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LOOKING FOR A NONLEGAL PROCESS: PHYSICIAN-ASSISTED SUICIDE AND THE CARE PERSPECTIVE

*Paul J. Zwier**

One of the many benefits of an interdisciplinary seminar like the Allen Chair-sponsored Bioethics seminar held at the University of Richmond Law School in 1995 was that members of the seminar had the opportunity to study the effects of the legal system's attempt to regulate bioethical issues. No question proved more troubling for the seminar than the question of physician-assisted suicide. Seminar participants, both members of the class and speakers, divided deeply on the legality of physician-assisted suicide, and for good reason. The discussions started with court decisions that were found to be both divisive and unsatisfactory.¹ A number of recent court decisions dealing with physician-assisted suicide² brought home the point that there are some dilemmas in life whose outcomes should not be left to the courts.³ Not only were the courts' holdings hopeless-

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1. The seminar members were not alone in their dissatisfaction with the legal analysis. See Michael R. Flick, Comment, *The Due Process of Dying*, 79 CAL. L. REV. 1121 (1991); Carl E. Schneider, *Bioethics with a Human Face*, 69 IND. L.J. 1075 (1994).

2. The most recent is *Lee v. Oregon*, 891 F. Supp. 1429 (D. Ore. 1995). I will also discuss other recent cases that deal with end-of-life issues that have physician-assisted suicide implications, including *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1989); *In re Baby K*, 16 F.3d 590 (4th Cir. 1994); *Quill v. Koppel*, 870 F. Supp. 78 (S.D.N.Y. 1994); *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994) *rev'd*, 49 F.3d 586 (9th Cir.), *reh'g granted*, 62 F.3d 299 (1995) (en banc).

3. One such situation in which the courts declare themselves ineligible, or at least reluctant, is where the courts are asked to determine whether corporate boards of directors have breached their duty of care to their shareholders. See WILLIAM L. CARY & MELVIN A. EISENBERG, *CASES AND MATERIALS ON CORPORATIONS* 541 (6th ed. 1988).

In many areas of law, a distinction is drawn between substance and process. The duty of care may be understood in that way too. In effect, the business judgment rule gives wide latitude to a substantive decision of a director or senior executive if, but only if, he has followed a process

ly contradictory to earlier pronouncements, but the courts' analyses were unsatisfactory due to the bipolarization caused by the language of equality and rights that pervaded the legal analyses.⁴ The courts' decisions seemed simply to miss the real issues and were unable to weigh the particular circumstances in which physician-assisted suicide seemed appropriate.⁵

When our discussion turned from the analysis of the courts' rulings and struggled instead with resolutions of individual patient cases, the class started to come together.⁶ In certain individual cases the class agreed that assisting someone in committing suicide would be wrong, but in other cases they were more comfortable with leaving, or at least willing to leave, the decision to a group consisting of the patient, physician, nurse, family and friends.⁷ Where there was real proof of a car-

that is reasonable, in terms of due preparation, in arriving at that decision. The process elements of the duty of care, involving such matters as preparing to make a decision, general monitoring, and following up suspicious circumstances, are governed by a standard of reasonability, while the substantive element, involving review of management decisions, is governed by the much looser standard of rationality.

Id. See also *Smith v. Van Gorkum*, 488 A.2d 858 (1985) (describing the elaborate process that the board should go through in deciding whether to recommend a sale of the corporation to the corporation's shareholders).

4. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994) *rev'd*, 49 F.3d 586 (9th Cir.), *reh'g granted*, 62 F.3d 299 (1995) (en banc); Peter Westen, *The Empty Idea of Equality*, 95 HARV. L. REV. 537 (1982); cf. Kent Greenawalt, *How Empty is the Idea of Equality?*, 83 COLUM. L. REV. 1167 (1983).

5. Westen, *supra* note 4, at 581-84.

6. Cases which were not presented as legal opinions, but as patient dilemmas, include *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (1986); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626 (Mass. 1986). *Bouvia* was a case involving a twenty-eight-year-old woman who was afflicted with cerebral palsy and degenerative arthritis. She was almost completely paralyzed, suffered continual pain, and needed constant nursing care. Although not terminally ill, she had no chance of recovery and would need continual medical care for the fifteen to twenty years her doctors expected her to live. Her family and friends were no longer able to house and care for her. She checked herself into a California hospital to die. She did not want to be fed. When the hospital refused, she sought a court order. Once it was attained, she decided to accept treatment. *Brophy* was a case involving a comatose patient's wife who sought successfully on her husband's behalf to have his feeding tubes removed because he had previously indicated that he would not want treatment in such circumstances.

7. Ann Hamric, a clinical nurse specialist and member of the Medical College of Virginia's Ethics Committee, presented the case of Stan to the seminar. [hereinafter *Stan's Case*]. Stan was almost seventeen, a junior in high school, and an excellent gymnast when he fell head first off the rings during practice. He sustained a C1 spinal fracture and contusion of the spinal cord which resulted in total paralysis from the neck down. After six months, he had no return of function, and he remained

ing and loving decision-making process that valued the patient and understood not only his or her medical situation but also his or her social and psychological setting, then the allowance for physician-assisted suicide was made.⁸

It became clear that a new way of looking at the problem was needed, one that relied less on universal principles like "equal protection" and "rights," and instead borrowed from bioethics,⁹ and more particularly from the care perspective.¹⁰ Using a care perspective, society would be better able to deal with the real issues that are involved in physician-assisted suicide and create a framework that would allow both for adequate safeguards and individualized analysis.¹¹ By using a

paralyzed and ventilator-dependent. Stan could mouth words, but could not talk because of his tracheotomy. Stan spent three months trying to identify ways of ending his life. He first asked to become a Christian Scientist so that he could refuse treatment on religious grounds. He refused to eat, so the medical team inserted a nasogastric tube which was so unpleasant that he agreed to eat again. He was placed on Elavil for continued "depression." He sought a lawyer to be declared an emancipated minor so that he could sue his parents for the right to refuse treatment. The lawyer refused. Stan's mother was very upset about his questions, often crying and looking away so she could not read his lips. His father refused to talk to him and left the room whenever Stan started to talk about dying. Both parents insisted that he would get better and were opposed to any plan for ending his life.

8. *See id.*

9. *See* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (4th ed. 1994). The authors write:

Another family of moral reflections is widely referred to as the *ethics of care*. It shares some premises with communitarian ethics, including some objections to central features of liberalism and an emphasis on traits valued in intimate personal relationships, such as sympathy, compassion, fidelity, discernment, and love. *Caring* in these accounts refers to care for, emotional commitment to, and willingness to act on behalf of persons with whom one has a significant relationship. Noticeably downplayed are Kantian universal rules, impartial utilitarian calculations, and individual rights.

Id. at 85.

10. The ethics of care is more fully described later in the paper. *See generally* CAROL GILLIGAN, *IN A DIFFERENT VOICE: A PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* (1982); NEL NODDINGS, *CARING, A FEMININE APPROACH TO ETHICS AND MORAL EDUCATION* (1984); Alisa L. Carse, *The 'Voice of Care': Implications for Bioethical Education*, 16 *J. MED. & PHIL.* 5 (1991); Carol Gilligan, *Moral Orientation and Moral Development*, in *WOMEN AND MORAL THEORY* 19 (Eva F. Kittay & Diana T. Meyers eds., 1987); Diana T. Meyers, *The Socialized Individual and Individual Autonomy: An Intersection between Philosophy and Psychology*, in *WOMEN AND MORAL THEORY* 139 (Eva F. Kittay & Diana T. Meyers eds., 1987).

11. In constitutional law, the courts have developed the doctrine of nonjusticiability of "political questions." *See, e.g., Baker v. Carr*, 369 U.S. 186 (1962).

care perspective, care providers for the terminally ill would be able to insure that caring and careful decisions would be reached about when to assist a patient in her wish to end her life.

This article will first review the cases that deal with physician-assisted suicide and show how unsatisfactory the legal analysis has been. Second, it will describe a care perspective and demonstrate how a perspective that revolves around caring, listening, and consensus-building improves and enhances the moral responsibility for the choices that are to be made. Rejecting blanket legal solutions, I will discuss how the care perspective also better deals with the psychological factors of depression and hopelessness that bring about the suicide request in the first place. Part of this section will argue that the law prohibiting suicide has the reverse effect of that intended and causes more suicides; that studies of attempted suicide suggest that in listening to and respecting a request for suicide, the

It is apparent that several formulations which vary slightly according to the settings in which the questions arise may describe a political question, although each has one or more elements which identify it as essentially a function of the separation of powers. Prominent on the surface of any case held to involve a political question is found a textually demonstrable constitutional commitment of the issue to a coordinate political department; or a lack of judicially discoverable and manageable standards for resolving it; or the impossibility of deciding without an initial policy determination of a kind clearly for nonjudicial discretion; or the impossibility of a court's undertaking independent resolution without expressing lack of the respect due coordinate branches of government; or an unusual need for unquestioning adherence to a political decision already made; or the potentiality of embarrassment from multifarious pronouncements by various departments on one question.

Id. at 216-17.

My idea is to create a new "branch of government." I have in mind one like a jury but composed of people who know and care for the patient and have a stake in the patient's reaching a good decision. *See infra* part III.

In addition, the courts have recognized in other situations that they should resist becoming too involved in making the decision. Even in the more mundane world of corporate decision-making, the courts have given the corporation's board of directors the power to make the decisions that legally bind the corporation, and the courts grant the board the protection of the business judgment rule. State statutes provide that the board's litigation committee can move to dismiss shareholder complaints if the litigation committee shows that they fully investigated the matter and are acting independently. Some courts go further and second-guess the business judgment of the committee, while others will dismiss if the procedural requirements of the statute are met. I propose that this same procedural protection be given to care providers who assist in suicide.

patient will more likely be persuaded not to commit suicide. Finally, I will suggest a framework in which the care perspective can be implemented, which should satisfy concerns about care providers' abuse of helpless and depressed patients when we allow for the possibility that patients be assisted in suicide.

I. LEGAL SETTING

A. *Statement of the Philosophical Problem*

One problem that leads to a tortured legal analysis of physician-assisted suicide is philosophical. It is referred to as the slippery slope:¹² how do we decide when a person is "reasonable" in a request to end his or her life without opening the door to honoring the request of the momentarily depressed patient or the request of someone who is highly susceptible to inappropriate suggestion? And, how do we adequately guard against society's bias against the old and sick because of cost factors of medical care at the end of life?

Traditional criminal law once tried to answer the questions clearly.¹³ It not only prohibited the assistance of suicide, it prohibited suicide itself.¹⁴ Taking the view that life was sacred, and that the individual's life was in God's hands and not in the individual's own, the law prohibited someone from taking

12. Tom L. Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia*, in *ETHICAL ISSUES IN DEATH AND DYING* 246 (Tom L. Beauchamp & Seymour Perlin eds., 1978); Eugenie A. Gifford, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 *UCLA L. REV.* 1545, 1568 (1993); see *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995), *reh'g granted*, 62 F.3d 299 (1995) (en banc). The Ninth Circuit reasoned:

If at the heart of the liberty protected by the Fourteenth Amendment is the uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. The attempt to restrict such rights to the terminally ill is illusory. If such liberty exists in this context, . . . every man and woman in the United States must enjoy it. . . . The conclusion is a *reductio ad absurdum*.

