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Inconsistencies in the Treatment of Physician-Assisted Suicide & Passive Euthanasia

Arielle Simkins

Introduction:

Philosophy is often used to rationalize and justify human behavior. Philosopher James Rachels writes that the distinction between the acceptability of active and passive euthanasia is that “it is permissible, at least in some cases, to withhold treatment and allow a patient to die, but it is never permissible to take any direct action designed to kill the patient.”¹ The disparity is one between action and inaction.²

Rachels illustrates the difference using an anecdote of Smith and Jones, both of whom will inherit a large fortune upon the death of their respective six-year-old cousins.³ Rachels examines two situations, one in which Smith drowns the child and proceeds to make it look accidental, and another in which Jones intends to drown the child, but as he enters the bathroom, the child slips and falls face first into the bathtub.⁴ Jones watches the child, unconscious from his fall, as he drowns, and does nothing to stop the event.⁵ Although these circumstances yielded the same result, Smith is both legally and morally more guilty than Jones because of his direct action to kill the child.

Nevertheless, in further examination of the situation, Rachels denies that it is permissible for Jones to defend himself because he did not kill the child, but merely allowed him to die.⁶ The difference is a moral quibble; engaging in a positive action to kill an individual versus an

¹ James Rachels, *Active and Passive Euthanasia*, 292:2 NEW ENG. J. MED. 78 (Jan. 9, 1975).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

inaction letting the individual die leaves the actor in the morally equivalent position.⁷ Despite the moral conformity of the two circumstances, medical professionals are in the precise position to differentiate between their actions and inactions for but one reason: the law. In doing so, there has been a division of euthanasia into active and passive. However, this ignores the category of physician-assisted suicide, which implicates legal and ethical principles of both active and passive euthanasia.

These forms of euthanasia are morally indistinguishable as they produce an identical result: they bring about death. This is a moral wrong. However, no form of euthanasia may be more or less wrong than another, as irrespective of intent, the ultimate act in fact hastens death. Therefore, physician-assisted suicide is no different from any acceptable means of hastening death, such as passive euthanasia.

This paper will explore the background of euthanasia, including the three common forms of such treatment. Ultimately, despite the various arguments of distinction, no form of euthanasia can be justified as more or less permissible than another. Section I will provide a brief history of the right to die and physician-assisted suicide in the United States and will discuss Oregon's successful implementation of Death with Dignity legislation. It will then provide a background of the American Medical Association's ethical perspective in the area of end of life care. Finally, Section II will argue that physician-assisted suicide is morally equivalent to passive euthanasia. In light of this fact, arguments in favor of treatment termination are applied in an inconsistent manor when analyzing physician-assisted suicide.

Background:

There are three distinct and recognized forms of assistance in ending life. Active euthanasia occurs when a physician takes an affirmative action that deliberately causes the death

⁷ Rachels, *supra* note 1, at 78.

of a patient.⁸ This is perhaps the least controversial of the categories, as it is universally impermissible in the United States. The second category, passive euthanasia, involves a physician withholding or withdrawing life-sustaining treatment from a patient, which ultimately results in death.⁹ Finally, there is physician-assisted suicide, which is sometimes referred to as physician “aid in dying.” In this case, though the physician does not participate actively in the suicide, he or she provides the necessary medical means by which the patient may end his or her life.¹⁰ However, the distinction among these forms of assistance in order to legally and ethically justify passive euthanasia is wrongfully relied upon.

I. **History:**

The legalization of physician-assisted suicide represents a relatively recent movement in the United States, with advocacy and legislation only attaining momentum and public support in the 1990s.¹¹ However, in order to appreciate the controversy at hand, it is important to distinguish, as law and ethics have, among the designated forms of assistance in ending life and to understand the history of the abstract right to die.

A. **The Right to Die:**

⁸ *Active and passive euthanasia*, BBC ETHICS GUIDE, http://www.bbc.co.uk/ethics/euthanasia/overview/activepassive_1.shtml (last visited Nov. 23, 2013) [hereinafter *BBC Ethics Guide*]; See also Katherine A. Chamberlain, *Looking For A “Good Death”: The Elderly Terminally Ill’s Right To Die By Physician-Assisted Suicide*, 17 ELDER L.J. 61, 65 (2009).

⁹ *BBC Ethics Guide*, *supra* note 8; Council on Ethical & Judicial Affairs, *Physician-Assisted Suicide*, 8 AMA CODE OF MEDICAL ETHICS 1, 1 (1993), available at http://www.ama-assn.org/resources/doc/ethics/ceja_8i93.pdf [hereinafter *CEJA Report*]; See also Chamberlain, *supra* note 8, at 65.

¹⁰ AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS, OPINION 2.211 – PHYSICIAN-ASSISTED SUICIDE, (1994), available at <http://www.ama-assn.org//ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page> [hereinafter *Code of Ethics: Physician-Assisted Suicide*]; See also Chamberlain, *supra* note 8, at 65.

¹¹ *Vacco v. Quill*, 521 U.S. 793, 796 (1997); *Washington v. Glucksberg*, 521 U.S. 702 (1997); Susan O. Scheutzwow, *Physician-assisted suicide*, 1 HEALTH L. PRAC. GUIDE § 11:25 (2013).

The medicalization of death required the legalization of passive euthanasia, which preceded in modern times the call for physician-assisted suicide.¹² In 1975, 21-year-old Karen Ann Quinlan suffered irreparable brain damage during a period of respiratory failure.¹³ As a result, Quinlan's condition was that of a persistent vegetative state.¹⁴ The ultimate issue before the New Jersey Court was whether or not her co-guardian parents could act as surrogate decision makers in order to request termination of Quinlan's life-sustaining ventilator.¹⁵ In its answer, the Court conclusively stated that a competent person has the right to refuse medical intervention, up to and including the termination of life-sustaining treatment.¹⁶ This derived from an implied right to privacy grounded in the Constitution and recognized by the United States Supreme Court in the context of pregnancy termination and the right to control what happens in and to one's body.¹⁷ While the State has an interest in preserving life, the court found that this interest weakens and the right to privacy increases in proportion to the invasiveness of the treatment.¹⁸ Therefore, according to the New Jersey Supreme Court, competent individuals have a Constitutionally protected right to refuse medical treatment in the form of a respirator and, when appropriate, surrogate decisions makers may act with substituted judgment on behalf of an incompetent individual.¹⁹

¹² *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 70 N.J. 10 (1976); *In re Conroy*, 98 N.J. 321, 340 (1985).

