PAS is inherently immoral, those who object to it on the basis that it calls upon physicians to do the killing, and those who recognize that although it may occasionally be a positive good its legalization would have overriding negative social consequences.[12] He focuses his analysis on the arguments of the third group, identifying concerns that the safeguards against abuse in any statutory or judge-made regime permitting PAS are inherently difficult to implement in a complex U.S. medical system across the broad spectrum of patients, with varying types of insurance, covering various types of medical services, at various levels of completeness.[13]

In an article published more than a decade later, a decade in which actual experience with legalized PAS in Oregon and Washington gave us real data on PAS in practice under a regime of strong regulation, Kamisar identifies a number of ongoing objections to the claimed right.[14] From a strictly legal perspective it is

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9. For a compelling argument for the moral basis of a right to PAS, *see* Timothy Quill & Robert Brody, *You Promised Me I Wouldn't Die Like This!*, 155 ARCH. INTERN. MED. 1250 (1995).

10. *See generally* Velleman, *supra* note 8.

11. Yale Kamisar, *Physician Assisted Suicide: The Problems Presented By The Compelling, Heartwrenching Case*, 88 J. CRIM. L. & CRIMINOLOGY 1121 (1998) [hereinafter *Kamisar Lecture*] (from the October 25, 1997 Pope & John Lecture on Professionalism at Northwestern School of Law).

12. *Id.* at 1122

13. *Id.* at 1130-32. Fifteen years later, this problem has, if anything, become more acute, and will likely remain so even if the Supreme Court upholds the system reforms contained in the Affordable Care Act.

14. *See generally* Kamisar, *supra* note 7. In this sense, he is speaking of the right as implemented in the Oregon statute, which limits PAS to patients deter-

difficult, he points out, to cabin a right to PAS in two critical areas: its limitation to the terminally ill (what about patients who are desperately ill but not now actively dying – is it just to require them to suffer intractable pain and loss of dignity for an even longer time than those who are actively dying?); and its limitation to suicide enacted by the patient himself (why should patients who otherwise qualify but are unable to self-administer the lethal agent be denied relief?).[15]

Emanuel, also writing in 1997, focuses on the consequences of routinizing PAS and the likelihood that the resultant increasing comfort level with it would lead to an ever-widening expansion of the circumstances in which we would offer it.[16]

David Velleman's thinking on the moral problems posed by the creation of a legal right, especially when coupled with the psychological and public policy work of Barry Schwartz,[17] Richard Thaler and Cass Sunstein,[18] provides an explanatory framework for Kamisar's and Emanuel's concerns. Velleman, drawing from both negotiation theory and philosophy, points out a number of circumstances in which *not* having an option actually provides a benefit. A union labor negotiator may prefer not to have the authority to settle a contract for a pay cut, in order to make a strike option more threatening. A night cashier at a convenience store prefers not to have the option of opening the safe. I may prefer that you not invite me to a dinner party, because although I would rather not attend, I don't want to offend you by declining your invitation.[19]

Moreover, having options can be undesirable simply because they prevent their possessor from simply having the *status quo ante* by default. Once I have the choice to select the *status quo* or an alternative, the only way I can have the *status quo* is by making an active choice to have it. Thus, giving me the choice has also deprived me of something – the ability to enjoy the *status quo* without having to reject any other alternative – and that some-

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mined to have six months or less to live and limits physician involvement to writing a prescription for a lethal dose of oral medication to be administered by the patient himself or with the help of others who do not include the physician.

15. *Id.* at 112-16.

16. Ezekiel J. Emanuel, *Whose Right to Die?*, THE ATLANTIC (Mar. 1997), http://www.theatlantic.com/magazine/archive/1997/03/whose-right-to-die/4641/5/.

17. BARRY SCHWARTZ, THE PARADOX OF CHOICE: WHY MORE IS LESS (2004).

18. RICHARD THALER & CASS SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH AND HAPPINESS (Kindle ed. 2008).

19. Velleman, *supra* note 8, at 671-72.

thing may be of value to me. "Having choices can thus deprive one of desirable outcomes whose desirability depends on their being unchosen."[20]

Thus, in the context of PAS, Velleman argues that creating a right to die requires a choice about whether to exercise the right or not, removing the ability to stay alive by default.[21] And losing that ability requires the person at the end of life to justify the choice she has made, even if that justification has to be made only to herself.

> [I]f people ever come to regard you as existing by choice, they may expect you to justify your continued existence… Forcing a patient to take responsibility for his continued existence may therefore be tantamount to confronting with the following prospect: unless he can explain, to the satisfaction of others, why he chooses to exist, his only remaining reason for existence may vanish.[22]

In the real world of end-of-life medical care, it can be seen that this "forcing" need not amount to the exercise of what lawyers call undue influence by others. Now that the choice of PAS is on the table, even in the absence of any expression of preference by family members or others, the patient herself will have to make assumptions and predictions about what she feels and thinks. And the fact that the choice for PAS has indeed already been made by others similarly situated will weigh in the balance, as it becomes evidence that at least some people view this patient's life as one not worth living.

Particularly in our culture, the existence of rights seems to argue for their exercise – we are distinguished by our palette of legally protected rights; they have become part of what it means to be an American: what is the purpose, then, of not exercising them? As Velleman notes:

> Establishing a right to die in our culture may thus be like establishing a right to duel in a culture obsessed with personal honor. If someone defended the right to duel by arguing that a duel is a private transaction between consenting adults, he would have missed the point of laws against dueling. What makes it rational for someone to throw down or pick up a gauntlet may be the social costs of choosing not to, costs that result from failing to duel

20. *Id.* at 672.
21. *Id.* at 673.
22. *Id.* at 674-75.

> only if one fails to duel by choice. Such costs disappear if the choice of dueling can be removed. By eliminating the option of dueling…we eliminate the reasons that make it rational for people to duel in most cases. [23]

That the creation of choices can have adverse psychological effects, as well as determinative effects on the choices that people make, is amply demonstrated in a variety of empirical contexts. Schwartz cites work that correlates a cultural emphasis on autonomy and control, including the maximization of choice, with rates of depression.[24] Thaler and Sunstein demonstrate that an extensive catalogue of normal human perceptual fallibilities can have more powerful effects than personal values, beliefs, and other factors we might prefer to govern choice-making by providing subtle, often imperceptible "nudges" toward one choice or another.[25] These nudges contribute to a "choice architecture" that can be designed to increase the likelihood that someone choosing without coercion will select one of an available range of choices.