Compassion in Dying, 49 F.3d at 591 (emphasis added).

13. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 292 (Scalia, J. concurring); Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 *DUQ. L. REV.* 1 (1985).

14. See Marzen, *supra* note 13, at 67 (detailing the acceptance by the thirteen colonies of the English common law which treated suicide as a crime).

his own life.¹⁵ Yet, even early on, there was deep division on the question of the morality of suicide.¹⁶ Was it not the height of morality for an individual to sacrifice herself in the waning moments of life for the benefit of those she left behind?¹⁷ Or was suicide always a weak and faithless response to the fear of pain and the fear of the unknown?¹⁸ The American response to the moral debate was to gradually do away with the criminal treatment of suicide attempts.¹⁹ Add to the moral and legal debate about suicide the "improved" life-ending technology and the prospect of technology endlessly prolonging the body long after life had left it,²⁰ and the prohibitions against suicide become even weaker.²¹ The cost of life-sustaining technology has proved enormous.²² These huge costs in artificial life support technology add to the moral calculation that suicide may be a legitimate act of self-sacrifice.²³

Yet, while no longer prohibiting suicide, criminal law has continued to prohibit assisting suicide on the grounds that it is troublesomely close to murder.²⁴ The distinction that criminal

15. *Id.* at 20-27.

16. *Id.* at 31-50.

17. *Id.* at 50-56.

18. *Id.*

19. *Id.* at 56-75.

20. The American Medical Association has recognized "that the dying process is too often needlessly protracted by medical technology." *AMA Council on Ethical and Judicial Decisions Near End of Life*, 267 JAMA 2229 (1992).

21. See Marjorie Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 295-96 (1985).

22. Some estimates of long-term nursing care run as high as \$100,000 for the average person. The average stay is 19 months and runs from \$30,000 to \$60,000 a year. See PETER DAWSON & JOHN STAN, *PUBLIC EXPENDITURES IN THE UNITED STATES, 1952-1993* (1995) (detailing increases in public expenditures on health care).

23. See GERALD A. LARUE, *EUTHANASIA AND RELIGION: A SURVEY OF THE ATTITUDES OF WORLD RELIGIONS TO THE RIGHT-TO-DIE 1* (1985). One is reminded of the biblical passage, "Greater love hath no man than this, that he lay down his life for his friend." *John* 15:13. A 1981 survey of Christian laities' attitudes toward suicide reveals that 61% would allow suicide for those with incurable disease. See Marzen, *supra* note 13, at 56.

24. For example, the Model Penal Code provides in section 210.5 on causing or aiding suicide: "(1) Causing Suicide as Criminal Homicide. A person may be convicted of criminal homicide for causing another to commit suicide only if he purposely causes such suicide by force, duress or deception." MODEL PENAL CODE § 210.5 (Tentative Draft 1962); *cf.* *Grace v. State*, 69 S.W. 529, 530 (1902) ("We have no statute denouncing suicidal acts; nor does our law denounce a punishment against those who furnish the suicide with the means by which the suicide takes his own life."). *But see*

law attempts to draw is that, while allowing someone to commit suicide is not a crime, assisting or soliciting them to commit suicide is.²⁵ The distinction is said to be that between nonfeasance and misfeasance.²⁶ Yet, the philosophical problem between nonfeasance and misfeasance, or withholding or withdrawing treatment and causing someone's death, is also a troublesome one.²⁷ In fact, most commentators would say that the distinction is meaningless in this context.²⁸

The distinction between misfeasance and nonfeasance is troubling because many commentators include in the definition of an "act" the willful withholding of physical movement where there is an earlier act, like a promise, that is not fulfilled, or a status that gives rise to duty, that must be carried out.²⁹ The person is responsible for acting carelessly when she fails to do something.³⁰ Yet, the act can be labeled as "misfeasance" be-

Aven v. State, 277 S.W. 1080 (1925) (holding that a person who actually caused the victim to put arsenic in her mouth and swallow it committed murder).

25. See MODEL PENAL CODE § 210.5 (1962). "Aiding or Soliciting Suicide as an Independent Offense. A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor." *Id.* § 210.5(2).

26. See generally James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975).

27. *Id.*; cf. Beauchamp, *supra* note 12, at 249-53 (wherein Beauchamp admits that the active/passive distinction is not a sufficient reason for distinguishing between criminal and non-criminal activity, but argues that it is a reason that should be given some weight).

28. Cruzan v. Director, Missouri: Dep't of Health, 497 U.S. 261, 296 (Scalia, J., concurring); see Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958); Todd D. Robichand, *Toward a More Perfect Union: A Federal Cause of Action for Physician Aid in Dying*, 27 U. MICH J.L. REF. 521 (1994); Glanville Williams, *"Mercy-Killing" Legislation—A Rejoinder*, 43 MINN. L. REV. 1 (1958).

29. See WILLIAM L. PROSSER, HANDBOOK OF THE LAW OF TORTS 343-48 (4th ed. 1971).

30. *Id.* at 344. Prosser writes that "this idea of voluntary assumption of a duty by affirmative conduct runs through a variety of cases. Just when the duty is undertaken, when it ends and what conduct is required, are nowhere clearly defined, and perhaps cannot be." *Id.* One of the reasons why Prosser may be right that the distinction between misfeasance and nonfeasance may never be clear is that there continues to be great difficulty in even defining what it means to say someone acted. See Norman S. Care & Charles Landesman, *Introduction to READINGS IN THE THEORY OF ACTION* xi-xxxv (Norman S. Care & Charles Landesman eds., 1968); see also P.J. Fitzgerald, *Voluntary and Involuntary Acts*, in *READINGS IN THE THEORY OF ACTION* 373 (Norman S. Care & Charles Landesman eds., 1968). Fitzgerald argues that the common law distinctions between those acts for which someone is or is not responsi-

cause it can be described as acting in a way that is inappropriate.³¹ At the same time, the behavior can be described as nonfeasance because the person was failing to act immediately before the harm was caused.³² For example, in an automobile accident, the immediate cause can be that a person failed to stop in time or failed to apply the brakes. However, an equally apt description is that the driver was going too fast or was looking where he should not have been looking. The artificiality of the distinction arises from an inability to determine how broadly to describe actions; whether to focus solely on the bit of bodily behavior before injury or to include the acts that led up to the inaction.³³

To illustrate the above definitional problem in the medical setting, take, for example, the hypothetical of someone running through the intensive care unit of a hospital and intentionally unplugging respirators.³⁴ Would such a person have acted in a way that makes them responsible for killing these patients? Would they be criminally responsible? Of course they would. The act is an act of killing, even though it involves the failure to provide life support. What distinguishes, then, the doctor from turning off the respirator? The doctor's conduct is not excused because the act is one of nonfeasance.

When the courts deal with difficult questions of philosophy, policy and value in other areas of the law and they want to maintain an individualized case-by-case treatment of an issue, they often attempt definitional solutions that try to make the answers look objective and universal, yet process the decision by allowing a jury to decide whether "a fact" exists. Some courts give credence to the misfeasance/nonfeasance distinction by giving to the jury the question posed earlier, of determining whether a duty exists between two individuals that gives rise to an obligation to act.³⁵ In the alternative, the courts often try the language of "proximate cause,"³⁶ or of "natural vs. non-

ble can be drawn fairly on misfeasance and nonfeasance grounds. Fitzgerald, *supra*.

31. PROSSER, *supra* note 29, at 343-48.

32. *Id.*

33. Care & Landesman, *supra* note 30, at xvii-xxii.

34. See generally BEAUCHAMP & CHILDRESS, *supra* note 9, at 219.

35. Wierum v. RKO General, 539 P.2d 36 (1975); see also PROSSER, *supra* note 29.

36. Leon Green, *The Causal Relation Issue in Negligence Law*, 60 MICH. L. REV.

natural,"³⁷ "reasonable vs. unreasonable,"³⁸ or "foreseeable vs. unforeseeable,"³⁹ or the distinction between "extraordinary and ordinary,"⁴⁰ to create clear divisions where none exist. The benefit of these "rules" is that the court can turn a question of law into a question of fact and give the question to the jury for case-by-case determination.

While the problem the legal cases tackle in physician-assisted suicide is undoubtedly a very difficult, value-laden one, the courts have yet to free up a case-by-case analysis by using the jury through any of the above described legal language. Acts of withholding and withdrawing are not excused because the cause of death is natural. Nor do the courts find that there is some intervening act on the part of the patient which breaks the proximate causal chain of responsibility. Instead, withdrawal of treatment by the doctor is said to be an act which foreseeably causes the death of the individual.

The reason why withdrawal of technology by the doctor is acceptable in some circumstances is instead handled by proof of intent. If the patient can be shown to have wanted withdrawal or termination in these circumstances, then withdrawal is allowed. As we will see, the courts' reliance on autonomy will cause problems of its own in the case of physician-assisted suicide. At this point it is important to see that the law has turned the question of termination of life support into a question of intent and has thereby made it a question of autonomy. At the same time, it has provided a chance for the courts to second-guess the decision to terminate by allowing a jury to consider the proof of the patient's intent.

Before getting to the constitutionalization of this processing by the courts, it is important to stop and consider the "real" reasons for the court's allowance of termination of life support. After all, the jury or fact finder would likely be asking a num-

543 (1962). Green argues that it is better to ask whether the risk of injury is within the scope of duty that the defendant owed the plaintiff. In any event, he would give the question to the jury. *Id.* at 552-55.

37. *Rylands v. Fletcher*, L.R. 3 H.L. 330 (1868).

38. Leon Green, *Foreseeability in Negligence Law*, 61 COLUM. L. REV. 1401 (1961).

39. *Id.*

40. BEAUCHAMP & CHILDRESS, *supra* note 9, at 200; see also PAUL RAMSEY, *THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS* 118-24 (1970).

ber of value-laden questions when second-guessing the state of proof of a person's intent to terminate life support. They would ask not only whether the patient intended it but whether the act is justified in the light of the prognosis that the person is in a persistent vegetative state, has a terminal illness, and has indicated in a living will or through a surrogate that the patient does not want to be maintained on a respirator. The act of the doctor is justified by a balancing process of individual circumstances, with reference to autonomy and utilitarian principles against waste, and for proper management with regard to spending scarce health care dollars on the sick who have a better prognosis.⁴¹ Yet, determining justifications involves weighing of values and circumstances. The processing of this weighing and valuing is first given to the physician, surrogate, and/or family member, and only falls to the court if someone complains.