¹³ *In re Quinlan*, 137 N.J. Super. 227, 237 (1975).

¹⁴ *Quinlan*, 137 N.J. Super. at 237; *Quinlan*, 70 N.J. at 24-25 (defining a persistent vegetative state as one where an individual retains "the capacity to maintain the vegetative parts of neurological function but who.... no longer has any cognitive function...." [The individual has] no awareness of anything or anyone around her and exits[s] at a primitive reflex level.").

¹⁵ *Quinlan*, 70 N.J. at 39.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.* at 41.

¹⁹ *Id.*; See *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 271 (1990) (holding that "After *Quinlan*... most courts have based a right to refuse treatment on the common-law right to informed consent or on both that right and a constitutional privacy right.").

Quinlan, however, was merely the beginning of a nationwide pursuit in asserting the right to treatment termination on behalf of incompetent individuals. Only ten years later, another patient's right to refuse treatment was decided by the New Jersey Supreme Court.²⁰ Claire Conroy, however, was not in a persistent vegetative state.²¹ Instead, Conroy was terminally ill and had recently become incompetent.²² In light of her condition, her nephew, as her surrogate decision maker, sought to terminate the artificial nutrition and hydration provided to her.²³ Again the Court found that an individual has a right to control his or her own body, "free from all restraint or interference of others,"²⁴ grounded in the right to privacy and the common-law right to self-determination.²⁵ Ultimately, the Court expanded the class of eligible incompetent persons for whom surrogates seek treatment termination to include those with terminal illness.²⁶ In doing so, it established subjective and objective tests requiring clear and convincing evidence before a terminally ill patient's treatment may be withheld or withdrawn.²⁷ These tests were developed to protect a patient's right to bodily integrity and demand clear evidence of a patient's wish to terminate treatment,²⁸ or a balancing of the burdens and benefits of a patient's prolonged life.²⁹

While the New Jersey Supreme Court and numerous state courts over the next decade recognized a right grounded in informed consent to demand the removal of artificial nutrition and hydration, the issue did not reach the United States Supreme Court until 1990, in the case of Nancy Cruzan.³⁰ Cruzan, like *Quinlan*, was in a persistent vegetative state and her surrogate

²⁰ *In re Conroy*, 98 N.J. 321, 336-8 (1985).

²¹ *Id.*

²² *Id.*

²³ *Id.* at 340.

²⁴ *Id.* at 346.

²⁵ *Id.* at 348.

²⁶ *Conroy*, 98 N.J. at 374.

²⁷ *Id.* at 360-365.

²⁸ *Id.* at 360.

²⁹ *Id.* at 365-366.

³⁰ *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261 (1990).

sought to remove the life-sustaining treatment she was receiving.³¹ The Supreme Court, reiterating the finding of the Missouri Supreme Court, discussed the right at issue in terms of liberty grounded in the Fourteenth Amendment rather than a right to privacy.³² This liberty interest granted individuals the right to refuse medical treatment.³³ The Court, however, found that the Constitution does not prevent a state from implementing a clear and convincing evidence standard requiring the subjective wishes of the patient as a prerequisite to treatment termination.³⁴

Cumulatively, these cases represent the beginning of a right to die movement. Through these instances of passive euthanasia, the Supreme Courts of New Jersey and of the United States have found that surrogate decision makers may make treatment termination decisions on behalf of incompetent patients, and when applicable, termination is a legally and ethically acceptable medical practice.³⁵ At the Supreme Court level, the interest in patient self-determination at issue has been based on the 14th Amendment's liberty interest as well as the doctrine of informed consent, but only by means of dictum.³⁶ Through the protections discussed, it is permissible for a patient to remove and or refuse life-sustaining treatment, specifically in the form of artificial respiration or nutrition and hydration.³⁷

B. Physician-Assisted Suicide

i. In Federal Courts

The Supreme Court soon faced Constitutional challenges against bans on physician-assisted suicide. While the *Cruzan* court provided that it was in the states' discretion to

³¹ *Id.*

³² *Id.* at 278; *Cruzan v. Harmon*, 760 S.W.2d 408, 439 (1988).

³³ *Cruzan*, 497 U.S. at 278.

³⁴ *Id.* at 286.

³⁵ *In re Quinlan*, 70 N.J. 10, 51 (1976); *In re Conroy*, 98 N.J. 321, 384 (1985); *See also Cruzan*, 497 U.S. at 284.

³⁶ *Cruzan*, 497 U.S. at 268.

³⁷ *Quinlan*, 70 N.J. at 51; *Conroy*, 98 N.J. at 384; *See also Cruzan*, 497 U.S. at 284.

determine standards for removing life-sustaining treatment, it only briefly discussed the state interests in the preservation of life, the prevention of suicide, the protection of innocent third parties and the “maintenance of the ethical integrity of the medical profession.”³⁸ Within a decade of the Cruzan decision, the Court confronted the particular roles, duties, and privileges physicians have in end of life decisions.

In 1997, several physicians challenged a New York State ban on aiding in committing or attempting to commit suicide.³⁹ The challenge was one of equal protection and the Court of Appeals agreed,

Despite the assisted-suicide ban’s apparent general applicability, ‘New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths,’ because ‘those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.’⁴⁰

The Supreme Court rejected this position.⁴¹ It found that, for purposes of causation and intent, assisting suicide and withdrawing life-sustaining treatment were separate and distinct.⁴² It asserted, “when a patient refuses life-sustaining treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”⁴³ The physician’s affirmative act, which the Court saw as the cause of death, relative to the physician’s omission or inaction in the withdrawal of life-sustaining

³⁸ *Cruzan*, 497 U.S. at 271 (discussing that the preservation of life is the most significant interest and is “greatest when an affliction [is] curable, ‘as opposed to the State interest, where, as here, the issue not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended.’”).

³⁹ *Vacco v. Quill*, 521 U.S. 793, 796 (1997).

⁴⁰ *Id.* at 798.

⁴¹ *Id.* at 799.

⁴² *Id.* at 800.