The point here is not that creating a right to PAS is likely to lead to a nefarious system of coercion through "death panels" or anything else. It is simply to point out that the addition of any new choice can have negative psychological impacts on the chooser, and is likely to be presented or perceived (intentionally or not) in ways that load the deck in favor of one or another result. The creation of new rights establishes new choices, and when the new choice is whether or not to bring about one's own death, or to assist a patient who wishes to do so, these factors take on a special weight and significance.

Unfortunately, available empirical evidence from the experiences with the regulatory regimes in Oregon and the Netherlands lend credence to these concerns. In Oregon, the legislature chose not to require intolerable suffering as a precondition for receiving PAS, requiring only a confirmed diagnosis of terminal illness with a prognosis of less than six months to live as threshold conditions.[26] Herbert Hendin and Kathleen Foley, two physicians who

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23. *Id.* at 676.

24. SCHWARTZ, *supra* note 17, at 212-17.

25. *See generally* THALER & SUNSTEIN, *supra* note 18.

26. It is important to note in this regard that polling data indicates that levels of public support for PAS seem to rely in large part on the notion of relief from intolerable pain. Ezekiel J. Emanuel, *Euthanasia and Physician-Assisted Suicide: A Review of the Empirical Data from the United States*, 162 ARCHIVES INTERN. MED. 142, 145 (2002). Conversely, the Dutch statute has such a re-

have written critically of the Oregon law and its implementation, point out in a ten year retrospective on the law that this setting of the threshold condition "enables physicians to assist in suicide without inquiring into the source of the medical, psychological, social, and existential concerns that usually underlie requests for assisted suicide, even though this type of inquiry produces the kind of discussion that often leads to relief for patients and makes assisted suicide seem unnecessary."[27] In addition, they point to circumstances in which organizations seeking to assist patients to access PAS help them find physicians who will grant their request even when the patients' treating physician or other consulting physicians have refused it,[28] and to the appearance of physicians who seem to specialize in qualifying patients for PAS and providing that service.[29]

The history of Holland's experience with PAS underscores these slippery slope concerns. There, the initial legalization of PAS for patients suffering from intense physical pain has expanded over the course of twenty years to acceptance of requested euthanasia for such patients, to euthanasia requested by incompetent patients' surrogates, to euthanasia for severe mental distress, to proposals for euthanasia of handicapped infants.[30]

These slopes are formed, and made all the more slippery, by the convergence of four characteristics of our culture: 1) a tendency to articulate social goods in terms of rights; 2) a system that implements rights casuistically; 3) an inclination to view any right as tending to the universal and the exercise of rights to be preferred over non-exercise; and 4) an ethical culture that prioritizes indi-

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quirement. Termination of Life on Request and Assisted Suicide Act, *as reprinted in* MARSHA GARRISON & CARL SCHNEIDER, THE LAW OF BIOETHICS: INDIVIDUAL AUTONOMY AND SOCIAL REGULATION (2d ed. 2009).

27. Herbert Hendin & Kathleen Foley, *Physician-Assisted Suicide in Oregon: A Medical Perspective*, 106 MICH. L. REV. 1613, 1615 (2008).

28. *Id*. at 1629-34.

29. *Id.* at 1617-18.

30. *See generally* Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427 (1996). *See also* Tony Sheldon, *Dutch GP Cleared After Helping to End Man's 'Hopeless Existence*,' 321 BRIT. MED. J. 1174 (2000) (reporting on the acquittal of a physician who provided PAS to an eighty-six-year-old man who had no serious physical or psychiatric diagnosis but who reported unbearable suffering because of his age-normal physical decline and "hopeless existence"). The Dutch experience demonstrates how even what initially appears as a correction for the deficiencies of another regime (i.e. Oregon's lack of a requirement that intractable suffering be a prerequisite for PAS) creates its own irresolvable problems in practice.

vidual autonomy over competing moral considerations. An enunciated right to PAS must be limited by statute, regulation or judicial decision to a particular set of circumstances that places some patients within its guarantees and others outside them. As a result, those operating within an implementation regime will focus on classifying patients according to their qualifications under the relevant controlling authority, tending inevitably toward a "checklist" approach that discourages the kind of compassionate partnership and dialogue considered critical to the physician-patient relationship. Patients placed outside the scope of the right, and their advocates, will raise arguments as to why they should be included. A legal system that proceeds casuistically will find reasons that some previously unforeseen circumstances are reached by earlier precedent, extending the boundaries of the permissible. The fact that a competent individual patient urgently desires PAS will trump the reluctance of others to agree.[31] And the very articulation of PAS as a right will shift conversations (both external and internal) at the end of life toward the need to justify continuing to live.

B. PAS in the U.S. Courts

The friction between our popular concept of autonomy and our historical resistance to condoning any suicide has led U.S. courts to struggle with PAS. Both *Glucksberg* and *Vacco* reversed carefully reasoned and eloquently articulated Circuit Court decisions.

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31. As a general matter, the emphasis on patient autonomy has assumed primary importance in American bioethics. *See* TOM BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS, 101 (6th ed. 2008). But it is a cramped and result-oriented concept of autonomy, making it little more than a synonym for "control," that is used to justify a broad right to PAS. Although a thorough examination of the philosophical problems with the popular understanding of autonomy in medical ethics is beyond the scope of this paper, it is worth noting that Velleman's, Thaler and Sunstein's, and Schwartz's work, discussed *supra*, poses the very real possibility that "choice" and "autonomy" can be related in a *Heisenbergian* way, in which the very injection of a choice actually reduces the autonomous nature of the act of choosing. Even farther beyond the scope of this paper, but worth posing in passing, is whether the reduction of the concept of autonomy to that of maximizing control over life's circumstances is ethically appropriate. *See* John Garvey, *Control Freaks*, 47 DRAKE L. REV. 1, 7-8 (1998). For a cogent argument that an autonomy analysis is irrelevant to end-of-life scenarios, *see* Kate Greasley, *R(Purdy) v DPP and the Case for Wilful Blindness*, 30 OXFORD J. LEGAL STUD., 301, 316 (2010) (explaining that the exercise of autonomy requires a range of good options, where death is the only option autonomy cannot exist).