B. *Modern Cases Involving End of Life Issues*

If we do justify physicians' acting to withdraw treatment, then the problem with legal answers to the question of physician-assisted suicide is that we are already on the slippery slope.⁴² How so? We have passed to the slippery slope once we recognize that in some situations, withholding or withdrawing treatment is acceptable because we permit the care provider to act to bring about the end. That is what the court allowed in *Cruzan v. Director, Missouri Department of Health*.⁴³

In the *Cruzan* case, the Supreme Court recognized a privacy right in allowing someone to make decisions about her own health, even if that meant that she would want to end her life.⁴⁴ It found an inherent right of the individual to control the decision as to when enough was enough and required the physician to not only stand by while the individual wasted, but indeed to remove life support, whether it be respirator, nutrition tube, or hydration tube, in order that the end come soon-

41. See Rachels, *supra* note 26, at 80.

42. See generally BEAUCHAMP & CHILDRESS, *supra* note 9, at 226-27.

43. 497 U.S. 261 (1990).

44. Such a right is a liberty interest that is derived from the common law of informed consent, which implies the right to refuse treatment. *Id.*

er.⁴⁵ Not only could a state support the conscious request of a patient, it could also set its own evidentiary standard for determining whether a surrogate could speak for an unconscious patient where that patient had indicated a desire to have life support withdrawn. The line that was crossed in *Cruzan* was that the physician could "assist" in hastening death by withdrawal of life support, which places the court on the downhill side of the slippery slope. The withdrawal of technology includes an affirmative act of doing something, whether it be removing a tube or turning off the respirator. The court said that the question was one of the patient's autonomous right to refuse treatment, which in turn justified the physician's act of withdrawing or withholding treatment.⁴⁶

The same reasoning that the Supreme Court used in *Cruzan* supports physician-assisted suicide. The doctor acts in prescribing medicine, usually a pain medication, that has the dual effect of ending someone's life while attempting to relieve suffering.⁴⁷ By prescribing the medication, the doctor "flips the switch." (While some argue that the patient still flips the switch in taking the medicine, it is clear on foreseeability grounds and substantial-certainty grounds that, in these cases, the prescribing physician is at least a cause. If a physician prescribes the wrong dose of a medicine, the physician does not escape liability by saying that it was the patient's taking of the medicine that caused his death.) In most cases, what is sought is that the physician *administer* the medication, to make sure nothing goes wrong, that the suicide is not botched, and that the family is spared any of the gory death scene consequences. The physician is thus actively involved in "letting the patient die."⁴⁸

If we are already on the slippery slope when we allow for withdrawal of treatment, it is not surprising that the courts would be put in a difficult situation when analyzing physician-

45. Note, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 224-27 (1985).

46. Some have tried to base the distinction upon the difference between ordinary and extraordinary acts in preservation of life. See RAMSEY, *supra* note 40, at 118-24.

47. For a philosophical discussion of the dual effects of treatments, see EIKEHENNER W. KLUGE, *THE ETHICS OF DELIBERATIVE DEATH* 15-18 (1981).

48. See RAMSEY, *supra* note 40, at 118-24.

assisted suicide. The legal analysis is heavily influenced by reasoning by analogy. The argument in favor of physician-assisted suicide would assert that we need to take a careful look at why withdrawal of treatment, flipping the switch or withdrawing feeding and hydration, is allowed in some circumstances, and determine whether the same can be done for physician-assisted suicide. That is essentially the process that the federal district court went through in *Compassion in Dying v. Washington*.⁴⁹

The *Compassion in Dying* case attempted to use the rights-based analysis to uphold the argument for physician-assisted suicide. The district court found that there was support for a constitutional right to die in the privacy rights analysis in *Cruzan* and in *Planned Parenthood v. Casey*.⁵⁰ As stated earlier in *Cruzan*, the Supreme Court considered whether a competent person has a constitutionally protected liberty interest in refusing unwanted life-sustaining medical treatment, including artificially delivered food and water essential to prolonging life.⁵¹ Chief Justice Rehnquist, writing for the majority, acknowledged that such a right "may be inferred from our prior decisions"⁵² and that "the logic of the cases . . . would embrace such a liberty interest."⁵³ He then assumed for the purposes of the case before the Court "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."⁵⁴

The district court in *Compassion in Dying* also relied on *Planned Parenthood*, one of the earlier decisions which dealt with personal decisions regarding abortion. *Planned Parenthood* reasoned as follows:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of

49. 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir.), *reh'g granted* 62 F.3d 299 (1995) (en banc).

50. 850 F. Supp. at 1459-62.

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

52. *Id.* at 278.

53. *Id.* at 279.

54. *Id.*

liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.⁵⁵

In *Compassion in Dying*, the district court took the position that “[f]rom a constitutional perspective, the court does not believe that a distinction can be drawn between the refusal of life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult.”⁵⁶ Once the “right” was established, the court found that the Washington criminal statute against physician-assisted suicide placed an undue burden on the patient’s constitutional right.⁵⁷ After all, protection from abuse would be just as necessary in withdrawal cases, where the Washington statute allowed even a surrogate to make the decision. The court also recognized that equal protection principles supported physician-assisted suicide.⁵⁸ It held that if terminally ill persons on life support could request physician assistance in terminating life support, why shouldn’t terminally ill persons not on life support be able to request physician assistance?⁵⁹

The Ninth Circuit Court of Appeals reversed.⁶⁰ It found that the language in *Casey* must have been taken out of context, in that the language would support terminating life support for a depressed twenty year old, the romantically devastated twenty-eight year old, and the alcoholic forty year old who chose suicide, because they are expressing their views of existence, meaning, the universe and life.⁶¹ Quoting Yale Kamisar, the Ninth Circuit found that if such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every

55. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459 (W.D. 1994) (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992)).

56. 850 F. Supp. at 1461.

57. *Id.* at 1465.

58. *Id.* at 1466-67.

59. *Id.*

60. 49 F.3d 586 (9th Cir.), *reh'g granted*, 62 F.3d 299 (1995) (en banc).

61. 49 F.3d at 590-91.

man and woman in the United States must enjoy it.⁶² The court held that such a conclusion is a *reductio ad absurdum*.⁶³

The Ninth Circuit continued with a historical argument against such a constitutional right to physician-assisted suicide.⁶⁴ In its opinion, 205 years of prohibiting assisted suicide suggested that the right is not constitutional.⁶⁵ Of course its historical argument ignored recent history and the progress of technology beyond anything contemplated by the criminal law or the Constitution.⁶⁶

The circuit court also cited Alexander Capron's article, *Euthanasia in the Netherlands: American Observations*,⁶⁷ for the proposition that the self-understanding of physicians would be affected by the removal of the state's support for their professional stance against assisted suicide.⁶⁸ The court added to Capron's position the statement that "[t]he physician's commit-

62. *Id.*; see Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?* 23 THE HASTINGS CENT. REP., May 1993, at 32, 36-37.

63. 49 F.3d at 591 (emphasis added).

64. *Id.*

65. *Id.*

66. *Id.* at 591-92. Additionally, the Ninth Circuit cited two studies that had recently concluded that physician-assisted suicide was a bad idea and had recommended against a change in the law to permit physician-assisted suicide. First, Governor Cuomo in 1985 set up a task force of twenty-four members, representing a broad spectrum of ethical and religious views and ethical, health, legal, and medical competencies. Its membership disagreed on the morality of suicide. Unanimously, the members agreed against recommending a change in the New York law to permit assisted suicide. NEW YORK STATE TASK FORCE, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994). Second, a Michigan commission, set up in 1992, voted by a majority in 1994 to recommend a legislative change in the Michigan law. The Commission did not challenge the existing law against physician-assisted suicide as unconstitutional. The court argued that since the commission was deeply divided and did not find suicide unconstitutional, its only option was to find that there was no right to suicide. MICHIGAN COMMISSION OF DEATH AND DYING, FINAL REPORT (1994).

It is the "therefore" I find most troubling in the court's position. Where there is deep moral division, there need not necessarily be a finding of no right. After all, in the abortion cases, the court instead fashioned a sliding scale of a decision-making, where before viability the mother has absolute control, and after viability, abortion is legal only to save the life of the mother. Similarly, on the issue of physician-assisted suicide, the court could fashion a decision-making system that would try to take into account the particulars of the patient's situation, for which I will argue in part II, *infra*.

67. Alexander M. Capron, *Euthanasia in the Netherlands: American Observations*, 22 THE HASTINGS CENTER REP., Mar.-Apr. 1992, at 30, 32.

68. 49 F.3d at 591.

ment to curing is the medical profession's commitment to medical progress. Medically-assisted suicide as an acceptable alternative is a blind alley; Washington has a stake in barring it."⁶⁹

The court worried that such a change in the basic patient-physician relationship that arises from even the possibility of physician-assisted suicide would have a negative effect on the elderly, on the poor, and on minorities.⁷⁰ The court also stated that *Compassion in Dying* is perhaps the sole case law of its type, ignoring the Dutch experience.⁷¹ The court's definitional approach, then, (that a right is something that everyone must have or no one may have), is the all or nothing support for the court's finding that there is no right to commit suicide, and no corresponding constitutional prohibition to criminally prosecuting someone for assisting in suicide.

The court's analysis denies the inevitability of death. The court seems afraid of the "blind alley" that the new world technology has brought. Rather than open itself up to the possibility that there could be adequate justification for assisted suicide, it decides that patients always want physicians to favor pushing back the end of life further and further, no matter what the cost or suffering. But what is the cost to society and to the dignity of a particular individual?⁷² Also, what if everyone in

69. *Id.* at 592. Of course, what I argue with is whether the medical profession is committed solely to curing, or also to caring. I will argue that a commitment to curing would justify technological support of a body, presumably until a cure is found. This is also a *reductio ad absurdum*. A better perspective is a perspective of care, which manages pain, and respects the autonomy of the patient and the care providers, as well as the perspectives of the patient's significant others in arriving at a treatment plan. See *infra* part II.

70. 49 F.3d at 592.

71. John Keown, *On Regulating Death*, 22 THE HASTINGS CENTER REP., Mar.-Apr. 1992, at 39-44 (citing the concerns of Carlos F. Gomez, enumerated in CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* (1991)).

72. See Joel Feinberg, *Overlooking the Merits of the Individual Case: An Unpromising Approach to the Right to Die*, 4 RATIO JURIS. 131 (1991). Feinberg writes:

[M]ost of the arguments against the legalization of voluntary euthanasia (or in favor of creating legal impediments to it) are indirect arguments. They don't argue that individual cases judged internally, that is on their own merits, do not warrant euthanasia. Indeed, some of these arguments candidly concede that judged on the merits, many individual cases do deserve euthanasia. Rather these arguments favor deliberately overlooking

the family and in a significant relationship with the individual agreed and supported the patient's decision, including the medical care providers? The cases do not even reach these issues.⁷³

So what do we have at this point? We have a federal district court that logically analogizes to *Cruzan* and decides there is a liberty interest or right to physician-assisted suicide. We also have the Ninth Circuit Court of Appeals, a state supreme court, and a federal district court⁷⁴ that argue there is either no right (because if there is a right everyone has it and that would be absurd), or if there is a right, the court is justified in taking it away from everyone. The rights-based language is stuck on an all or nothing solution to a question of values and the definition of the meaning of life.