⁴³ *Id.* at 801.

treatment, done to comport with the patient's right to refuse treatment, became the crux of defining the distinction.⁴⁴

Fundamentally, this difference is one of intent, and can be best illustrated in the nuanced example of palliative care that potentially hastens death.⁴⁵ The legal and ethical justifications for palliative care come from the principle of double effect.⁴⁶ Double effect exists in circumstances in which palliative care is provided despite the foreseeability that it may hasten death, so long as the intention of the treatment is to relieve pain and not to cause death.⁴⁷ In these circumstances, the decision to provide such treatment is morally and legally permissible.⁴⁸ This suggests that intent is the difference between permissible treatment and assisted suicide.

The Court also distinguished between the right to refuse treatment and the right to hasten death, the latter of which is not provided any protection.⁴⁹ In emphasizing these two distinctions, the Court found that the classes of individuals with terminal illness were not similarly situated to those requiring life-supporting measures.⁵⁰ Therefore the equal protection argument failed and the New York statutes did not infringe on patients' Constitutional rights.⁵¹

In a companion case from Washington State, the Supreme Court also rejected a due process argument to a ban on physician-assisted suicide.⁵² This examination included an understanding that individuals are entitled to "heightened protection against government interference with certain fundamental rights and liberty interests."⁵³ The due process question

⁴⁴ *Id.*

⁴⁵ *Quill*, 521 U.S. at 802 ("The law has long used actors' intent or purpose to distinguish between two acts that may have the same result.").

⁴⁶ *Id.*

⁴⁷ *Id.* at 807 n.11.

⁴⁸ *Id.*

⁴⁹ *Id.* at 807.

⁵⁰ *Id.*

⁵¹ *Quill*, 521 U.S. at 807.

⁵² *Washington v. Glucksberg*, 521 U.S. 702 (1997).

⁵³ *Id.*

analyzed whether individuals have a right to die based on a liberty interest, and if so, whether the right to commit suicide could be inferred from that interest.⁵⁴ Again, the Court highlighted the difference between physician-assisted suicide and withdrawing or withholding care.⁵⁵ While the right to die may have been assumed in the latter circumstance, the Court neither foresaw nor intended for that right to be extended into a right to commit suicide, let alone the right to assistance in doing so.⁵⁶ Additionally, the Washington legislation at issue stated that the “withholding or withdrawal of life-sustaining treatment...shall not, for any purpose, constitute a suicide.”⁵⁷ In finding that the state interests implicated by assisted suicide were legitimate and the law was rationally related to those interests, the Court did not deem it necessary to weigh the interests of the individuals against those of the state.⁵⁸ The ban on physician-assisted suicide did not violate the due process clause of the Constitution.⁵⁹

ii. Federal Legislation

The complexity and exposure of end of life decision-making issues continue to grow in the courts and Congress. Responding to the attempts of several states to pass assisted suicide legislation, Congress enacted law prohibiting the use of any federal financial assistance in support or promotion of assisted suicide, euthanasia, or mercy killing.⁶⁰ Congress enacted this law shortly after Oregon passed a ballot measure allowing assisted suicide.⁶¹ In light of this, it was Congress’ intent to prevent the use of federal funding in such circumstances,⁶² perhaps as a means to detach itself from implicitly condoning the states’ decisions. As of 2013, a small

⁵⁴ *Id.* at 722.

⁵⁵ *Id.* at 716.

⁵⁶ *Id.* at 726.

⁵⁷ *Id.* at 717.

⁵⁸ *Glucksberg*, 521 U.S. at 735.

⁵⁹ *Id.*

⁶⁰ 42 U.S.C.A. § 14401 (West 1997).

⁶¹ *Id.* § 14401; OR. REV. STAT. ANN. § 127.800 (West 1995).

⁶² 42 U.S.C.A. § 14401.

number of individual states permit the practice of assisted suicide,⁶³ but the proposal for Death with Dignity legislation in others is growing.⁶⁴

Subsection (a) of the federal law restricts the use of federal health care service funding from providing “any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by suicide, euthanasia, or mercy killing.”⁶⁵ However, it makes a familiar and explicit qualification in subsection (b) that provides that this law “shall not be construed to affect...the withholding or withdrawing of medical treatment or medical care [and] the withholding or withdrawing of nutrition or hydration.”⁶⁶ Here, Congress, like the Supreme Court, makes a clear distinction between assisted suicide and passive euthanasia.⁶⁷

Despite Congressional disapproval, four states have embraced initiatives to allow physician-assisted suicide, three through legislation and one by case law.⁶⁸ In 1994, Oregon became the first state to allow direct physician involvement.⁶⁹ Following suit, Washington enacted highly regulated legislation in a similar fashion to Oregon, while Vermont initiated a far more lax statute for end of life decision-making involving physician-assisted suicide.⁷⁰ Montana, as of 2013, is the fourth state allowing physician-assisted suicide.⁷¹ However, the state acknowledges assisted-suicide as a defense to homicide, rather than an affirmatively permissible

⁶³ OR. REV. STAT. ANN. § 127.800; VT. STATE. ANN. tit. 18, § 5289 (West 2013); WASH. REV. CODE ANN. § 70.245 (West 2009); *Baxter v. State*, 354 Mont. 234 (2009).

⁶⁴ *Death with Dignity Around the U.S.*, DEATH WITH DIGNITY NATIONAL CENTER (Nov. 6, 2013), <http://www.deathwithdignity.org/advocates/national> (discussing the pending status of Death with Dignity bills in Hawaii, Kansas, Massachusetts, New Jersey, and Pennsylvania, the Connecticut bill’s failure to meet deadlines to move forward, the tabling of the Montana bill, and the veto of the New Hampshire bill).

⁶⁵ 42 U.S.C.A. § 14402(a)(1).

⁶⁶ *Id.* § 14402(b)(1)-(2).

⁶⁷ *Id.*; *Washington v. Glucksberg*, 521 U.S. 702, 716 (1997).

⁶⁸ OR. REV. STAT. ANN. § 127.800; VT. STATE. ANN. tit. 18, § 5289; WASH. REV. CODE ANN. § 70.245; *Baxter*, 354 Mont. at 234.

⁶⁹ OR. REV. STAT. ANN. § 127.800.

⁷⁰ VT. STATE. ANN. tit. 18, § 5289; WASH. REV. CODE ANN. § 70.245.

⁷¹ *Baxter*, 354 Mont. at 234.

action.⁷² In the interest of effectively analyzing Death with Dignity legislation, this paper will examine that with the longest history, namely Oregon.