Glucksberg taken as whole, as Kamisar has pointed out, is a confusing welter of concurring opinions that seem to analyze the issue very differently and point to differing conceptions of what in the realm of end-of-life medical care may be entitled to substantive due process protection.[32] For example, Chief Justice Rehnquist's opinion for the Court appeared to be holding "that a state could, consistent with the Fourteenth Amendment, reject a 'sliding-scale approach' to protecting lives, whereby the 'weight' of the state's interest 'depends on the medical condition and the wishes of the person whose life is at stake.'"[33] But Justice O'Connor's concurring opinion (and critical fifth vote) joined Rehnquist on the basis of another articulation of the issue found elsewhere in the Court's opinion, that "there is no *generalized* right to commit suicide."[34] Justice O'Connor explicitly declined to reach the issue of "whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death."[35]

More telling, perhaps, was the short shrift given by the Court in *Glucksberg* to the famous language in *Planned Parenthood v. Casey*[36] providing constitutional protection to "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy…[because] [a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."[37] This fulsome articulation of the primacy of autonomy was subsequently reaffirmed in *Lawrence v. Texas*,[38] a case that struck down Texas' anti-sodomy statute on the grounds that private consensual sexual conduct falls within the fundamental liberty interest protected by the Fourteenth Amendment. The *Lawrence* Court quoted the *Casey* language with approval, saying that it shows "the respect the

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32. Kamisar, *supra* note 7, at 101-03.

33. *Id.* at 103 (quoting *Glucksberg*, 521 U.S. at 729).

34. *Id.* (quoting *Glucksberg*, 521 U.S. at 736) (O'Connor, J., concurring) (emphasis added).

35. *Id.*

36. 505 U.S. 833 (1992).

37. *Id.* at 851, *quoted in Kamisar Lecture*, *supra* note 11, at 99. The *Glucksberg* opinion noted "[t]hat many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, and Casey did not suggest otherwise." *Glucksberg*, 521 U.S. at 727-28 (citations omitted).

38. 539 U.S. 558 (2003).

Constitution demands for the autonomy of the person in making …choices [that include] personal decisions relating to marriage, procreation, … [and] family relationships…"[39]

Kamisar poses the question "is not controlling the time and manner of one's own death the most evident way – the most profound way – to 'define one's own concept of existence, of meaning, of the universe, and the mystery of human life'?"[40] The author then speculates that *Glucksberg* may not long remain good law good law after *Lawrence*. And although he believes that the answer to the question ultimately is "no" and that *Glucksberg* survives, other commentators differ.[41] In any event it is likely that the courts will continue to wrestle with this issue, and that the periods of lull in the attention to a proposed right to PAS do not indicate that the issue has been resolved either in the law or in public opinion.

C. PAS in Medical Practice

While that struggle goes on, what is happening in the clinic? Patients continue to die, and physicians continue to be faced with wrenching choices regarding their duties to both relieve suffering and do no harm. Has the prevailing legal model criminalizing PAS prevented patients from receiving assistance in dying when that is the only means of relieving their suffering? The evidence points to the conclusion that it has not. A 2002 article by Emanuel cites studies showing that while PAS (and euthanasia) occur in a very small proportion of all deaths, and that a similarly small percentage of surveyed physicians report having performed PAS or euthanasia, it is performed and likely under-reported.[42] An early small survey in Washington reported in 1996 found that physicians assisted with suicide requests in twenty-four percent of cases.[43]A larger national survey in 1996 reported that eleven percent of responding physicians in ten specialties selected for their likelihood to receive PAS or euthanasia requests reported that, even under then-existing legal constraints, they were willing to hasten a pa-

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39. *Id.* at 574, *quoted in Kamisar Lecture*, *supra* note 11, at 100.

40. *Kamisar Lecture*, *supra* note 11, at 100.

41. *See e.g.,* Diana Hassel, *Sex and Death: Lawrence's Liberty and Physician-Assisted Suicide*, 9 U.PA. J. CONST. L. 1003 (2007).

42. Emanuel, *supra* note 26.

43. Anthony Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 12 (1996).

tient's death under some circumstances.[44] Sixteen percent of responding physicians who had received a request for PAS reported that they had written at least one prescription to be used to hasten death.[45]

Although the data are variable, it seems evident that PAS is regularly provided, and in light of the remaining legal and social objections to its use it is reasonable to assume that it is provided more frequently than even these data suggest. Yet, despite the explicit legal prohibition of this practice in most jurisdictions, prosecutions of treating physicians for helping patients hasten death are almost non-existent. In 1996, Judge Reinhardt, writing for the majority on the Ninth Circuit in *Compassion in Dying v. Washington*, noted that "[t]here is no reported case of criminal punishment being meted out to a doctor for helping a patient hasten his own death."[46]

Thus, it can be argued that, in its own imperfect and even unintended way, our legal system has found a sort of working balance with the issues surrounding PAS – keep it illegal to honor the state's interest in preserving life, but allow it to be performed in cases where there is likely moral consensus that it is warranted. This balance seems to have worked relatively well for quite a long time, and an argument can be made that we tinker with it at our peril. However, one distinct problem created by the current "underground" status of PAS is that it disproportionately distributes the risk of legal sanction to the physician acceding to a request for PAS.[47] The balance of this paper, then, explores a number of ways

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44. Diane Meier et al., *A National Survey of Physician-Assisted Suicide and Euthanasia in the United States*, 338 NEW ENG. J. ON MED. 1193, 1195 (1998).

45. *Id.* at 1196.

46. 79 F.3d 790 (9th Cir. 1996), *reprinted in* GARRISON & SCHNEIDER, *supra* note 26, at 385. I have found only one such case reported since then, with the exception of the well-known Kevorkian prosecutions, which are distinguishable on the basis of the fact that Dr. Kevorkian was not a treating physician of his "patients," if not for the actual ghoulishness of his behavior. *See People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994); *People v. Kevorkian*, 639 N.W.2d 291 (Mich. Ct. App. 2001). Cases upholding professional sanctions against PAS-providing physicians are also exceedingly rare but do exist. *See, e.g.*, *Gallant v. Bd. of Med. Exam'rs*, 974 P. 2d 814 (Or. Ct. App. 1999) (primary treating physician prescribed over the telephone, at request of patient's family, a drug that would stop dying, unconscious seventy-eight-year-old patient's respiration without providing any palliative effect; court upheld Board of Medical Examiners' finding of unprofessional conduct).

47. *Gallant* is a good example. There, the defendant physician resisted the family's request to do more after deactivating the patient's pacemaker failed to cause death. *Id.* at 815. A nurse then suggested use of the paralytic drug, which

in which reforms might be instituted that relieve this disproportionate distribution of risk without going so far as to establish a right to PAS.