Enter Oregon. The source of Oregon's law was its electorate, not its court.⁷⁵ The referendum attempted to create a limited

the merits of individual cases, and cite extraneous considerations in favor of a blanket prohibition. The most plausible of these arguments is the argument from abusable discretion, which maintains that if legally competent individuals are granted the discretion to decide on their own whether in certain circumstances to continue or to terminate life-sustaining treatment, the inevitability of honest mistakes and not-so-honest abuses will create evils that outweigh the evils of sustaining the comatose and the pain-wracked against their presumed wills. Convincing as the argument from abusable discretion may be in some contexts, . . . it fails in its application to the euthanasia situation, because it cannot be shown that the likely number of mistakenly killed individuals would constitute a greater evil than the likely number of mistakenly sustained individuals. The philosophical problem of voluntary euthanasia errs in minimizing the evils of human suffering and overrating the value of merely biological life in the absence of a human person, or in the presence of a human person whose sufferings are too severe for him to have a human life, even though his heart beats on.

Id. at 150-51.

73. It is next important to take a look at Michigan, because its experience with Dr. Kevorkian prompted the state to study the issue even more closely. The Michigan Supreme Court took a strong position against physician-assisted suicide, holding that no constitutional right to end your life exists. The court relied on the distinction between misfeasance and nonfeasance, and argued that ending something that you need not have provided in the first place is different from acting to end a life. It refused to describe when assistance was permitted by simply refusing to recognize the right. Since the Michigan court said nothing about withdrawal of treatment, it is unclear whether physicians are in violation of the statute when they flip the switch in withdrawal cases. *See also* *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994) (reaching the same result as the Michigan court).

74. *See supra* note 73.

75. *Lee v. Oregon*, 891 F. Supp. 1429, 1431 (D. Or. 1995).

right to access to physician-assisted suicide.⁷⁶ Oregon's statute, the Death with Dignity Act [hereinafter DDA], has six parts.⁷⁷ The first part provides a series of twelve definitions, including definitions for: (1) adult (a person over the age of eighteen); (2) attending physician; (3) consulting physician (specialist in the patient's disease); (4) counseling (the consultation of a licensed psychiatrist or psychologist); (5) incapable (unable to communicate in person or through family members); (6) informed decision (a decision based upon the appreciation of relevant facts after being fully informed of medical diagnosis, prognosis, potential risks from the prescribed medicine, probable results of the medicine, and feasibility of alternatives including, but not limited to, comfort care, hospice care, and pain control); (7) qualified patient (an Oregon adult who meets the terms of the act); (8) physician (a physician licensed to practice in Oregon); and (9) terminable disease (an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months).⁷⁸

Part two states the general rule under the Act:

*An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.*⁷⁹

Additionally, part two provides guidelines as to the form of the written request and refers readers to section six which contains a sample form.⁸⁰ The writing must be signed and dated by the patient and witnessed by two individuals.⁸¹ The attending physician is not qualified to be a witness, and one of the witnesses cannot be a relative, a person entitled to any portion of the

76. *Id.*

77. Death with Dignity Act, 1995 OR. LAWS Ch. 3 (I.M. 16).

78. *Id.* § 1.01.

79. *Id.* § 2.01 (emphasis added).

80. *Id.* § 2.02.

81. *Id.*

patient's estate, or an owner, operator or employee of a health care facility where the patient is receiving treatment.⁸²

Part three of the DDA lists a series of protections for the patient.⁸³ The primary list outlines the attending physician's responsibilities which include: (1) making the initial determination that the patient is a capable adult, that the patient made a voluntary request, and that the patient is suffering from a terminal disease; (2) giving the patient the necessary information to make an informed decision; (3) referring the patient for a medical consultation; (4) referring a patient for a psychological consultation (if appropriate under the act); (5) *requesting* that the patient notify her family; (6) informing the patient of the opportunity to rescind the request at any time; (7) verifying that the patient is making an informed decision before writing the prescription; (8) fulfilling the documentation requirements; and (9) ensuring that all steps are carried out in accordance with the Act.⁸⁴

Part three also requires that the patient make two oral requests and at least one written request within the designated time periods to comply with waiting periods set forth in the DDA.⁸⁵ To combat developing practices which shirk the procedural requirements, section three also requires that the Health Division annually review a sample of submitted records to ensure compliance and then prepare an annual statistical report which is made available to the public.⁸⁶

Part four makes clear that health care providers are under no duty to participate, but they must transfer the file to another physician if the patient requests.⁸⁷ However, if they do participate, they are protected by good faith.⁸⁸ If they alter or forge a request, conceal or destroy a rescission, or exert undue influence on a patient, they will be guilty of a Class A felony. These penalties do not preclude other available criminal pen-

82. *Id.*

83. *Id.* § 3.01.

84. *Id.* (emphasis added).

85. *Id.* § 3.06.

86. *Id.* § 3.11.

87. *Id.* § 4.01.

88. *Id.* § 4.01(2). The good faith language in this section parallels Virginia's corporate business definition of due care. VA. CODE ANN. § 13.1-690 (Michie 1993).

alties or limit civil liability resulting from negligent or intentional misconduct.⁸⁹

The Oregon federal district court however, much to the surprise of those trained in traditional equal protection analysis, has rejected the state's right to provide for physician-assisted suicide on constitutional equal protection grounds.⁹⁰ It found the existence of a right to terminate one's own life problematic, along the same lines as the Ninth Circuit in *Compassion in Dying*.⁹¹ The court said that it was patently absurd to think that it would allow a forty-year-old alcoholic to be assisted in committing suicide.⁹² But the court was not just answering the question of whether there is a privacy right in committing sui-

89. Death with Dignity Act, 1995 OR. LAWS Ch. 3 (I.M. 16) § 4.02. The language is borrowed heavily from the Netherlands experience. The Netherlands guidelines are described in Margaret P. Battin, *The Least Worst Death Essays*, in *BIOETHICS ON THE END OF LIFE* 108 (1994):

1. The patient must be mentally competent and the desire for death must be "consistent, durable, and well considered." The physician must ensure that the a patient has a "clear picture of his medical situation and the appropriate prognosis."

2. The patient's request cannot be granted unless he/she is experiencing "unacceptable and hopeless suffering that cannot be rendered bearable." By "unbearable suffering" the report means either "unbearable physical pain" or "unbearable mental suffering as a result of a physical disorder." The report states that given current pain-control techniques, euthanasia is a rarely justified response to physical pain.

3. The patient need not be in the "terminal phase." Since the focus is upon a compassionate response to unbearable and unrelievable suffering which causes the patient to prefer death to life, it is unduly restrictive to insist that death be at hand.

4. The physician must consult with an experienced colleague, as his solitary judgment is not sufficient warrant to perform euthanasia.

5. Finally, if the physician has moral objections to euthanasia, he must refer the patient to another physician.

Id. at 130.

In comparison with the Netherlands position, Oregon was much more careful. Oregon's Act limited the choice to those diagnosed as having less than six months to live. It required both physician and patient to be Oregon residents, and therefore would prohibit Dr. Kevorkian from flying in to perform doctor-of-death services. It required consultation and a psychological evaluation whenever depression was suggested. The Act also suggested family counseling and provided for explicit monitoring by the community through review of assisted suicides and the publication of the findings.

90. *Lee v. Oregon*, 891 F. Supp. 1429, 1437 (D. Or. 1995); see, GUNTHER, *supra* note 11, at 617-22.

91. *Lee*, 891 F. Supp. at 1433.

92. *Compassion in Dying v. Washington*, 49 F.3d 586, 590-91 (9th Cir.), *reh'g granted*, 62 F.3d 299 (9th Cir. 1995) (en banc).

cide. It was, in addition, declaring the state's legislative will irrational, if not at least nonrational, by holding that the statute violated the federal equal protection law.⁹³

The court reached its result by manipulating classic equal protection analysis.⁹⁴ It declared that a state could not grant a

93. *Lee*, 891 F. Supp. at 1437; see generally GUNTHER, *supra* note 11, at 624 (citing *Vance v. Bradley*, 440 U.S. 93 (1979), for the proposition that to find a classification unconstitutional, the facts upon which a federal law was premised, requiring retirement of Foreign Service personnel at 60 could not reasonably be conceived to be true).

94. *Lee*, 891 F. Supp. at 1439-38; see generally, GUNTHER, *supra* note 11. Gunther summarizes the law of equal protection and describes its manipulability of fundamental value questions:

Traditionally, equal protection supported only minimal judicial intervention in most contexts. Ordinarily, the command of equal protection was only that government must not impose differences in treatment "except upon some reasonable differentiation fairly related to the object of regulation. . . . And usually that rational classification requirement was readily satisfied: the courts did not demand a tight fit between classification and purpose; perfect congruence between means and ends was not required; judges allowed legislators flexibility to act on the basis of broadly accurate generalizations and tolerated considerable over inclusiveness and under inclusiveness in classification schemes. Only in special, limited contexts was equal protection found to have a deeper bite during most of its history—most notably in racial discrimination cases.

From its traditional modest role, equal protection burgeoned into a major interventionist tool during the Warren era, especially in the 1960s. The Warren Court did not abandon the deferential ingredients of the old equal protection: in most areas of economic and social legislation, the demands imposed by equal protection remained minimal. . . . A sharply differentiated two-tier approach evolved by the late 1960s: in addition to the deferential "old" equal protection, a "new" equal protection, connoting strict scrutiny arose: . . . The intensive review associated with the new equal protection imposed two demands—a demand not only as to means but also to ends. Legislation qualifying for strict scrutiny required a far closer fit between classification and statutory purpose than the rough and ready flexibility traditionally tolerated by the old equal protection: means had to be shown "necessary" to achieve statutory ends, not merely "reasonably related." Moreover, equal protection became a source of ends scrutiny as well: legislation in the areas of the new equal protection had to be justified by compelling state interests, not merely the wide spectrum of "legitimate" state ends.

The Warren Court identified the areas appropriate for strict scrutiny by searching for two characteristics: the presence of a suspect classification; or an impact on "fundamental" rights or interests. . . .

In more recent years, there has been neither undiminished carrying forward nor wholesale turning back of the Warren Court approach. . . . Even while the two tier scheme has often been adhered to in form, there has also been an increasingly noticeable resistance to the sharp difference

right to some of its citizens if that right did not exist for everyone.⁹⁵ It found that the right then did not exist.⁹⁶ It found, in an interesting twist of logic, that the real right involved was a right to be *protected from* physician-assisted suicide, that should be extended to the infirm in the last six months of a terminal illness, as well as to the forty year old or the momentarily depressed.⁹⁷ It said that to discriminate against those in the last six months of life by demanding that they be protected from their own request to end their life was to discriminate against them in violation of the Constitution.⁹⁸

between deferential "old" and interventionist "new" equal protection. . . . A number of Justices, from all segments of the Court, have sought formulations that would blur the sharp distinctions of the two-tiered approach or that would narrow the gap between strict scrutiny and deferential review. . . . But the modern Court's results indicate at least two significant changes in equal protection law. *First*, invocation of the "old" equal protection formula no longer signals, as it did with the Warren Court, an extreme deference to legislative classifications and a virtually automatic validation of challenged statutes. Instead, several cases, even while voicing the minimal "rationality," "hands off" standards of the old equal protection, proceed to find the statute unconstitutional: for the first time in years, old equal protection standards occasionally mean something other than perfunctory opinions sustaining the law under attack. Occasionally, moreover, reformulations of "mere rationality" standards hint at increased bite to the scrutiny. . . .