C. Success in Oregon

Despite the Death with Dignity initiative's approval by Oregon voters in 1994, it was not until 1997 that the Act went into effect.⁷³ Almost ten years later, the United States Attorney General challenged the law and asserted that "using controlled substances to assist suicide [was] not a legitimate medical practice and that dispensing or prescribing them for this purpose is unlawful" under federal law.⁷⁴ However, the Supreme Court found that the Controlled Substances Act "conveys an unwillingness to cede medical judgments to an executive office who lacks medical expertise."⁷⁵ Additionally, Congress did not intend to alter the federal-state balance and grant officials such as the Attorney General the far-reaching power to interpret and use federal law to prosecute physicians for actions that were permissible under state law.⁷⁶ Thus, the Court upheld the Oregon Death with Dignity Act and medical treatment provided in compliance with the Act continues to be permissible.

The Oregon Death with Dignity Act provides that adults who are at least 18 years of age, competent, and suffering from a terminal illness may voluntarily make an informed decision to request "medication for the purpose of ending his or her life in a humane and dignified

⁷² *Baxter*, 354 Mont. at 234.

⁷³ *History*, DEATH WITH DIGNITY NATIONAL CENTER, <http://www.deathwithdignity.org/history> (last visited Nov. 23, 2013).

⁷⁴ *Gonzales v. Oregon*, 546 U.S. 243, 249 (2006).

⁷⁵ *Id.* at 266 (providing that "Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally.").

⁷⁶ *Id.* at 275.

manner.”⁷⁷ The qualifications for eligibility under the Act are explicitly provided and, along with the responsibilities of physicians, act as safeguards for the initiative.⁷⁸

i. Oregon Safeguards

Physicians must abide by a number of safeguards under the Death with Dignity Act in order to protect themselves against liability, but also to protect patients’ interests and prevent potential abuses such as involuntary euthanasia.⁷⁹ Among their responsibilities, physicians must determine whether a patient has a terminal illness, is competent, and has made an informed and voluntary decision.⁸⁰ Moreover, the physician must refer the patient to a second physician in order to confirm each of these conclusions.⁸¹ Additionally, the physician must consider whether the patient may be suffering from a psychological disorder or impairment and refer the patient to counseling, if appropriate.⁸² This safeguard is of particular importance, as research shows “many people who request physician-assisted suicide withdraw that request if their depression and pain are treated.”⁸³ These procedures ensure that the patient has an appropriate diagnosis and is making an acceptable autonomous decision.

There are also measures in place to ensure the patient retains his or her autonomy at all times.⁸⁴ These include a mandatory waiting period⁸⁵ and the right to rescind the request for medication.⁸⁶ Requiring the patient to wait fifteen days between the first oral request for medication and the formal written request ensures that the individual is given the time to reflect

⁷⁷ OR. REV. STAT. ANN. §§ 127.800-127.805 (West 1995).

⁷⁸ *Id.* §§ 127.800-127.880.

⁷⁹ Raphael Cohen-Almagor & Monica G. Hartman, *The Oregon Death With Dignity Act: Review and Proposals for Improvement*, 27 J. LEGIS. 269, 271 (2001).

⁸⁰ OR. REV. STAT. ANN. § 127.815(1)(a)-(c).

⁸¹ *Id.* § 127.815(1)(d).

⁸² *Id.* § 127.825.

⁸³ *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

⁸⁴ *See* OR. REV. STAT. ANN. §§ 127.840-127.850.

⁸⁵ *Id.*

⁸⁶ *Id.* § 127.845; *See id.* § 127.815(h) (requiring a physician to “Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15-day waiting period.”).

on whether his or her decision is in fact one with which he or she is ultimately comfortable. The same sentiment is echoed in continuing to remind the patient that he or she may cease with the process of attaining the medication at any time. Notwithstanding this mandatory waiting period, the patient is in no way mandated or forced to utilize the prescription even after a pharmacist has filled it. Upon choosing to take the medication that is provided, it must be self-administered.⁸⁷ In so doing, the patient is the ultimate actor in causing his or her own death and the physician is, at the very least, one step removed from the process.

While the procedures above act as safeguards for patients' interest as well as for physicians to avoid criminal and malpractice liability, there is an even more substantial regulation within Oregon's Death with Dignity Act that shields the physician from participation entirely, if so desired.⁸⁸ The Act provides immunity for any physician who does not wish to participate in the provision of medication that will end a patient's life.⁸⁹ Therefore, the patient's ability to exercise his or her autonomy does not and cannot exceed the physician's identical right. There is explicitly no duty placed on a physician to aid a patient in the process of assisted suicide.⁹⁰ Therefore, both the patients and physicians who choose to avail themselves of the Act consent not only to the premise of the Act, but also to the regulations and safeguards it provides.

ii. Oregon Statistics of Effectiveness

Oregon data provides that the average patient seeking relief under the Death with Dignity Act is a sixty-nine year old, well-educated, Caucasian individual who is privately insured.⁹¹ This individual has a 75.3 percent chance of suffering from a malignant neoplasm and his or her

⁸⁷ *Id.* § 127.805(1).

⁸⁸ *Id.* § 127.885(4).

⁸⁹ OR. REV. STAT. ANN. § 127.885(4).

⁹⁰ *Id.*

⁹¹ *Oregon's Death with Dignity Act—2012*, OREGON PUBLIC HEALTH DIVISION 1, 4 (2013), <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf> [hereinafter *ODWDA Report 15*].

greatest concerns include losing personal autonomy and the ability to engage in activities that make life enjoyable.⁹² 1,050 individuals have received prescriptions under the Death with Dignity Act since its effective date of 1997, but only 673 of these individuals have died from ingesting the medication.⁹³ This disparity, however, does not denote instances of failure of the medication. Instead, it comprises individuals who chose not to take the medication, or individuals for whom results were not made available. There have only been six patients in the history of the Act that have regained consciousness after ingesting the lethal medication.⁹⁴

Of the 115 patients for whom DWDA prescriptions were written during 2012, 67 (58.3%) ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion.⁹⁵

Regaining consciousness aside, there were no reported complications in 2012 and only twenty-two instances of complications, namely regurgitation, since physician-assisted suicide became available. Though these six instances of regaining consciousness are distressing, they also establish that there is an incredibly low rate of side effects and ineffectiveness in the treatment.

In terms of physician characteristics, in 2012, sixty-one physicians wrote the 115 prescriptions that were provided to patients under the Death with Dignity Act.⁹⁶ However, in 2005, the last annual report available that included a breakdown of physician characteristics, the state found that seventy-four percent of physicians who wrote a prescription for lethal medication did so only once during that statistical year.⁹⁷ While this breakdown is not available

⁹² *Id.* at 5.