III. REDISTRIBUTING OR ELIMINATING THE RISK TO PHYSICIAN PROVIDERS OF PAS

A. Structuring Prosecutorial Discretion: The Experience in the United Kingdom

Three recent cases in the U.K. have resulted in a substantial change to that country's approach to the criminal procedure incident to prosecuting violations of the U.K.'s anti-assisted suicide statute.[48] In *Pretty v. DPP*,[49] the plaintiff, Diane Pretty, suffered from a motor neuron disease[50] that was causing her to become progressively debilitated. She contemplated traveling to Switzerland, where PAS is legal, to use the services of a private organization that facilitated PAS. Unable to travel without assistance, she sought assurance from the Director of Public Prosecutions ("DPP")[51] that her husband would not be prosecuted under England's anti-assisted suicide law if he accompanied her to Switzerland for the purpose of obtaining PAS. The DPP refused to provide such an assurance, and Pretty sued first in the House of Lords and, after the Lords rejected her argument, in the European Court of Human Rights[52] claiming *inter alia* that the English law violated Article 8 of the European Convention on Human Rights, which guarantees

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the defendant also initially resisted because he had never used it before "in that way." *Id.* The nurse insisted that it had been used before to hasten death, and the defendant then prescribed the drug, directing the nurse to consult with the emergency room physician regarding the dose. *Id.* The defendant was the only provider called to account. *Id.* at 816.

48. Suicide Act, 1961, 9 & 10 Eliz. 2, c. 60, §§ 1-2 (Eng.).

49. Pretty v. DPP, [2001] UKHL 61, [2002] 1 A.C. 800 (H.L.) (appeal taken from Eng.).

50. A degenerative, progressive and incurable illness, probably *Amyotrophic Lateral Sclerosis* (also known as Lou Gehrig's Disease).

51. The DPP is the administrator of the Crown Prosecution Service, a national office that prosecutes cases investigated by the police in England and Wales. *See The Crown Prosecution Service*, CPS, http://cps.gov.uk (last visited May 8, 2013).

52. Pretty v. United Kingdom, 35 H.R. Rep. 1 (2002), *available at* http://cmiskp.echr.coe.int/tkp197/view.asp?action=html&documentId=698325&portal=hbkm&source=externalbydocnumber&table=F69A27FD8FB86142BF01C1166DEA398649. Ms. Pretty died of her disease shortly after the decision was handed down.

the right to respect for private and family life.[53] Where the Lords held that Article 8 was not engaged by the dispute because its guarantees of private and family life did not extend to a right to control one's own death, the European Court held that Article 8 was in fact engaged, but that the Article's allowance of infringements on its enunciated rights that protected legitimate interests of the state doomed Pretty's case because the English law helped insure against exploitation of vulnerable dying patients.

Six years later, a twenty-three-year-old former championship rugby player named Daniel James, who had been paralyzed in an injury sustained in rugby practice, traveled to Switzerland with the help of his parents and a friend to receive PAS at the same organization. The case received extensive publicity in the British press. The DPP determined it was not in the public interest to prosecute James's parents and issued an extensive statement giving the reasons for his decision, which included that James was competent and that his parents had actively discouraged him from resorting to PAS.[54]

Around the time the James matter was being addressed by the DPP, the case of Debbie Purdy came to attention. Ms. Purdy suffered from multiple sclerosis, another progressive degenerative disease with no cure. She feared that she would reach the point where her life was intolerable, and that at that point she would want PAS but would be unable to travel to Switzerland to obtain it. She therefore applied to the High Court for an order that would require the DPP to issue guidance to clarify his policy on prosecuting cases under the assisted suicide law so that Purdy's husband could determine his exposure should he help her travel to Switzerland to receive PAS. The High Court declined to issue the order, and Purdy appealed to the Court of Appeal, which upheld the court below.[55] Purdy then appealed to the House of Lords.

The Lords reversed, holding unanimously that the DPP had a duty to clarify his policy on prosecution of violations of the anti-assisted suicide law, and to disclose the factors that would be tak-

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53. European Convention on Human Rights, Nov. 4, 1050, 213 U.N.T.S. 221, *available at* http://www.echr.coe.int/NR/rdonlyres/D5CC24A7-DC13-4318-B457-5C9014916D7A/0/CONVENTION_ENG_WEB.pdf.

54. *Decision on Prosecution: The Death by Suicide of Daniel James*, CPS (Sept. 12. 2008), http://www.cps.gov.uk/news/articles/death_by_suicide_of_daniel_james/.

55. Purdy v. DPP, [2009] EWCA Civ 92 (Eng.).

en into account to argue for or against prosecution.[56] The Lords focused on what they found to be the inadequacy of the existing Code for Crown Prosecutors, a statement of general principles for prosecutors in exercising their discretion to pursue cases, to address the particulars of assisted suicide cases involving so-called "suicide tourism." The Lords did not hold that there was anything objectionable in the substantive law prohibiting assistance in suicide; they pointed instead to the James decision's admission that the Code for Crown Prosecutors could not fully explain the decision not to prosecute in that case. The DPP published an interim policy for comment shortly thereafter,[57] followed in February 2010 by its final policy.[58]

This line of English cases presents two questions for our current inquiry. The threshold question is whether requiring this kind of structuring or limitation of prosecutorial discretion could be implemented in the United States, where assisted suicide is a matter of state law and prosecution decisions are made by thousands of county and city district attorneys rather than by a centralized federal entity like the Crown Prosecution Service. The second question is whether, assuming that there is an avenue to accomplishing this result in our system, it would be wise to do so.

Calls for placing limits on prosecutorial discretion, and some significant efforts to implement such limits, are not new or unusual in the U.S. They have occurred in a number of contexts, including the rise in importance of sentencing commissions, which have tended to remove discretion in criminal sentencing from judges while leaving prosecutors' considerable discretion in charging and plea-bargaining untouched, and a diverse set of cases claiming insufficient attention by local prosecutors to victims' rights or a variety of practices by the police and other law enforcement officials.[59]

In response, several approaches similar to that ultimately adopted in England have been suggested or implemented. Local

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56. Purdy v. DPP, [2009] UKHL 45, 3 W.L.R. 403, 414 (appeal taken from Eng.).

57. Mark Hennessy & Gerry Moriarty, *New Guidelines on Assisted Suicide Published in UK,* IRISH TIMES, Sept. 24, 2009, at 12, *available at* www.irishtimes.com/newspaper/world/2009/0924/1224255131933.html.