Equal protection is in a state of flux. . . . The search for coherence in the volatile, sometimes chaotic field of equal protection, law, then is the challenge. . . . Value judgments underlie many of the decisions below. . . . Yet the legitimacy of fundamental values adjudication under the guise of equal protection is not at all clear. To say that persons who are alike must be treated alike does not tell us how to determine whether persons are alike or not for the purposes of the classification inherent in virtually all legislation. . . . The extent to which equal protection permits value-free, process oriented adjudication and the extent to which it inevitably involves governing assumptions about underlying (albeit often unarticulated) value choices, in short, is a problem to be borne in mind. . . .

Id. at 602-08.

Needless to say, equal protection has become an easily manipulated tool for judicial intervention into questions of fundamental values.

95. *Lee*, 891 F. Supp. at 1432.

96. *Id.* The court could instead have said that the right did exist for the state to create, relying on the reasoning in *Cruzan*. See Benjamin C. Zipursky, *The Pedigrees of Rights and Powers in Scalia's Cruzan Concurrence*, 56 U. PITT. L. REV. 283, 286 (1994).

97. *Lee*, 891 F. Supp at 1433.

98. *Id.* at 1432-38.

Of course, this reasoning is problematic because the whole idea of equality is so easily manipulated and so empty.⁹⁹

99. See Westen, *supra* note 4; cf. Greenawalt, *supra* note 4; see also Rodriguez v. British Columbia, 3 S.C.R. 519 (1993) (for an excellent discussion of physician-assisted suicide in the context of the Canadian Charter). The dissenters in *Rodriguez* (L'Heureux-Dube and McLachlin) turn the equal protection argument on its ear. They argue:

Section 241 (b) (a Canadian Criminal code section that makes assisting a crime) of the Code infringes the right to security of the person included section 7 of the Charter. This right has an element of personal autonomy, which protects the dignity and privacy of individuals with respect to decisions concerning their own body. A legislative scheme which limits the right of a person to deal with her body as she chooses may violate the principles of fundamental justice under section 7 if the limit is arbitrary. A particular limit will be arbitrary if it bears no relation to, or is inconsistent with, the objective that lies behind the legislation. When one is considering whether a law breaches the principles of fundamental justice under section 7 by reason of arbitrariness, the focus is on whether a legislative scheme infringes a particular person's protected interests in a way that cannot be justified having regard to the objective of this scheme. The principles of fundamental justice require that each person, considered individually be treated fairly by the law. The fear that abuse may arise if an individual is permitted that which she is wrongly denied plays no part at the section 7 state. Any balancing of societal interests against the interests of the individual should take place within the confines of section 1 of the Charter. Here, parliament has put into force a legislative scheme which makes suicide lawful but assisted suicide unlawful. The effect of this distinction is to deny to *some people the choice of ending their lives solely because they are physically unable to do so, preventing them from exercising the autonomy over their bodies available to other people* (my emphasis). The denial of the ability to end their life is arbitrary and hence amounts to a limit on the right to security of the person does not comport with the principles of fundamental justice.

While these dissenters are adamant that they are not making an equal protection/discrimination argument under Canadian Charter section 15, their argument could just as well be used as an equal protection response to Oregon's prohibition of physician-assisted suicide. The Canadian dissenters reject "discrimination" analysis because they find it unduly "deflects the equality jurisprudence from the true focus of section 15." I believe it further points out the relative emptiness and manipulability of equal protection analysis. Depending on how you first frame the right involved, and who is in or out of the class, you can support a position either for or against physician-assisted suicide.

Lets use this latter formulation of "right" and see where it leads. For example, if we analogized the criminal statute that protects against physician-assisted suicide to a safety regulation, like a seat belt child restraint statute, then the argument would go that a lesser seatbelt requirement for adults than for children would violate the adult's rights to the protection of the restraint law. If we used the Oregon court's reasoning, either everyone is entitled to the protection of a restraint/seatbelt law, or no one is. Of course this is absurd. Society has decided that adults need less protection than that provided to infants because they are more capable, mature, and able

Westen explains that "equality camouflages rights under a formula that makes no explicit reference to the substantive rights it incorporates from elsewhere."¹⁰⁰ . . . Equality blind[s] us not only to the existence of such rights but to their specific substantive content also."¹⁰¹ Equality "compounds the problem to subsume them under the 'catchall' proposition that 'likes should be treated alike,' a formula that is capable of incorporating any substantive right by reference."¹⁰² And so the Oregon court does not explicitly tell us what right it is referring to. Is it referring to a right to medical treatment to relieve suffering? What exactly is the nature of this right to physician-assisted suicide? Is it instead a right of the patient in the last six months to the same protections against assisted suicide that others have under state penal codes?¹⁰³

The problem with the equal protection analysis is that the court errs in believing the following:

[I]f two parties are morally or legally equivalent for one purpose, they must be morally or legally equivalent for all purposes. To say that one person is morally or legally "like" another in respect to some treatment is to say that, despite the nearly infinite differences between them, the features they share are made relevant by the particular moral or legal rule at hand. But it does not follow that, because their common features are made relevant by that rule, they are also relevant under other rules.¹⁰⁴

Similarly, Oregon's law applies to everyone who is terminally ill, with less than six months to live, regardless of age, sex, or race. So it provides equivalent treatment in some respects. The

to decide for themselves what level of seatbelt protection they need. Just because a certain group of people doesn't have some state protection doesn't make it prima facie violative of equal protection. The question is whether those in the last six months need less protection because they are more "mature" and should be allowed to decide for themselves what protections they need. The question is whether the lessening of protection is reasonable.

100. Westen, *supra* note 4, at 580.

101. *Id.* (footnotes omitted).

102. *Id.* at 581.

103. See generally *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993) (for an excellent discussion of physician-assisted suicide in the context of the Canadian Charter); Westen, *supra* note 4.

104. Westen, *supra* note 4, at 583.

classification is not suspect, as it would be if it were based on race, or even sex. If the right is to the protection of the criminal law of suicide, the right is not a privacy right nor is it fundamental.¹⁰⁵ Presumably strict scrutiny should not apply.¹⁰⁶

The court uses the classification regarding six months to live to excuse its discussion about what it finds unwise about the statute.¹⁰⁷ It decides that it is unreasonable to give the ability to get physician-assisted suicide to the terminally ill and not to others.¹⁰⁸ Yet it ignores the middle ground, having constrained itself by equality and its all or nothing definition of "rights."¹⁰⁹ Indeed, the statute is not unreasonable for its attempt to cabin the application of the statute to a definable class of patients with life expectancies of less than six months. It is at least reasonable to believe that some individuals in this situation would have more reason to want to control their last bit of life, and that society has a lesser interest in protecting the short life rather than the longer one. While some individuals in this group may be vulnerable, the issue should be how to protect them adequately and not to deny their requests wholesale. In any event, such an argument is at least reasonably and ratio-

105. Tort law is filled with other examples where different levels of protection are granted individuals depending on their status. These classifications are held to be rational. For example, a consumer of a product is protected, in many states, by strict liability law. A consumer of medical services from a physician is protected only from negligence. A corporate security holder is protected from misdeeds by a corporate officer or board member by only a good faith standard. An employee is denied the protection of suit and must recover under a worker's compensation statute. Each of these groups is given more or less protection depending on the courts' and society's belief that they need more or less protection. Once the reasons are understood for why more or less protection is given to that group, then the classification passes constitutional muster. In traditional equal protection language, the court must presume the classification reasonable.

Even if the court thought it was hard to see why employees need less protection than shareholders, than a doctor's patients, than consumers of products, the traditional constitutional analysis would presume rationality. Different people are treated differently because of the nature of their relationship and situation. From these cases one would think that the question is only whether it is patently irrational that individuals in the last six months of life are more prone to the need to be treated differently in order for their liberty to be protected.

106. See GUNTHER, *supra* note 11, at 603.

107. See Gerald Gunther, *The New Equal Protection*, 86 HARV. L. REV. 1 (1972).

108. *Lee v. Oregon*, 891 F. Supp. 1428, 1432-38 (D. Or. 1995).

109. See GUNTHER, *supra* note 11, at 579 (describing Scalia's states' rights approach to setting an evidentiary standard for finding whether a right exists).

nally related to the purpose of being compassionate to individuals in the last stages of terminal illness.

As the rights-based analysis of equal protection is too concerned with the state's right to protect its citizens, it is not possible to balance the relational, privacy and autonomy interests of the individual.¹¹⁰ In addition, at least up until most recently, the courts did not discuss the brave new world that patients face at the end of life.

There had been no airing of the plight of long term care patients who face a very real fear of endless suffering and powerlessness. It is a fact of life today that death occurs in hospitals more often than at home or at the accident scene.¹¹¹ Death is often finally the result of someone deciding to flip a switch or withhold some technology.¹¹² The timing of the decision to end life is left to the control of the institution and its view of futility. It is at least reasonable to suspect that some care providers may care little for the appearance of the patient, the memories his death will invoke, the pain that he will go through, or the financial resources of the patient and family which will be expended on the last technological gasps. The patient may understandably see herself as a burden—as requiring the family to waste the resources to maintain her in a painful and virtually incommunicado condition—until the money, the pain, and the technology is cut off by someone who neither knows her, nor really cares for her, but cares only that the medicare check comes in payment.

What is unreasonable about an individual patient's request to control the circumstances of death in the situation where he has less than six months to live and few resources to waste? The Oregon statute defines a class that reasonably has more interest in and need for its privacy right to be protected than

110. Westen, *supra* note 4, at 560; see also Stephen Toulmin, *The Tyranny of Principles*, 11 THE HASTINGS CENTER REP., Dec. 1981, at 31. Toulmin makes the case that in a world of strangers, the only ethic is equality. Better, he says, to see people in their individual relationships and give discretion to the decision-makers to determine whether equals are really equal, or whether the unique situation of the individual patient calls for different treatment. Toulmin, *supra* at 37-38.

111. Note, *Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1519 (1990) [hereinafter *Medical Technology*].

112. *Id.*

does the forty-year-old who is depressed.¹¹³ They, as a class, have less to lose. Yet this is exactly why the legal analysis is so unsatisfactory. Each side argues in terms of rights and classifications. Both sides take a broad rights-based regulatory approach to the issue.