⁹³ *Id.* at 2.

⁹⁴ *Id.* at 6, n.13.

⁹⁵ *Id.* at 2.

⁹⁶ *Id.* at 3.

⁹⁷ Department of Human Services, *Eighth Annual Report on Oregon's Death with Dignity Act*, OREGON PUBLIC HEALTH DIVISION 1, 13 (2006),

for the 2012 year, the range of prescriptions written was between one and ten per physician.⁹⁸ Additionally, the number of years in practice was also unavailable in the 2012 report. However, in 2005, the median was twenty-six years, with a range from three to fifty-five years.⁹⁹ These statistics establish that physicians are generally conservative in prescribing lethal medication, as intended by the Act, and they are not availing themselves and their patients to the Act without experience in their field.

D. American Medical Association Ethics

Many physicians and physician ethical societies argue that physician-assisted suicide is “fundamentally incompatible with the physician’s role as healer.”¹⁰⁰ In this argument, opponents often cite the Hippocratic Oath, as it provides that the physician shall neither harm a patient nor give him or her a lethal drug despite such a request.¹⁰¹ Arguments on behalf of physicians and physician groups often focus on the intent of the medical professional and the ethical implications associated with aiding in suicide.

The Council on Ethics and Judicial Affairs (CEJA) of the American Medical Association (AMA) has stated explicitly that it is unethical and therefore impermissible for a physician to engage in acts of “physician-assisted suicide” or “euthanasia.”¹⁰² The CEJA defines physician-assisted suicide as that which occurs “when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act,” and

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year8.pdf> [hereinafter *ODWDA Report 8*].

⁹⁸ *ODWDA Report 15*, *supra* note 91, at 3.

⁹⁹ *ODWDA Report 8*, *supra* note 97, at 13.

¹⁰⁰ Mishael Azam, *Opposition to A3328 “New Jersey Death with Dignity Act,”* Medical Society of New Jersey (Feb. 7, 2013), http://www.patientsrightscouncil.org/site/wp-content/uploads/2013/07/MSNJDeath_with_Dignity-MSNJ.pdf.

¹⁰¹ *CEJA Report*, *supra* note 9, at 2.

¹⁰² *Code of Ethics: Physician-Assisted Suicide*, *supra* note 10; AMERICAN MEDICAL ASSOCIATION CODE OF MEDICAL ETHICS, OPINION 2.21 – EUTHANASIA, (1994), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion221.page> [hereinafter *Code of Ethics: Euthanasia*].

euthanasia as “administration of a lethal agent...for the purpose of relieving the patient’s intolerable and incurable suffering.”¹⁰³ However, the organization finds it permissible for a physician to withhold or withdraw treatment from a patient, thereby causing death.¹⁰⁴ Analogous to the legal distinction, the AMA derives permissibility from intent.

i. The Principle of Double Effect

The AMA, by means of the CEJA, rationalizes what may otherwise be considered active euthanasia through the principle of double effect.¹⁰⁵ In an identical description as the one accepted by law, the AMA provides that “palliative treatment that may hasten a patient’s death is permissible.”¹⁰⁶ This premise, as stated previously, results in a philosophical question of intent.¹⁰⁷ There are four ethical conditions that must be met in order for a physician action to be permissible:

[T]he nature of the action must be good or morally neutral and, thus, not prohibited; a good effect or consequence must be intended to flow from the action, and not a bad or evil consequence; the good or positive result must not be used as a direct casual [sic] consequence of the evil result; and the good or positive result must be proportionate to any evil result.¹⁰⁸

These guidelines dictate that the action taken cannot be morally wrong; the physician must intend to relieve pain and not to cause death; death cannot be the means by which the physician intends to relieve pain; and the relief of pain must be proportionate to the near certainty that the action will result in death.¹⁰⁹ Therefore, in a circumstance where palliative treatment is intended to relieve pain, and not to hasten death, but the treatment’s effect may in fact hasten death, the treatment plan is ethically permissible. The double effect of a treatment does not prevent the

¹⁰³ *Code of Ethics: Physician-Assisted Suicide*, supra note 10; *Code of Ethics: Euthanasia*, supra note 102.

¹⁰⁴ *BBC Ethics Guide*, supra note 8; *CEJA Report*, supra note 9, at 1.

¹⁰⁵ *CEJA Report*, supra note 9, at 1.

¹⁰⁶ *Id.*

¹⁰⁷ See George P. Smith, II, *Refractory Pain, Existential Suffering, and Palliative Care: Releasing an Unbearable Lightness of Being*, 20 CORNELL J.L. & PUB. POL’Y 469, 539 (2011).

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

physician from engaging in a particular act, despite knowledge that, for example, particular medication may result in decreased respiration and ultimate death.¹¹⁰

Said differently, the foundation of double effect can be described in terms of Immanuel Kant's means and end logic.¹¹¹ Kant's framework proposes that human actions should not be a means to an end, but always an end in and of themselves.¹¹² Based on this premise, the sequences of events in the treatment decision, as well as the intent, are critical to the principle of double effect. In the event that there are two results from a treatment modality, so long as the permissible outcome—to treat pain—is the intent of the treatment and the end that is sought, and not the impermissible outcome—to hasten death—then the treatment is ethically justifiable. This remains true despite the foreseeability of the impermissible outcome because the treatment is an end in itself to relieve pain, not merely a means to hasten death. More simply, death cannot be the means of alleviating the patient's pain. However, if death results from the means of attaining pain relief, then this double effect will be ethically tolerable because the physician's intent does not treat treatment as a means to an end. Ethically, mirroring the accepted premises of the Supreme Court, the AMA provides physicians a defense for treatment decisions that hasten death, despite the correlation between this result and euthanasia.¹¹³

ii. The AMA on Passive Euthanasia

The CEJA maintains that withholding or withdrawing life-sustaining treatment is not attributable to the physician, and instead is the result of the patient's or the patient's proxy's intentional and permissible interference with medical care.¹¹⁴ Of utmost importance in this

¹¹⁰ *CEJA Report*, *supra* note 9, at 1.

¹¹¹ IMMANUEL KANT, *GROUNDING FOR THE METAPHYSICS OF MORALS* 30 (James W. Ellington trans., Hackett 3d ed. 1993) (1795).

¹¹² *Id.*

¹¹³ *CEJA Report*, *supra* note 9, at 1.