58. *See* Press Release, Crown Prosecution Serv., DPP Issues Assisted Suicide Policy (Feb. 25, 2012) *available at* http://www.cps.gov.uk/news/press_releases/109_10/.

59. *See generally* Peter Krug, *Prosecutorial Discretion and its Limits*, 50 AM. J. COMP. L. 643 (2002); Ronald Wright, *Sentencing Commissions as Provocateurs of Prosecutorial Self-Regulation*, 105 COLUM. L. REV. 1010 (2005).

district attorneys' offices have adopted internal standards governing decisions whether or not to charge and the timing of charging decisions, and the State of Minnesota has gone so far as to require that all county attorneys adopt such guidelines. The American Bar Association and the American Association of District Attorneys have adopted model guidelines. One state, Washington, has created statutory guidelines that address evidentiary sufficiency for decisions to prosecute or decline prosecution.[60] In a striking parallel to *Purdy*, the New Jersey Supreme Court held that a sentencing commission's limitation on the sentencing discretion of judges without parallel limitations on the charging discretion of prosecutors violated the state constitutional doctrine of separation of powers, and directed the State Attorney General to create guidelines governing county prosecutors.[61]

While even the Washington and New Jersey examples fall far short of the creation and publication of specific charging criteria relating to the specific offense of violation of anti-assisted suicide laws, the notion of boundaries on prosecutorial discretion in the U.S. context is not foreign, and it is at least conceivable that a decentralized approach that would provide physicians with some relief from the risk of providing PAS could be developed. It should be noted that both Krug and Wright observe that the imposition of any limits on prosecutorial discretion in the U.S. has been hard to come by and remains the exception rather than the rule, due perhaps to the political power of prosecutors at the state level, a general public sympathy with law enforcement, and the fact that many state legislators are former prosecutors.[62]

But even if it were possible to institute such a regime, would it be a good idea? Greasley presents a strong logical argument that the transition from the policy of what she calls "wilful [sic] blindness" to one that prioritizes "fair warning and consistency of practice in the law" is unwise.[63] She points out that the purpose of providing for wide prosecutorial discretion "is that it is not hemmed in by formal regulation, but can be influenced by any feature deemed relevant in a case."[64] To assume, as did the Lords, that the "unwritten law" that constitutes the matrix by which decisions to prosecute are made is the equivalent of substantive,

60. Krug, *supra* note 59, at 650-52.
61. State v. Vazquez, 609 A.2d 29 (N.J. 1992).
62. Wright, *supra* note 59, at 1016-17.
63. Greasley, supra note 31, at 307.
64. *Id.* at 309.

written law is to change that substantive law: "It is not the law that one may not assist in the suicide of another *unless* it is done with altruistic motivation…[W]hile the conferral of prosecutorial discretion forms part of the substantive law, the same is not true of the principles called upon in its exercise."[65] Excuses for violating a law, such as altruistic motivation, cannot be categorized, reduced to a writing, and relied on – they then cease to be excuses and become a prospective guide to behavior.

Neither does the structuring of prosecutorial discretion substantially advance consistency of practice, in Greasley's view. She points out that practice by the Crown Prosecution Service has been remarkably consistent over time, favoring non-prosecution, and concludes that "the need for administrative consistency cannot shoulder much argumentative weight when there is nothing to rectify."[66]

Thus, the cumulative weight of the entrenched nature of prosecutorial discretion in the U.S. and the solid philosophical arguments against it make taking the *Purdy* route a less than attractive alternative for mitigating physician risk without abandoning legal proscriptions against PAS.

B. New Defenses: Consent, Compassion and Necessity

A variety of possible defenses to a charge of unlawful assistance in an act of suicide have been presented and suggested in a broad diversity of legal contexts. Three of the most cogent have been the position on consent taken by the Montana Supreme Court in the case of *Baxter v. State*,[67] the suggestions in France made by the National Bioethics Committee on taking cognizance of motivation,[68] and the proposals for the expansion of the defense of medical necessity by U.S. commentators.[69]

In *Baxter*, a patient suffering from lymphocytic leukemia, who had undergone multiple rounds of chemotherapy and was experiencing a range of debilitating side effects and symptoms of the disease and whose prognosis was hopeless, sued to challenge the constitutionality, under the state constitution's guarantee of individu-

65. *Id.*
66. *Id.* at 311.
67. 224 P.3d 1211 (Mont. 2009).
68. *Avis sur fin de vie, arret de vie, euthanasie*, 63 COMITÉ CONSULTATIF NATIONAL D'ETHIQUE 1, Jan. 2000, at 27 [hereinafter *CCNE Report*].
69. Derrick Carter, *Knight in the Duel with Death: Physician Assisted Suicide and the Medical Necessity Defense*, 41 VILL. L. REV. 663, 700 (1996).

al dignity and privacy, of Montana's application of criminal homicide laws to physicians who provided PAS.[70] The trial court held that the Montana constitution protected the right of a competent, terminally ill patient to die with dignity, and that this right encompassed protection of a physician assisting in such a death from prosecution.[71] The state appealed to the Montana Supreme Court.[72]

The State Supreme Court decided not to reach the constitutional issue, because its analysis of the availability of the recognized statutory defense of consent allowed it to decide the case. The court noted that the state's general consent statute provided four exceptions in which consent would be ineffective: 1) the victim was incompetent to authorize the conduct charged; 2) the victim was, by nature of youth, mental disease or defect, or intoxication unable to reasonably judge the harmfulness of the conduct; 3) the consent was induced by force, duress or deception; and 4) it is against public policy to permit the conduct or resulting harm, even if consented to.[73] The court confined its opinion to the last of these exceptions, finding that the first three were fact-dependent.

Only one previous case had examined the public policy exception, and that case dealt with a barroom fight in which the defendant to an assault charge argued that the victim had consented to his attack by virtue of his own bellicose behavior. The defendant appealed his conviction to the Montana Supreme Court, which found that public policy barred the defense of consent to an assault. The *Baxter* court noted other, similar results from other states.[74]

The court went on to distinguish the PAS scenario from cases of assault, and concluded that:

> [C]ourts deem consent ineffective when defendants directly commit blatantly aggressive, peace-breaching acts…In contrast, a physician who aids a terminally ill patient in dying is not directly involved in the final decision or the final act. He or she only provides a means by which a terminally ill patient *himself* can give effect to his life-ending decision… Each stage of the physician-patient interaction is private, civil and compassionate. The phy-

70. *Baxter*, 224 P.3d at 1214.
71. Baxter v. State, 2008 Mont. Dist. LEXIS 482, at *36 (Mont. Dist. Ct. 2008).
72. *Baxter*, 224 P.3d at 1214.
73. *Id.* at 1215.
74. *Id.* at 1216-17.