And indeed the last chapter of the *Compassion in Dying* had not been written. While this article was going to press, the Ninth Circuit, on appeal, reversed the three judge en banc panel, and affirmed the district court decision, holding, once again that there was a constitutionally protected liberty interest or "right to die."¹¹⁴ It defined the right to die as "determining the time and manner of one's death," and "hastening one's death."¹¹⁵ It thereby reaffirmed, as did the district court, that withdrawal of treatment decisions are at least very similar, if not indistinguishable from physician assisted suicide.¹¹⁶

Choosing its words carefully, the court began by limiting its decision to the prescribing of medication by a physician for the purpose of enabling a patient to end his life.¹¹⁷ It then took a broader historical look a suicide, finding support for suicide in the examples and reactions to suicide in the Greeks (including Socrates and Plato), Stoics, and Romans.¹¹⁸ While admitting that Christianity outlawed suicide for 1000 years, it again found support for the moral act of suicide in the writings of Voltaire, Diderot, Francis Bacon, David Hume, John Donne, and Sir Thomas Moore.¹¹⁹ It also found support in polls, including a 1990 Roper poll that found 64% of Americans believed that the terminally ill should have the right to request and receive physician aid in dying, another national poll in 1991 that showed that nearly two thirds of Americans favored doctor-assisted suicide, and a 1994 Harris poll that found 73% of Americans favored legalizing physician-suicide.¹²⁰

113. Death with dignity Act, 1995 OR. LAWS Ch. 3 (I.M. 16).

114. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (en banc).

115. *Id.* at *9.

116. *Id.*

117. *Id.*

118. *Id.* at *13-16.

119. *Id.*

120. *Id.* at *16.

The Ninth Circuit also returned to *Casey* and *Cruzan* to find a liberty interest in the right to die.¹²¹ It chose a due process analysis, rather than an equal protection analysis.¹²² It refused to apply the two-tiered or three-tiered due process analysis.¹²³ It simply argued that it must balance the states interest against the right it found to exist.¹²⁴ The state's interest it found to be in six regards: 1) preserving life; 2) preventing suicide; 3) avoiding the involvement of third parties; precluding the use of arbitrary, unfair, or undue influence; 4) preventing the effects on children, other family members, and loved ones; 5) protecting the integrity of the medical profession; and 6) preventing a deterioration of the view of life in society by opening "a pandora's box."¹²⁵ Yet it found that each one of these state interests was overcome by a person's liberty right in preventing suffering and choosing the circumstances of their dying.¹²⁶ It found the strength of the liberty interest to depend on the individual circumstances of the patient.¹²⁷ If the person was terminally ill and suffering then it found the person's interest to be stronger than the state's. The court then measured the burdens of a total ban on physician-assisted suicide to be too great.¹²⁸

It concluded by stating that the Oregon district court was simply wrong in that what Oregon saw as a benefit (and a needed protection), the Ninth Circuit saw as an unconstitution-

121. *Id.* at *11.

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.* at *21-33.

126. *Id.* at *35-38.

127. *Id.* at *35. In the court's words:

We noted that an individual's liberty interest in hastening his death is at its low point when that person is young and healthy, because forcing a robust individual to continue living does not, at least absent extraordinary circumstances, subject him to "pain . . . [and] suffering that is too intimate and personal for the State to insist on. . . ." *Casey*, 112 S.Ct. at 2807. As we also made clear, when a mentally competent adult is terminally ill, and wishes free of any coercion, to hasten his death because remaining days are an unmitigated torture, that person's liberty interest is at its height. For such a person, being forced to live is indeed being subjected to "pain . . . [and] suffering that is too intimate and personal for the State to insist on. . . ."

Id.

128. *Id.*

al burden on the right to die. The Ninth Circuit held that the *Lee* was clearly in error, was not helpful and was directly contrary to their holding.¹²⁹ One wonders then whether the effect of the Ninth circuit's opinion is that it revives the Oregon state statute.

This due process balancing analysis again came up with a one answer fits all solution. It declared those portions of the state of Washington's criminal statute that violated the patient's right to die as being unconstitutional. Of course the following uncertainty is whether individual doctors who assist a suicide might still be subject to prosecution where the individual circumstances would allow the state to step in and protect the individual from a biased or blameworthy decision to help terminate life. On its face however, the case seems to stand for the proposition that everyone has some right to die with physician assistance. The extent of that right, and the extent to which the state can limit that right, is not specified.

The court recognized the uncertainty its ruling would cause. It seemed to be inviting more cases to come before it so that it could develop, through common law, guidance on the issue.¹³⁰ It saw, however, a number of side benefits to their approach. The court argued that its decision would eventually remove the issue from the courts and leave it for individual determinations about what should be done. It invited society as a whole to study the issue and contribute to its solution. It predicted that discussing this issue in the light of the Constitution would engender respect for the Constitution.¹³¹

The difficulty with the Constitutional rights-based analysis is that it leaves the court ill equipped to do the individualized balancing act it recognizes is required. How will the court measure the good faith of the care providers who are involved with the patient? Rights analysis also doesn't give direction as to what role patient depression might play in causing an individual patient to make a bad determination about their suffering and their future quality of life. The rights language simply leaves the society with a language of argument, "I have a

129. *Id.* at *38.

130. *Id.* at *39.

131. *Id.*

right." "No you don't." "Yes I do." "No you don't." There is no frame work for insuring that a caring, good faith discussion will be had with the patient. Neither is there provision made or assurance given that society's long range concerns regarding the sanctity of life will be continually considered.

If rights language takes an objective "one answer fits all" approach to legal problems, it is motivated by a proper concern, that the law ought to be universal. It is also accurate for society to fear that if the law does take a "one answer fits all" approach to providing a right to suicide, that the institutions and care providers might encourage suicide for the sick, oppressed, disabled, and unpopular in society. The courts also are right to deal as little as they can with questions of motives and individual circumstances because they know that proof of motive is very difficult, and a flood of litigation can often follow. As every physician knows, even a legal analysis where motive, individual circumstance, and balancing are part of the conditions for deciding when treatment can be withdrawn or withheld, the physician or other assistor may be in a risky position. Out of fear that they may be accused of a criminal act, these potential assistors stay away from acts which could be construed as the results of improper motives or bias against the patient. Thus, the law either then deters assistors too broadly or encourages them too much. In any event, so goes the debate using traditional rights-based analysis that attempts a court processed solution.¹³² Yet the argument here is meant to be

132. See, GUNTHER, *supra* note 11 and accompanying text. Traditional bioethics is also of little help. Its four principles of autonomy, nonmaleficence, beneficence and justice lean in opposite directions. While the principle of autonomy suggests that we do whatever the patient freely chooses, autonomy also flounders on the informed choice that is necessary in order for autonomy to work. Beneficence also flounders on the definition of the good. The physician says that he or she must heal and fight disease to do good. The patient says that he is held captive by the physician and doing good means releasing the captive and making choice available.

Related, of course, is the principle of nonmaleficence, or doing no harm. Here the arguments revolve around definitions of suffering. One side argues that killing is the ultimate harm, the other that suffering and loss of dignity is worse. The principle that one does no harm tries to measure future affects of individual decisions. If the patient is temporarily depressed, or subtly encouraged into committing suicide when they otherwise would not, and would otherwise live a long and happy life, then the physician is causing harm to these people by confirming that they should give up and helping them do so. On the other hand, if a person would suffer immeasurably for longer periods than if they could end the suffering with dignity, then more harm is

more than a "foot stomping" statement that physician-assisted suicide is a right and is reasonable *at times*. The better, deeper issue is whether society can balance the state interest in protecting its citizens with a dying patient's interest in dignity.

Professor Carl Schneider captures the problem of traditional bioethical rights-based analysis and directs our attention toward the ethics of care. Schneider contends that "a powerfully stated and too-often simple autonomy paradigm has become the central feature of bioethical thought and law. Yet, despite the undoubted and true importance of that paradigm, its reiteration has become stale, flat, and unprofitable, and its simplicities have become too costly."¹³³ He argues that the courts have be-

caused by denying the patient request. The question, then, is how can the physician be sure that a person not terminally ill or in a persistent vegetative state really wants to end life? In withdrawal situations, we already know that everyone has vigorously tried to save the life. The life support systems evidence that. There then is no subtle message being sent to the person that "we want you to give up, because you're not worth saving." We also send the message that the decision will be made after there has been a calm discussion with the surrogate or a careful examination of the living will and after there has been agreement by the medical providers that the person is in a terminal condition (with a life expectancy less than six months when off the artificial life support).

Issues of justice are the most complex. If we do assume a world of scarce resources, then dollars spent on patients who don't want help are better spent on patients who want to get better and live productive lives. Money spent on food, clothing, and housing, as well as prenatal care and preventive care, would be dollars better spent than spent on long, expensive medical care for someone who doesn't want it, has given up, and insists on dying. The debate flounders on the immeasurability of the suffering and value of life of an individual, the inability to measure whether the individual is making an authentic choice, and the inability to make a blanket justice determination.

The language of justice arguably leads to a utilitarian analysis. Of course, all of the criticism of utility is applicable. Who is to say what is better? How will we know what is better? Who defines the good? Yet nonconsequentialist analysis is no better. See Toulmin, *supra* note 110.

133. Carl E. Schneider, *Bioethics with a Human Face*, 69 IND. L.J. 1075, 1076 (1994).

"[The rationalist] does not neglect experience, but he often appears to do so because . . . of the rapidity with which he reduces the tangle and variety of experience to a set of principles which he will then attack or defend only upon rational grounds. He has no sense of the cumulation of experience, only of the readiness of experience when it has been converted into a formula. . . ."

Id. at 1077 n.7 (quoting MICHAEL OAKESHOTT, *RATIONALISM IN POLITICS, AND OTHER ESSAYS* (1962)).

"[O]rdered, cerebral armchair inquiry is given precedence, partly because the formalistic "data" it generates more closely fit the norms of bioethical

come hyper-rationalists on the theory that the best decisions are made objectively and in a cold and dispassionate manner.¹³⁴ That is, the particular emotions and feelings of the individuals involved will only muck up the process and lead to bad decisions. Schneider instead argues, to the contrary:

Hyper-rationalism's substantive assumptions could be true, but that has hardly been demonstrated. And they are much likelier to be false. Their picture of human nature is far too simple, far too disembodied to be convincing. They present a bloodless, flat, distant, abstract, depersonalized, impoverished view of the way people think, feel, and act, of the social circumstances in which people live, of the ethical lives they lead. And hyper-rationalism's simplifications are particularly injurious in bioethics, a field that treats people in their least rational moments, in their most emotional travails, in their most contextual complexity.¹³⁵

In other words, the courts simply miss the real issue. The issue is not one of rights. The issue is whether, taking the patient in the context of his relationships, his decision to commit suicide ought to be honored.

II. THE CARE PERSPECTIVE

What exactly then is a "care perspective," and what are its benefits?¹³⁶ The language of the care perspective is still evol-

logic and rationality than information gathered through first-hand research. Thought experiments are one of an array of cognitive techniques used in bioethics to distance and abstract itself from the human settings in which ethical questions are embedded and experienced, reduce their complexity and ambiguity, limit the number and kinds of morally relevant factors to be dealt with, dispel dilemmas, and siphon off the emotion, suffering, bewilderment, and tragedy that many medical moral predicaments entail for patients, families, and medical professionals."

Id. at 1077-78 (quoting Renee C. Fox & Judith P. Swazey, *Medical Morality Is not Bioethics*, in *ESSAYS IN MEDICAL SOCIOLOGY* 645, 666 (1988)).

134. *Id.* at 1076-80.

135. *Id.* at 1080.