¹¹⁴ *CEJA Report*, *supra* note 9, at 2.

ethical distinction is the principle of self-determination.¹¹⁵ In this, “individuals are the best judges of their own interests”¹¹⁶ and therefore should be permitted to make decisions regarding their medical care, especially in circumstances that may result in death. Self-determination has been an important focus of moral, ethical, and legal considerations in end of life decision making. However, there is a “fundamental difference between refusing life-sustaining treatment and demanding life-ending treatment.”¹¹⁷ The AMA, perhaps properly, reduces self-determination to a right to “accept or refuse offered interventions, but not to decide what should be offered.”¹¹⁸ Although a patient has a legally protected right to refuse life-sustaining medical treatment, this does not implicate a duty on a physician to participate in ending the life of the patient. When a patient refuses life-sustaining treatment, his or her underlying disease takes its natural course and is the ultimate cause of death.¹¹⁹ While it is impermissible for a physician to hasten the death of an individual when outside of the scope of double effect, the physician must comply with patient rights to refuse treatment.¹²⁰ It is entirely different, according to the AMA, for the physician to take part in the intentional death of the patient.¹²¹

II. The Fundamental Inconsistencies in Arguing Against Physician-Assisted Suicide

Many legal and ethical arguments in favor of passive euthanasia are applied to issues of physician-assisted suicide inconsistently. This section will first explore this difference in application in terms of Constitutional questions. Though the Constitution is mentioned as a source of analysis at the state and federal level, this discussion is misplaced. Even when considering due process arguments of liberty, the ultimate question is whether a right to die

¹¹⁵ *CEJA Report*, *supra* note 9, at 2.

¹¹⁶ Peter Singer, *Voluntary Euthanasia: A Utilitarian Perspective*, 17 *Bioethics* (ISSUE) 5-6, 526 (2003).

¹¹⁷ *CEJA Report*, *supra* note 9, at 2.

¹¹⁸ *Id.*

¹¹⁹ *Id.*

¹²⁰ *Id.*

¹²¹ *Id.*

exists, and consequently, whether that right translates to a right to commit suicide. Scalia finds that the Constitution does not provide answers to either of these questions. Therefore, a proper analysis of physician-assisted suicide must begin with a state's right to interfere with such behavior. Thus, this section will analyze whether states' interference with suicide in other contexts is consistent with their interpretation and application of the right to interfere with physician-assisted suicide. This paper will then address the potential concerns and abuses associated with physician-assisted suicide. Finally, this section will analyze causation and intent, as well as AMA arguments, and find that the arguments against physician-assisted suicide are fundamentally inconsistent with the foundations for which we argue in favor of passive euthanasia.

As Justice Scalia noted in his concurrence in *Cruzan*, the Constitution is an inappropriate foundation for determining rights and legislating in situations in which taking life is the objective.¹²² When discussing passive euthanasia, the majority opinion provided that “the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving” treatment.¹²³ As discussed, while this right was once derived from a constitutional right to privacy or the doctrine of informed consent, the *Cruzan* court instead framed the issue as a liberty interest under the Due Process Clause.¹²⁴

Though the majority found that Missouri's clear and convincing evidence standard for surrogate judgment did not violate Cruzan's right to due process, Scalia noted that a the liberty interest at issue is not a right to liberty “*simpliciter*,” but a “protection against deprivations of liberty ‘without due process of law.’”¹²⁵ Under the Due Process Clause, a substantive claim

¹²² *Cruzan v. Dir., Missouri Dep't of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring).

¹²³ *Id.* at 279 (majority opinion).

¹²⁴ *Id.* at 278.

¹²⁵ *Id.* at 293 (Scalia, J., concurring).

cannot be successful unless “the State [had] deprived [an individual] of a right historically and traditionally protected against state interference.”¹²⁶ According to Scalia, when a patient seeks to have life-sustaining treatment withheld or withdrawn, she fundamentally seeks to commit an act of suicide.¹²⁷ Though the act of passive euthanasia may be successfully grounded in the common law doctrine of informed consent, in order to examine the due process argument, one must analyze whether suicide is a “historically and traditionally” protected right.¹²⁸ Scalia argues it is not.¹²⁹ In common law, suicide has never been an approved act.¹³⁰ Even to commit such an act in order “to avoid those ills which [persons] had not the fortitude to endure” has been deemed inexcusable.¹³¹ It is therefore impossible to differentiate between requests for passive euthanasia and an act of suicide.

Although the Constitution is silent, it has been universally accepted that a state may act in order to prevent suicide.¹³² Though the state may have a right to interfere with such an act, it is within the discretion of the state to choose not to assert that right. Thus, when states exemplify their acceptance of suicide in their allowance of passive euthanasia,¹³³ the same state’s prohibition of physician-assisted suicide on the basis of its right to prevent suicide is illogical and inconsistent.

¹²⁶ *Id.* at 294.

¹²⁷ *Id.* at 296-297.

¹²⁸ *Cruzan*, 497 U.S. at 294 (Scalia, J., concurring).

¹²⁹ *Id.* at 295 (“There is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed ‘fundamental’ or ‘implicit in the concept of ordered liberty.’” (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937))).

¹³⁰ *Id.* at 294.

¹³¹ *Id.* at 295 (“The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life’s enjoyment, and anxious to continue to live.” (quoting *Blackburn v. State*, 23 Ohio St. 146, 163 (1873))).

¹³² *Id.* at 298.

¹³³ *Id.* at 278 (majority opinion); *In re Quinlan*, 70 N.J. 10, 41 (1976); *In re Conroy*, 98 N.J. 321, 374 (1985).

Another distinction courts and ethicists draw is that between action and inaction.¹³⁴ According to Scalia, the logic of this distinction is that suicide is not an “affirmative act” causing death, but instead is the inaction found in accepting natural death.¹³⁵ However, this is an unpalatable argument as the distinction is found instead between various forms of inaction.

It would not make much sense to say that *one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide....* [I]n other words, the intelligent line does not fall between action and inaction but between those forms of inaction that consist of abstaining from “ordinary” care and those that consist of abstaining from “excessive” or “heroic” measures.¹³⁶

However, this proposed distinction is not one to be made through legal analysis.¹³⁷ Irrespective of the appropriate arena for this analysis outside of the legal sphere, the indistinction brings closer the acts of passive euthanasia and physician-assisted suicide. If suicide is the ultimate issue, whether it is committed by the discontinuation of artificial nutrition and hydration or through ingestion of lethal medication is not relevant. Instead, if we are to allow one, we must allow both. And, conversely, if one form is deemed morally unacceptable, then this analysis should be applied to the other as well.