> sician and terminally ill patient work together to create a means by which the patient can be in control of his own mortality. The patient's subsequent private decision…does not breach public peace or endanger others…Although the 'against public policy' exception…is not limited to violent breaches of the peace…we see nothing in the case law facts or analysis suggesting that a patient's private interaction with his physician, and subsequent decision whether to take medication provided by a physician, violate public policy…We similarly find no indication in Montana statutes that physician aid in dying is against public policy.[75]

Thus, one U.S. state has found a way to legitimize PAS (at least that form of PAS in which the physician prescribes medication that can be used by the patient acting alone to end her life) without creating a constitutional right to PAS. Whether this approach of a public policy analysis, whether or not joined to the use of the consent defense, can be applied in other jurisdictions will depend on the governing statutory schemes and judicial interpretations of such schemes in those jurisdictions. But the consent defense is commonly provided for, and this route may prove useful outside Montana's borders.

Far beyond those borders, recent developments in France have intensified discussions about the appropriateness of injecting an analysis of motivation into the decision-making process regarding possible prosecution of acts hastening death in a clinical setting, following the reversal of position by the highly influential Comité Consultatif Nationale d'Ethique ("CCNE").[76] In 1991 the CCNE had issued an opinion opposing a draft resolution on assistance in dying pending before the European Parliament, in which it cited the fundamental principle of respect for human dignity as a basis

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75. *Id.* at 1217 (emphasis in original). Operative state law included a Rights of the Terminally Ill Act that provided for withdrawal and withholding of care but was silent on PAS. *See* MONT. CODE ANN. §§ 50-9-101-111, 50-9-201-206 (1991). The court took note of the fact that withdrawal or withholding of treatment pursuant to the patient's request was "direct participation" by the physician in the patient's death, and the Terminally Ill Act explicitly immunized such conduct. *Baxter*, 224 P.3d at 1218. Moreover, the Act specifically excepted "mercy killing or euthanasia" from its coverage, and the Baxter court noted that PAS did not constitute either of these actions. *Id.* at 1119. Montana did not have any statutes specifically prohibiting assistance in suicide. Historically, such cases were prosecuted under the homicide law.

76. The specific context of the French discussion was what was labeled euthanasia in the *CCNE Report*, *supra* note 68, but the context indicates a broader scope of all manner of assistance in dying.

for opposing any legitimization of euthanasia.[77] However, in 2000 the CCNE issued its "Opinion on the End of Life, Ending Life, Euthanasia"[78] which called for changing the way in which assisted dying is dealt with by the criminal law. The CCNE opinion called for no change in the substantive prohibition against euthanasia, but instead for changes in criminal procedure that would more properly address cases in which palliative care and avoidance of futile medical procedures were insufficient to result in a "tolerable end of life."[79]

Specifically, the CCNE called for recognition of a "defense of euthanasia,"[80] which would trigger review by a multi-disciplinary body "whose task would be to evaluate the [defendants'] claims…not so much regarding…guilt in fact and law, but as regards their motivation, i.e. concern to end suffering, respect for a request made by the patient, compassion in the face of the inevitable."[81] This body would be strictly advisory to the court, and the CCNE would restrict its deployment to a limited number of "borderline or extreme cases."[82]

The examination of a criminal defendant's motives in the decision whether to prosecute is foreign to common as well as code law, so the CCNE proposal would require as significant a readjustment if adopted in the U.S. as it would in France. Nevertheless, to the extent that motive is not taken into account in the exercise of prosecutorial discretion, the CCNE proposal seems to add an important missing element to the exercise of that discretion. Whether prosecutorial discretion is channeled in a *Purdy*-type regime or simply guided by local, state or national guidelines, the consideration of whether a health care provider acted out of compassion for an individual patient's suffering would seem to attune the exercise of that discretion more to the realities of the difficult end-of-life cases that arise in the clinic.

A third approach using the idea of a substantive defense has focused on the traditionally recognized defense of necessity. The classic example of a necessity defense is that of self-defense, in which a defendant has committed an offense but acted in the rea-

77. *CCNE Report, supra* note 68. *See also* Penney Lewis, *The Evolution of Assisted Dying in France: A Third Way?,* 14 MED. L. R. 44, 66 (2006).

78. *CCNE Report, supra* note 68.

79. Lewis, *supra* note 77, at 67.

80. The defense is not envisioned to be embodied in substantive law, but as a preliminary consideration in determining whether a violation is chargeable.

81. *CCNE Report*, *supra* note 68, *quoted in* Lewis, *supra* note 77, at 67.

82. *Id.*

sonable belief that he had to in order to avoid death or serious injury. English law recognizes self-defense as one of a class of situations establishing "duress of circumstances," and the determination of both the severity of the threat and reasonableness of the response are jury questions.[83] In the U.S., where several commentators have called for the adoption of a special medical necessity defense against a variety of crimes,[84] the doctrine of necessity is frequently related to the common law doctrine of "choice of evils." In cases such as destruction of property to prevent the spread of a fire, speeding to get a patient to a hospital, or dispensing a drug without a prescription to relieve pain in an emergency,[85] a defendant can argue that the violation charged actually yielded a better result than alternative choices. The Model Penal Code codifies the doctrine by establishing that in order to assert the defense a defendant must show that: 1) the threatened injury must be worse than the violation of law charged; 2) the law does not provide any other defenses or exceptions under the facts at issue; 3) no legislation specifically prohibits the necessity defense; and 4) the defendant must not have negligently or recklessly caused the situation that he alleges required breaking the law.[86]

Ost argues that there are two forms of cognizable necessity, either of which could constitute a defense to an infraction: necessity as an excuse and necessity as a justification.[87] The American choice of evils conceptualization lends itself best to the necessity as a justification formulation (the justification in this sense being that the best possible result was obtained); Ost points out that necessity as justification also proceeds from the argument that the "defendant's actions are justified because they are carried out in defense of his own or another's interests."[88]

There are a number of barriers to use of a necessity defense by physicians in PAS cases. From the famous lifeboat case *R v. Dudley and Stephens* (in which shipwrecked sailors killed and ate the already ill cabin boy in order to survive and the court denied their defense of necessity) to the present, the defense has not been al-

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83. Suzanne Ost, *Euthanasia and the Defence of Necessity: Advocating a More Appropriate Legal Response*, *in* CHARLES ERIN AND SUZANNE OST, THE CRIMINAL JUSTICE SYSTEM AND HEALTH CARE 99-117 (2006).