136. See Ann Hamric, Using the Care Perspective in Case Analysis (article in preparation); Donald P. Judges, *Taking Care Seriously: Relational Feminism, Sexual Difference, and Abortion*, 73 N.C. L. REV. 1323, 1390 (1995). Judges writes:

Noddings argues that moral philosophy's reliance on traditional Kantian criteria of universality and objectivity "has led to a serious imbalance in moral discussion." The universals of Noddings's ethic are attitudinal and

ing and is admittedly fuzzy. The best description comes from Alisa Carse. Carse says:

According to Gilligan, the justice orientation construes the moral point of view as an impartial point of view, understands particular moral judgments as derived from abstract and universal principles, sees moral judgment as essentially dispassionate rather than passionate, and emphasizes individual rights and norms of formal equality and reciprocity in modelling our moral relationships. By contrast, the care orientation rejects impartiality as an essential mark of the moral, understands moral judgments as situation-attuned perceptions sensitive to others' needs and to the dynamics of particular relationships, construes moral reasoning as involving empathy and concern, and emphasizes norms of

motivational rather than behavioral: "[A]n ethic of caring locates morality in the pre-act consciousness" of the one who cares. Caring and relatedness thus are desirable ends in themselves; caring is not an *obligation* that one must discharge to achieve morality. To the contrary, "[w]e want to be *moral* in order to remain in the caring relation and to enhance the ideal of ourselves" as persons who care. Morality under this view derives from a natural desire to become and to remain related, which gradually unfolds in a succession of caring relations. Such relations allow "identity-conferring commitments," that: reveal personal integrity; provide the sense that one's life has meaning, foundation, and a place in the community; and elicit the values of patience, trust, and a moderation of manipulative striving.

While the caring relation is the ethical ideal, even when the empathic connection is strong and a motivation to act naturally arises the individual can choose whether to accept and act upon or to reject that feeling. Furthermore, in some personal encounters such sentiments either do not arise naturally at all or do so only faintly and are displaced by other feelings such as hostility or revulsion. In such cases, an individual may summon motivation from remembrance of his or her own natural caring and being cared for, to take care of his or her ethical self. Noddings refers to this process as "ethical caring."

An ethic of care thus "is a natural derivative of the desire to be related. It springs from our experience of caring and the inevitable assessment of this relation as 'good'. What we seek in caring is not payment or reciprocity in kind but the special reciprocity that connotes completion." This ethic of care leads to self-fulfillment; it does not require self-sacrifice on the altar of abstract altruistic ideal. Moreover, the roles of caring and being cared for are neither static nor predetermined, but shift over time and between persons.

A caring attitude is not enough, though; there must be connection.

Id. at 1389-92 (footnotes omitted).

responsiveness and responsibility in our relationships with others.¹³⁷

How, then, would a process that is created from a care perspective be initiated, what would it look like, and how would such a process resist the constraints that arise from the role-playing hierarchical model, where the physician, or judge, or even the individual patient has been given the right to make the decision? First the care perspective should be initiated, as it is now, with a request from the patient to the treating physician. The patient's request and the physician's decision to prescribe the medication then place the physician in the role of initiator of the caring discussion. There should be no coercion on the part of the physician. If the physician does not want to be involved, she should recommend another physician who is willing to be involved. Once a physician is found willing to initiate the process, the physician should engage in building a consensus decision-making process as follows.¹³⁸

First, the professional care provider should gather information and identify which factors are relevant to the analysis. This requirement goes beyond the usual rights-based methodology in requiring the identification of salient features of the context as well as the individual's perceptions of the events.

Key to resisting the role-playing involved in most problem-solving models would be for the professional to instead initially serve in the role as "listener."¹³⁹ A "listener" recognizes that moral persuasion can best occur only after a person has been understood.¹⁴⁰ The need for true understanding as a threshold for any connectedness or caring is best described in the work of psychiatrist Tom Rusk. He writes:

137. Carse, *supra* note 10, at 5-6.

138. See Hamric, *supra* note 136.

139. We were first introduced to the role of "listener" by Maude Pervere and Janeen Kerper at a planning conference held by the National Institute for Trial Advocacy for the development of a new program for lawyers to reimagine the lawyer-client relationship. Pervere and Kerper then referred us to TOM RUSK, *THE POWER OF ETHICAL PERSUASION: FROM CONFLICT TO PARTNERSHIP AT WORK AND IN PRIVATE LIFE* (1993).

140. *Id.* at 67-70.

It's mysterious and ironic that after millions of years of evolution—and a hundred or so of modern psychological theorizing and research—we human beings have not advanced very far in person-to-person communications. We can generally exchange thoughts and ideas pretty well, but nonetheless we often fail to *understand* each other. For the most part, what we fail to communicate clearly is our feelings, those nonverbal, deeply rooted energies that can lead us to act in contradiction to our will and our rational decisions. Between people, strong feelings can easily escalate a simple misunderstanding into a senseless battle of wills. Even wars between nations have begun that way.

Modern psychology has done relatively little to help us comprehend our feelings, or learn to manage them in accordance with the fundamental values of *respect*, *understanding*, *caring*, and *fairness* in order to create happier, more fulfilling lives. Many successful books on communication strategies have sought to teach people how to expedite problem solving or gain the upper hand in all kinds of negotiations. But these strategies almost always ignore the power of feelings in all kinds of relationships, and the need to uphold explicit social values in the conduct of human communication.

As far as I'm concerned, there never was or will be a better basic communication strategy than the Golden Rule: *Do unto others as you would have them do unto you*. Ethical Persuasion is a practical, strategic method of applying the Golden Rule to every kind of important communication—not as a means of merely doing a “good deed,” but as a means of giving everyone a fair hearing, creating the optimal solutions for thorny problems, and fostering long-term, trusting relationships.¹⁴¹

Rusk's listening techniques then correspond with the values that Noddings and Carse describe in the ethic of care. Rusk's “Ethical Persuasion” is the practical “how to” for the moral philosophy of care. Rusk describes the following seven steps to good listening:

1. Establish that your immediate goal is mutual understanding, not problem solving.

141. *Id.* at 7-8 (footnote omitted).

2. Elicit the other person's thoughts, feelings, and desires about the subject at hand.
3. Ask for the other person's help in understanding him or her. Try not to defend or disagree.
4. Repeat the other person's position in your own words to show you understand.
5. Ask the other person to correct your understanding and keep restating his or her position.
6. Refer back to your position only to keep things going.
7. Repeat steps 1 through 6 until the other person unreservedly agrees that you understand his or her position.¹⁴²

Listening is a key to understanding, and understanding is a key to caring. Listening should be done first because it will help break the care-provider out of the problem-solving role playing. It establishes the care-provider in the learning mode first, as opposed to the doing mode. It subverts what the care provider knows about what the law says is legal to what the patient knows and feels. In addition, to the extent that information is power, the listener has the advantage of knowing both sides (his and the patient's) before speaking. Listening earns the listener the leverage of fairness. The more the patient is listened to and understood, the more the patient will likely listen and seek understanding. Finally, these seven steps cultivate in the listener patience and openness, qualities that evince respect.¹⁴³

After engaging in a controlled listening stage the counselor would next identify the persons involved in interdependent relationships, if they have not already been identified. For the medical practitioner this step disallows a narrow focus on the patient. All persons who are in significant relationships with the one cared for are to be considered.¹⁴⁴

The next step is the most radical. The care perspective identifies the central issue of care, asking what caring demands in this particular situation with these particular persons to strengthen (or at least maintain) the primary relationships and

142. *Id.* at 70-71.

143. *Id.* at 63-70.

144. See Hamric, *supra* note 136; Ann Hamric & Paul Zwier, *The Ethics of Care and Reimagining the Lawyer-Client Relationship*, __ J. Contemp. L. __ (1996) (forthcoming).

to avoid hurt and harm. This step can be taken only after identifying the interdependent parties and the primary relationships. One then must consider the view of both the one cared for (in the medical context, the patient) and the one caring.¹⁴⁵

Again, this stage can be broken into some concrete steps that the care-provider could take to ensure that he is acting out of care. Rusk describes these as follows:

1. Ask for a fair hearing in return.
2. Begin with an explanation of how the other person's thoughts and feelings affect you. Avoid blaming and self-defense as much as possible.
3. Carefully explain your thoughts, desires, and feelings as *your* truth, not *the* truth.
4. Ask for restatements of your position—and corrections of any factual inaccuracies—as necessary.
5. Review your respective positions.¹⁴⁶

The above steps in this stage of caring need to be used to draw out each person in a significant relationship with the patient. It provides for the subjectivity that caring requires. It allows for the moral self to express itself. It necessitates a true understanding reflection of the feelings of others, without designating to one or the other the moral responsibility for the decision.

In Phase Three, the care providers and the one cared for should discuss and think through all possible alternative activities to determine which are responsible (i.e. loving and just) to those who are involved in the situation. They should ask how the action will affect each person's life, including their shared life together. The view of the treating physician arises from this attempt to enter and understand the context of the situation. The counselor enters the situation as a caring participant. The counselor's view is to be communicated to and carefully considered by the parties involved. Again, any actions proposed and consequences of proposed alternatives are evaluated in terms of whether they are loving and just for the individuals and their shared life.¹⁴⁷

145. RUSK, *supra* note 139, at 87-100.

146. *Id.* at 89.

147. *Id.* at 107-21. Again Rusk has three steps to creating resolutions. They are:

Finally, the involved parties should jointly select an alternative from those deemed acceptable, anticipate objections and answer them, and devise a workable plan for carrying out the proposed solution.¹⁴⁸

Using this care perspective and these procedural steps, consider what would most likely happen in the physician-assisted suicide situation. The care counselor will very quickly and directly involve all the family members. There would need to be a joint meeting with the patient, the client's other siblings and friends, the medical practitioner, and anyone else who might have a strong caring interest.¹⁴⁹

The result is that the "do it/don't do it" dichotomy may immediately be broken. The possible solutions multiply greatly

1. Affirm your mutual understanding and confirm that you are both ready to consider options for resolution.
2. Brainstorm multiple options.
3. If a mutually agreeable solution is not yet obvious, try one or more of the following options:
 - Take time out to reconsider, consult, exchange proposals, and reconvene.
 - Agree to neutral arbitration, mediation, or counseling.
 - Compromise between alternate solutions.
 - Take turns between alternate solutions.
 - Yield (for now) once your position is thoroughly and respectfully considered.
 - Assert your positional power after thoroughly and respectfully considering their position.
 - Agree to disagree and still respect each other; then, if you can, go your separate ways on the particular issue.

Id. at 108.

148. *Id.* at 114-21. As a possible final step, the counselor might consider drafting an agreement which memorializes the solutions the parties reach. Yet such a process suggests bargaining over the rights and duties of the parties. The ethics of care does not consider bargaining a useful tool. See Annette Baier, *Trust and Antitrust*, 96 ETHICS 231, 248-53 (1986) (criticizing contractarians because they ignore the costs to relationships from adversarial self-interested bargaining).