Scalia’s arguments persuasively establish that, while perhaps permissible, suicide is not an act that can be analyzed in the context of the United States Constitution.¹³⁸ This is not to say that the failure of equal protection and due process challenges in *Quill* and *Glucksberg* were incorrectly decided;¹³⁹ rather, these cases were appropriate in light of the fact that there is no constitutional issue at hand.¹⁴⁰ But in rejecting a constitutional argument and providing states

¹³⁴ *Cruzan*, 497 U.S. at 296 (Scalia, J., concurring).

¹³⁵ *Id.*

¹³⁶ *Id.* (emphasis added).

¹³⁷ *Id.*

¹³⁸ *Id.* at 300.

¹³⁹ *Vacco v. Quill*, 521 U.S. 793, 807 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 735 (1997).

¹⁴⁰ *Cruzan*, 497 U.S. at 300 (Scalia, J., concurring).

with the discretion to legislate in end of life care, states have overlooked the inconsistencies of their distinction between passive euthanasia and physician-assisted suicide.

Many argue that the difference between life-support termination and physician-assisted suicide lies in the potentially grave abuses of the latter. However, with respect to actually enacting physician-assisted suicide legislation, there are a variety of safeguards to ensure that the availability is not abused.¹⁴¹ The responsibilities of the physician alone are voluminous in order to ensure that the patient is able to retain autonomy in making an informed decision.¹⁴² Additionally, there are strict reporting requirements for physicians that not only track the success of the initiative but ensure transparency.¹⁴³ Finally, the legislation's expansive list of definitions prevents confusion or exploitation under the Act.¹⁴⁴

Perhaps the only arbitrary definition within the Oregon statute is that of "terminal disease."¹⁴⁵ As per the statute, which is mirrored by Washington legislation,¹⁴⁶ this diagnosis is given to an individual who has "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, product death within six months."¹⁴⁷ However, it is incredibly difficult to project this with certainty. In fact, according to Oregon data, some individuals who were given a six-month diagnosis not only outlived this projection, but did not ingest lethal medication until 1009 days after their first request.¹⁴⁸ This is more than two years longer than the six-month assertion. While this was the longest period noted by Oregon data in its fifteen-year history, in 2012 alone there were individuals who did not ingest the

¹⁴¹ OR. REV. STAT. ANN. §§ 127.800-127.897 (West 1995).

¹⁴² *Id.* § 127.815.

¹⁴³ *Id.* § 127.865.

¹⁴⁴ *Id.* § 127.800.

¹⁴⁵ *Id.* § 127.800(12).

¹⁴⁶ WASH. REV. CODE ANN. § 70.245.010(13) (West 2009).

¹⁴⁷ OR. REV. STAT. ANN. § 127.800(12).

¹⁴⁸ *ODWDA Report 15, supra* note 91, at 6.

medication until 388 days after the first request.¹⁴⁹ Though it is not within the legislative intent for physicians to prescribe lethal medication to individuals outside of the final six-months of life, this is not what the statistic suggests. Instead, it establishes the difficulty in estimating how long it will take for a disease to take its course.

This discrepancy should not act as discouragement for purposes of physician-assisted suicide. Rather, it can be defended by our choice as a society to trust the judgment of physicians. This trust is something we choose to accept in other areas, such as prescribing dangerous controlled substances appropriately or determining gestational development. Despite the difficulty in making decisions in areas that lack scientific certainty, society has accepted the judgment of physicians to make these determinations. At times, the law must defer to medical judgment, even in light of the fact that it may not provide complete accuracy.

As stated in *Glucksberg*, allowing assisted suicide would pose “profound risks to many individuals,” including those who are ill and vulnerable.¹⁵⁰ However this is a danger that is equally present in situations of passive euthanasia. In the termination of life-supportive measures, especially for those who are incompetent and must have a surrogate decision maker, the objective is to reject the treatment that is sustaining life. Individuals on life-support are ill and vulnerable by definition. However, passive euthanasia is permissible and surrogates are entitled to act on behalf of incompetent individuals because the Supreme Court has recognized the right of a competent individual to choose to terminate treatment in similar circumstances.¹⁵¹

States have reacted to termination requests by imposing requirements that surrogate decision makers must meet in order to establish that it is the wish of the patient, or in the

¹⁴⁹ *ODWDA Report 15*, *supra* note 91, at 6.

¹⁵⁰ *Washington v. Glucksberg*, 521 U.S. 702, 719 (1997).

¹⁵¹ *Cruzan v. Dir., Missouri Dep’t of Health*, 497 U.S. 261, 278 (1990).

patient's best interest, to terminate life support.¹⁵² Though these requirements may make it incredibly difficult for surrogates to meet the states' standard for decision making in these matters, they are permissible in order to protect the interests of an incompetent person.¹⁵³ However, if these standards are sufficient to protect the interests of an incompetent patient's ultimate right to die, a competent patient could surely assert this right as well. In Death with Dignity legislation, the autonomous and informed decision to physician-assisted suicide is inherently protected by the very requirements that provide eligibility under the Act.¹⁵⁴

In terms of a physician's moral culpability, physician-assisted suicide is wrong. However, it is no more wrong than the acts required in passive euthanasia. Contrary to the current legal argument for passive euthanasia, a moral wrong cannot be justified on the basis on informed consent.

The bare difference between killing and letting die does not, in itself, make a moral difference. If a doctor lets a patient die, for humane reasons, he is in the same moral position as if he had given the patient a lethal injection for humane reasons. If his decision was wrong... the decision would be equally regrettable no matter which method was used to carry it out.¹⁵⁵

The premise creates a conflict with the legally and ethically accepted principle of double effect. If we choose to see death as fundamentally wrong in certain circumstances, it cannot be morally justified under any principle, including intent. Yet, it is legally and ethically permissible to both engage in acts of passive euthanasia as well as acts that can be defended under the principle of double effect.¹⁵⁶ Therefore, death cannot be seen as a universal wrong. Instead, it is judged on behalf on the individual who lives the particular life in question.¹⁵⁷ Thus, if we grant individuals

¹⁵² *Id.* at 285; *In re Conroy*, 98 N.J. 321, 360-365 (1985).