84. *See* Carter, *supra* note 69, at 666 n.12.

85. *Id.* at 667, 698.

86. MODEL PENAL CODE § 3.02 (1985). *See* Carter, *supra* note 69, at 697.

87. Ost, *supra* note 83, at 110.

88. *Id.*

lowed where a defendant took the life of another.[89] However, a 2000 case of conjoined twins decided by the English Court of Appeal distinguished the *Dudley and Stephens* line of cases in several significant ways.[90] In *Re A*, conjoined twins were born attached at the abdomen. One infant had only a rudimentary circulatory system and relied entirely on that of her twin to survive. Without surgery to separate them, physicians estimated that both twins would die within months; with separation, the twin with a complete circulatory system could survive and lead a normal life, but the other would die. The twins' parents refused permission for the surgery, and the treating hospital petitioned the court for an order to separate the twins.

The High Court granted the hospital's request, and the Court of Appeal affirmed. In doing so, the court cited the defense of necessity, distinguishing *Dudley and Stephens* by citing the court's reasons for refusal to apply the necessity defense: the impossibility of judging the necessity under the facts of the case, and the resultant divorcing of law from morality. In the twins case, the court reasoned, the necessity of the surgery as the only alternative to the death of a person who could otherwise live was clear, and the moral question was at least one on which some would argue that separation was the only way to conform the law to morality.[91]Thus, for perhaps the first time, a necessity defense to the taking of human life was allowed.[92]

Nevertheless, the typical PAS case is sufficiently distinguishable from the *Re A* circumstances as to require at the least a significant extension of the defense recognized there. In a PAS case, the possible continued, healthy life of one patient is not balanced against the death of another. Instead, death of one patient is valued against that same patient's continued life; in other words, the greater evil to be avoided is continued life, and the defense must

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89. *Id.* at 111.

90. Re A (Children) (Conjoined Twins: Surgical Separation), [2000] 3 F.C.R. 577 (C.A.), *cited in English Law – Court of Appeal Authorizes Separation of Conjoined Twins Although Procedure Will Kill One Twin*, 114 HARV. L. REV. 1800 (2001).

91. *See* Michael Bohlander, *Of Shipwrecked Sailors, Unborn Children, Conjoined Twins, and Hijacked Airplanes – Taking Human Life and the Defence of Necessity*, 70 J. CRIM. L. 147, 155-57 (2006).

92. Of course, the posture of the *Re A* case is distinguishable from a theoretical case in which a physician is a defendant in a prosecution for violation of an anti-PAS law. To this extent, the Court of Appeal's discussion of the defense is dicta.

argue that causing death is an appropriate and proportional response to the imminence of that evil.

This has proven a bridge too far for both English and U.S. courts to date. But there have been hints that severe and untreatable suffering might be enough to cause a court to view physician-assisted death as a lesser evil, particularly where the patient himself is competent and requests PAS and where the medical evidence is indisputable. Recall Justice O'Connor's explicit declaration that she had not reached this issue in *Glucksberg*, holding out the possibility that just such circumstances might have caused her (and in that case a majority of the Court) to find a limited right to PAS.[93] The U.K. Criminal Law Revision Committee has suggested a defense of necessity to certain cases of euthanasia,[94] and the Dutch legal regime permitting PAS and euthanasia has explicitly adopted a *force majeure* analysis in which the physician's accession to a competent patient's request for PAS or euthanasia is viewed as a response that is compelled by the patient's extreme suffering and the physician's duty to relieve it.[95]

Thus, the possibility of the further elaboration of a medical necessity defense is real. While the mere availability of such a defense would likely be of little comfort to physicians faced with requests for PAS, since it could only be raised once charges had been filed, it is likely that the recognition of such a defense would further diminish the likelihood of charges being brought in all but the most egregious cases.

C. Mooting the Problem? – The Maturation of Palliative Care, Jettisoning the Doctrine of Dual Effect, and the Creation of a Right that Doesn't Cause Harm

One of the most significant advances in medicine since the *Karen Ann Quinlan* case started the controversy over the "right to die" has been the maturation of the medical specialty focused on the relief of pain, especially at the end of life, known most commonly as palliative care. The growth of the specialty has been associated with the growth of the hospice movement, which itself

93. *See supra* note 35 and accompanying text.

94. Ost, *supra* note 83, at 117.

95. Carter, *supra* note 69, at 699. *See also* Evelien Delbeke, *The Way Assisted Suicide is Legalised: Balancing a Medical Framework against a Demedicalised Model*, 18 EUR. J. HEALTH L. 2 (2011) (discussing *force majeure*, its applicability, and its current legal status).

took off as a direct consequence of the public awareness of the gravity of end-of-life issues brought about by *Quinlan* and its progeny, and has proceeded rapidly. Between 2000 and 2003, for example, the growth of hospital-based palliative care programs increased from 632 (fifteen percent of all hospitals) to 1027 (twenty-five percent of all hospitals),[96] and by 2011 had increased to almost half of all U.S. hospitals.[97] A subspecialty in palliative medicine was recognized in 2007, and the number of accredited subspecialty training programs stood at seventy- three in 2010.[98] Beginning in 2013, physicians seeking subspecialty board certification will have to complete an accredited twelve-month fellowship in order to sit for the palliative medicine boards.[99]

The hospice and palliative care movement from its inception has taken a broad-spectrum approach to the management of pain, paying attention not only to relief of physical symptoms but also to the psychological, emotional and spiritual components of what we label "suffering".[100] Clinical practice in pain management has advanced substantially with the growth of palliative care as a specialty, and it is likely that the professionalization and institutionalization of the subspecialty will further accelerate the pace of research and clinical practice innovation.[101] In fact, many palliative care specialists already view a request for PAS as a failure of palliative medicine.[102]

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96. R. Sean Morrison et al., *The Growth of Palliative Care Programs in United States Hospitals*, 8 J. PALLIATIVE MED. 6, 1127-34 (2005) (detailing the linear increase in growth of palliative care programs in U.S. hospitals).

97. *Recommendations for Action*, CTR. TO ADVANCE PALLIATIVE CARE, http://www.capc.org/reportcard/recommendations (last visited May 8, 2013).