¹⁵³ *Cruzan*, 497 U.S. at 280.

¹⁵⁴ OR. REV. STAT. ANN. § 127.815 (West 1995).

¹⁵⁵ Rachels, *supra* note 1.

¹⁵⁶ *Vacco v. Quill*, 521 U.S. 793, 802 (1997); *CEJA Report*, *supra* note 9, at 1.

¹⁵⁷ *Cruzan*, 497 U.S. at 300 (Scalia, J., concurring).

the privilege to determine whether life is worth living, the privilege must be granted to *all* individuals.

This argument of indistinction also directly contradicts the position of the AMA Council on Ethics and Judicial Affairs.¹⁵⁸ The CEJA argues that, based on intent and the physician's legal responsibility to accept a patient's refusal of care, the physician may not participate in physician-assisted suicide, but may engage in passive euthanasia.¹⁵⁹

This is where the mistake comes in, for what is the cessation of treatment, in these circumstances, if it is not the 'intentional termination of the life of one human being by another?' Of course it is exactly that, and if it were not, there would be no point to it.¹⁶⁰

As expressed, this distinction is morally inappropriate. Physician-assisted suicide is an act that hastens death. Withholding or withdrawing the life-supporting treatment of an individual will produce an identical result. Therefore, while hastening death is the result, consent to do so in passive euthanasia is morally indistinguishable from consent to engage in physician-assisted suicide.

A stronger argument on behalf of the AMA is the distinction drawn between a patient asserting his or her right to refuse treatment and the patient demanding a prescription for lethal medication.¹⁶¹ At the crux of this argument is why a physician should not have to participate in assisted suicide, and for that it is valid. However, practically speaking, no patient may ever make such a demand upon a physician. Under Death with Dignity legislation, there is no affirmative duty on any physician to participate in any of the procedures.¹⁶² Additionally, physicians may permissibly enact policies on behalf of their entire practice to refrain from participation, despite

¹⁵⁸ *CEJA Report*, *supra* note 9, at 2.

¹⁵⁹ *Id.*

¹⁶⁰ Rachels, *supra* note 1.

¹⁶¹ *CEJA Report*, *supra* note 9, at 2.

¹⁶² OR. REV. STAT. ANN. § 127.885(4) (West 1995).

the views of each individual practitioner associated with the entity.¹⁶³ Therefore, the patient's decision to avail herself to the Death with Dignity Act is not the result of a demand, but rather an exploration of options discussed with a consenting physician.

Additionally, the AMA's restriction on the practice of physician-assisted suicide is not a universal prohibition. The Oregon Death with Dignity Act provides that no individual will be subject to "professional disciplinary action for participating in good faith compliance" with the Act.¹⁶⁴ The AMA recognizes its position relative to the law, and in order to accommodate both, suggests that the actual prescriptions for lethal medication be written by nurse practitioners and physician assistants in order to protect the physician's professional ethics.¹⁶⁵ However, suggesting subordinates write the prescription is inconsistent with the AMA's finding that physician-assisted suicide is impermissible.

The most common distinction between physician-assisted suicide and passive euthanasia is that of causation and intent.¹⁶⁶ As discussed, the intent of the physician should not be a distinguishable characteristic in a circumstance in which the patient is consenting to the ultimate outcome, namely death. As stated in *Quill*, "when a patient refuses life-sustaining treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."¹⁶⁷ While this assertion is accurate, the Court went on to suggest that the physician's act in prescribing the medication was the cause of death.¹⁶⁸ This is a mistake. The chain of causation must contain several events in order for the patient to end his or her life. It is true that the provision of the prescription initiates this chain,

¹⁶³ *Id.* § 127.885(5).

¹⁶⁴ *Id.* § 127.885(1).

¹⁶⁵ Faith Lagay, *Physician-Assisted Suicide: The Law and Professional Ethics*, AMERICAN MEDICAL ASSOCIATION JOURNAL OF ETHICS VIRTUAL MENTOR (Jan. 2003), <http://virtualmentor.ama-assn.org/2003/01/pfor1-0301.html>.

¹⁶⁶ *Vacco v. Quill*, 521 U.S. 793, 801 (1997).

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

and perhaps is a substantial factor in the outcome. However, in order for death to occur, the pharmacist must fill the prescription, the patient must receive the lethal medication, and finally the patient must self-administer the medication. If any of these events do not happen, then death will not occur. The most important factor in this chain is whether the patient chooses to take the lethal medication. Oregon statistics establish that 36 percent of patients do not. Therefore, in 36 percent of cases, the physician's act is not the cause of death. The provision of a prescription thus cannot be considered the cause of death, as it does not in fact cause death.

Finally, the United States allows medical intervention in order to end life in other circumstances. A woman's right to an abortion was initially argued under the right to privacy, but like passive euthanasia cases, it was reaffirmed under the liberty interest found in the Due Process Clause.¹⁶⁹ In the case of abortion, which involves the **ending of a life, or potential life**, we allow medical intervention. This intervention is far more direct in ending life than the provision of a prescription that an individual may or may not self-administer. Additionally, we allow situations of terminal sedation in which a physician may place a patient into a medically induced coma prior to removing life-sustaining treatment. While this is often justified in terms of preventing pain, it is also a direct action resulting in death. The situation of terminal sedation also illustrates the actual action a physician must take in order to remove life-sustaining treatment. Typically, terminal sedation is justified through double effect, which, as established is morally unsound. Despite our allowance of medical intervention in these situations, opponents of physician-assisted suicide still choose to assert the argument that the physician's action in aiding death is what makes assisted-suicide "wrong." This is fundamentally inconsistent with the approach taken for ending life outside of assisted suicide.

Conclusion

¹⁶⁹ Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 901 (1992).

Withhold or withdrawing life-sustaining treatment and allowing a patient to die is morally indistinguishable from physician-assisted suicide. Ethical and legal analyses that suggest the two are dissimilar are misguided because both physician-assisted suicide and passive euthanasia are methods used to end life. Attempts to distinguish the two based on causation and intent, or action and inaction must fail, as these are not relevant to the ultimate issue of whether a physician or patient may engage in an act that will hasten death. If society is willing to defend the morality of a physician's actions in cases of passive euthanasia, then this defense should be equally applicable to situations of physician-assisted suicide. However, the moral culpability associated with hastening death is inconsistently applied. If an act that hastens death is an inappropriate, it must be inappropriate in all circumstances.