98. *Id.*

99. Stacey Butterfield, *Growing Specialty Offers Opportunities for Hospitalists*, ACP HOSPITALIST (Feb. 2009), http://www.acphospitalist.org/archives/2009/02/cover.htm. *See also Hospice and Palliative Medicine Policies*, AM. BD. OF INTERNAL MED., http://www.abim.org/certification/policies/imss/hospice.aspx#tpr (last visited May 8, 2013).

100. George Smith, *Refractory Pain, Existential Suffering, and Palliative Care: Releasing an Unbearable Lightness of Being*, 20 CORNELL J.L. & PUB. POL'Y. 469, 473 (2011) (defining existential pain and how palliative care helps alleviate it). *See also* Butterfield, *supra* note 99 (discussing the goals of palliative care).

101. *See generally* Smith, *supra* note 100, at 479-80 (describing the clinical practice advancements in pain management). *See also* Norman Cantor, *On Hastening Death Without Violating Legal and Moral Prohibitions*, 37 LOY. U. CHI. L.J. 407, 429-31 (2006) (delineating the effects the advancements in palliative care might have).

102. Letter from Jeffrey M. Bell, M.D., board certified geriatrician, former member, Vermont Ethics Network, to author (on file with the author).

The growth of palliative care likely means that some percentage of patients who have sought PAS either because they are experiencing intractable pain or because they fear that they will experience it as their disease progresses, will have their symptoms adequately controlled and therefore not seek PAS. Others, whose interest in PAS proceeds more from psychological concerns, may also be sufficiently comforted by counseling and other attention available through hospital and hospice palliative care services to further reduce the demand for PAS. It is thus at least conceivable that the effect of the growth of palliative care will reduce the demand for PAS to a sufficiently small number that both the pressure to recognize a legal right and the risks to physicians described above will become vanishingly small.

In order for this solution to the problems described here to occur, certain palliative care approaches will themselves have to be legally differentiated from PAS and euthanasia. Cantor and Smith both refer to terminal sedation (in which a patient near the end of life is rendered unconscious or stuporous to relieve agitation, discomfort, or respiratory distress with or without the provision of artificial hydration, nutrition, or mechanical ventilation) and the administration of analgesics to relieve pain, even where dosages may hasten death by retarding respiration, as practices that require legal clarification.[103] These practices have traditionally been defended by citing the so-called "doctrine of double effect," which holds that "there is a … moral difference between acting with the foresight that one's conduct will have some evil consequence and acting with the intent to produce that same evil…"[104]

The logical issues with this doctrine have been pointed out often in the bioethics literature,[105] and legal commentators have more recently addressed the particular difficulties of adapting a legal rule based on the doctrine. For example, in tort law, "legal liability is imposed upon those who cause injury to another and foresaw or should have foreseen the consequences of their ac-

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103. Smith, *supra* note 100, at 474-75. *See also* Cantor, *supra* note 101, at 409-10 (defining terminal sedation and describing when this practice is authorized).

104. F.M. Kamm, *A Right to Choose Death?*, BOSTON REV., (Summer 1997), *reprinted in* Tom L. BEAUCHAMP ET AL.,, CONTEMPORARY ISSUES IN BIOETHICS 187 (6th ed. 2003).

105. *See, e.g.*, *id*. *See also* Timothy Quill et al., *The Rule of Double Effect – A Critique of its Role in End-of-Life Decision Making*, 24 NEW ENG. J. MED. 1768, 1768 (1997) (discussing the rule of double effect and its complexities).

tions."[106] In criminal law, " [u]nder both the Model Penal Code and state law definitions of homicide, conduct certain or practically certain to hasten death is deemed to be knowing and unlawful, even if the actor's intent is to relieve suffering."[107] Thus, some legal test other than the doctrine of double effect is required to test the clinical practice in palliative care at the end of life. This test should not try to tease apart physicians' intentions as between relieving suffering and hastening death, or set the duty to alleviate pain against the duty not to cause harm.

One way out of this dilemma would be a strictly medical approach to the legal issue, which would look entirely to the professional standard of care as the measure by which a physician's legal obligations would be determined. Such is the common rule in malpractice litigation. The professionalization of palliative care, with the growth of training and board certification criteria, coupled with advances in medical knowledge regarding pain and pain management, makes finding an external referent for that standard of care increasingly possible. The prevailing standard appears to be one of proportionality – i.e., is any particular intervention proportionate to the patient's symptoms?[108]

The courts' adoption of this standard-of-care approach to assessing criminal liability where a PAS charge is leveled against a physician would be greatly facilitated by the formal recognition of a right to relief from suffering at the end of life. Recognition of such a right would not carry with it the dangers discussed above of a "right to die" or a right to receive assistance in ending one's life. The discussion of *Glucksberg* above indicates that such a right would be consistent with, albeit not compelled by, the Court's existing precedents.[109] It is likely that the recognition of a constitutionally protected right to access the full panoply of palliation available to current medical practice would greatly reduce the uncertainty of physicians regarding their potential criminal liability for treating end-of-life patients' suffering aggressively without requiring recognition of a right to assisted suicide.

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106. Smith, *supra* note 100, at 504.

107. Cantor, *supra* note 101, at 425.

108. *Statement on Palliative Sedation*, AM. ACAD. OF HOSPICE AND PALLIATIVE MED. (Sept. 15, 2006), http://www.aahpm.org/positions/default/sedation.html. *See also* Cantor, *supra* note 101, at 424.

109. See, e.g., Stephen Arons, *Palliative Care in the U.S. Health Care System: Constitutional Right or Criminal Act?*, 29 W. NEW ENG. L. REV. 309 (2007); Robert Burt, *The Supreme Court Speaks – Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1234-36 (1997).

IV. CONCLUSION

It is unlikely that any legal regime addressing suffering at the end of life can eliminate entirely the likelihood that some patients will seek medical assistance in bringing their lives to an end. Short of recognition of a right to receive medical assistance in doing so, legal exposure of physicians for providing end-of-life services that constitute or can be construed to constitute physician-assisted suicide cannot be eliminated. But the negative effects of recognition of a broad-based right to PAS outweigh the benefits to patients and physicians of such recognition. Alternative means exist that provide the simultaneous benefit of addressing many of the circumstances that drive patients to request PAS and clarify that most interventions physicians will pursue in end-of-life care are on the right side of the law. For the few remaining cases, in which morality argues for the availability of PAS but the law does not sanction it, the *status quo* of compassionate blindness is likely to provide adequate protection from adverse consequences to physicians, patients and their loved ones.