149. Of course, the lawyer could argue that the court process would eventually sort this out when it considers issues of standing and when evidence is presented about the competence of the patient, but the ethics of care requires that the lawyer/counselor becomes a more active participant in the case in light of the demand of caring. Principled ethicists might argue that what is really going on here is a negotiation of who will be the primary decision-maker to solve the problem. The ethics of care perspective instead does not designate a primary counselor, but allows the counselor, as one of the care providers, to focus on both the legal and medical needs and the relationship needs. The client will be replaced by a group of caring decision-makers. See RUSK, *supra* note 139 and accompanying text.

when the focus turns to what will create, maintain or maximize the healthy relationships already present in the situation. At the same time, care would not automatically rule physician-assisted suicide out of bounds. The role of care-providers more likely will force the asking of tough questions. Who cares about the patient? What does caring demand? Where do these individuals live? What is each party's capacity to care? What is fair for each to contribute? Depending on the answers to these questions, the counselor and decision-makers can cut through the adversarial rights-based analysis and frame a more tailored, particularized solution. If however, the caring thing to do is to prevent suffering and allow physician-assisted suicide, then so be it.

Yet how can caring ever produce the option to assist in suicide? It seldom should. Yet it is because caring denies neither the inevitability of death nor the existence of suffering that is not solely physical that the individual's request should be considered. Eric Cassel's article entitled *The Nature of Suffering and the Goals of Medicine*, makes the case for caring. He writes about the case of a woman at the end of her life:

Three facts stand out: The first is that this woman's suffering was not confined to her physical symptoms. The second is that she suffered not only from her disease but also from its treatment. The third is that one could not anticipate what she would describe as a source of suffering; like other patients, she had to be asked. Some features of her condition she would call painful, upsetting, uncomfortable, and distressing, but not a source of suffering. In these characteristics her case was ordinary.

The relief of suffering, it would appear, is considered one of the primary ends of medicine by patients and lay persons, but not by the medical profession. As in the care of the dying, patients and their friends and families do not make a distinction between physical and nonphysical sources of suffering in the same way that doctors do.

This phenomenon reflects a historically constrained and currently inadequate view of the ends of medicine. Medicine's traditional concern primarily for the body and for physical disease is well known, as are the widespread effects of the mind-body dichotomy on medical theory and practice. I believe that this dichotomy itself is a source of

paradoxical situations in which doctors cause suffering in their care of the sick. Today, as ideas about the separation of mind and body are called into question, physicians are concerning themselves with new aspects of the human condition. The profession of medicine is being pushed and pulled into new areas, both by its technology and by the demands of patients. Attempting to understand what suffering is and how physicians might truly be devoted to its relief will require that medicine and its critics overcome the dichotomy between mind and body and the associated dichotomies between subjective and objective and between person and object.

I am going to make three points. The first is that suffering is experienced by persons. In the separation between mind and body, the concept of the person, or personhood, has been associated with that of mind, spirit, and the subjective. However, as I will show, a person is not merely mind, merely spiritual, or only subjectively knowable. Personhood has many facets, and it is ignorance of them that actively contributes to patients' suffering. The understanding of the place of the person in human illness requires a rejection of the historical dualism of mind and body.

The second point derives from my interpretation of clinical observations: Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. It follows then, that although suffering often occurs in the presence of acute pain, shortness of breath, or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as the state of severe distress associated with events that threaten the intactness of the person.

The third point is that suffering can occur in relation to any aspect of the person, whether it is in the realm of social roles, group identification, the relation with self, body, or family, or the relation with a transpersonal, transcendent source of meaning.¹⁵⁰

150. Eric J. Cassel, *The Nature of Suffering and the Goals of Medicine*, 306 NEW ENG. J. MED. 639, 640 (1982).

If suffering is related to the intactness of a person, and can occur in relation to any aspect of the person including his or her social, family and religious setting, then caring could end in acting to relieve this suffering in certain circumstances. The caring thing to do could be to permit a loving end to life as a necessary response to the suffering a particular person is experiencing.

III. LEGISLATING CARING

There are at least two difficulties that spring to mind that the care perspective presents. First, can such a listening and caring process be legislated? I am not thinking here about whether the statute that provides for a care perspective can withstand equal protection analysis. The answer to that question is that caring is reasonable, even though it may not be hyper-rational, and should be able to withstand equal protection analysis. It also seems to me that drawing a line at six months from the end of life is a reasonable classification analogous to voting or drinking age restrictions. In this case, the restriction is measured from the end of life rather than from the beginning. But even if these arguments are not successful, and the court is right that a six-month-from-the-end-of-life classification is unreasonable, then I would instead argue for a broader care approach, that any adult could be assisted in suicide if it is the "caring" thing to do. In other words, I mean to ask here whether you can adequately ensure that a group that will truly listen and care for the patient will be formed. A second difficulty is whether a legislative scheme based on care will adequately protect against decision-making bias and paralysis.

A return look at the Oregon statute may be helpful to answer these questions. The Oregon statute can be refined and edited using the care perspective, to create the framework necessary to a workable process. The Oregon statute already has a number of caring attributes. It tries to ensure that the treating physician will take the time to listen and "care" by requiring: (1) residency of both physician and patient, (which should help protect against "doctors of death" who fly in for terminations); (2) consultation with a specialist in the field of the patient's disease (which fits care's demands that salient medical circum-

stances be gathered); (3) consultation with a licensed psychologist or psychiatrist where warranted (to help in determining whether the patient has a treatable psychological condition, and to engage the group in a caring consultation); (4) consultation with the family, unless the patient declines or can't reach them (to break the patient out of his or her isolation); (5) repeated requests (to make sure the depression is not momentary); (6) advice that the request can be withdrawn at any time; and (7) reporting of actions to an agency for public dissemination (to monitor decisions to reassess caring).¹⁵¹

I suggest a few changes in order to make sure that the caring conversation will actually occur. First, I would suggest that a provision require that the patient and physician meet with the family. In addition, I would require that the group meeting also be attended by all those individuals who are in significant relationships with the patient. Some decisions should just not be left to an individual, or even to two or three, in isolation. Just as we require boards of directors to meet when deciding important corporate business decisions, the patient's "board of directors" ought to gather to ensure that a comprehensive conversation occurs.

Additionally, contrary to the Oregon DDA, members of the care-provider team should be included in attendance. While long-term health care facilities under the Oregon statute designate witnesses having the qualifications specified by the Department of Human Resources,¹⁵² there is otherwise no explicit role that they play. These care-providers should be involved more than just as witnesses because they often bring more information about the manner of suffering experienced by the patient. In addition, while their position should not control, it should matter, so that the caring may involve the persons who presently and continuously know and care for the patient. Care demands that their subjective perspective be considered because making them subjective participants in the process invests them with a role in a caring decision. Excluding them or pretending their objectivity may lead to greater isolation of the patient, rather than less isolation.¹⁵³ As opposed to being pro-

151. See *supra* notes 75-88 and accompanying text.

152. Death with Dignity Act, 1995 OR. LAWS Ch. 3 (I.M. 16) § 2.02.

153. See Flick, *supra* note 1. In arguing for greater involvement, or paternalism of

tected from institutional bias, the patient ought to hear the concerns of the care-providers just as they hear the concerns of family and close friends.

I envision something like the non-adversarial "IEP meeting," attempted between school, social worker, parent and child in questions of special education.¹⁵⁴ Under my view, only the patient could initiate a meeting, only after he or she had met the informed consent provisions of the DDA. Yet, while the patient initiates the process and needs to make an informed decision to initiate it, the group needs to take a role in defining caring options and group makeup. The patient would provide the most important information concerning who is in a significant relationship with the patient. Yet the care-provider should inquire of these others whether there are yet others who should be in attendance, until a complete caring group has been agreed upon.

I would also mandate involvement of a licensed psychologist or psychiatrist, not just for their expertise in psychology, but also to facilitate a caring conversation in the group. She should help the group focus on listening to and caring for the patient. Facilitated caring conversation needs to be part of the process, and the psychologist or psychiatrist usually is trained in con-

the doctor, Flick writes:

What is left when autonomy is a fiction and paternalism a tyranny is a responsibility to care and to take the risks care engenders. This is the soul of medicine's legitimate task. "People are idiots." They need to be protected against themselves, and others, because people do not always know or choose the possibility they ought to prefer. The underlying theory is human fallibility and finitude. This theory is an insult to human dignity only if the contrary assumptions—that people are infallible and immortal—are correct. The conviction that a modest theory of humanity is correct is the very foundation of both law and medicine. It is what judgment and care are all about.

Id. at 1149-50 (footnotes omitted).

"[I]magine a society in which everyone agreed that in particular situations or states of mind, everyone was likely to make mistakes and needed to be protected from themselves. The category of paternalism might come up mainly with strong positive connotations of loving care for others." *Id.* at 1167 n.106. I agree that the doctor should care. I disagree that we should leave it at that.

154. See KATHE KLARE & THOMAS GUERNSEY, SPECIAL EDUCATION LAW 91 (1993). Any change in a child's IEP (Individualized Educational Program) involves the agreement of school and parents. Though it often turns adversarial, the process as drafted was an attempt to insure that the various individuals who are in a relationship with the child act together for the best interests of the child.

ducting such a conversation. If there is any doubt about the ability of a psychologist or psychiatrist to conduct a group like the one described above, her training could be administered through the state department of health or made part of the licensing process for these professionals.

Yet what if everyone is not able to attend? Or what if everyone cannot agree? Then the answer the statute should provide is that physician-assisted suicide should not be allowed. More conversation would need to take place so that a consensus can be reached. The result is a very conservative decision-making process that puts the prescribing physician at risk unless there is informed agreement by all of the caring group's members. The physician should not prescribe unless a consensus is reached by the group.

Yet what if no one cares; who protects the patient? Then the physician, consulting physician, psychologist and psychiatrist, become the care-providers and must open themselves up to understanding and listening to the patient. If the care-providers and patient reach a consensus, then they must do the caring thing. The smaller the group and the less input from those who are in relationship with the patient, the more at risk the physician would be. If the physician does not identify those in significant relationships with the patient, the prescribing physician risks the second-guessing of his or her decision to prescribe.

As to the second concern, that the ethics of care leads to deadlock, note instead what studies concerning the motivation of those who have attempted or contemplated suicides suggest.¹⁵⁵ What these studies suggest is that the request for sui-

155. See Marzen *supra* note 14, at 107-20. Marzen cites studies on the psychology of those who attempt suicide. The authors reach the opposite conclusion, that is, that since suicides are so "treatable" we should not allow their request. I argue that to deny the request outright does not open the physician up to the kind of listening that suicide counselors argue is necessary. See Kate E. Bloch, Note, *The Role of Law in Suicide Prevention: Beyond Civil Commitment—A Bystander Duty to Report Suicide Threats*, 39 STAN. L. REV. 929 (1987).

The question could certainly be asked whether or not changing the Oregon statutory scheme to require that a psychiatrist or psychologist be involved does not already ensure sufficient protection for the authenticity of the patient's request. After all, why not make the psychiatrist or psychologist evaluate the patient's decision-making ability like they do with questions of competency in commitment hearings and make them responsible for getting informed consent to the patient's decision? And,

cide signals a bipolar hopelessness and isolation. The patient needs to be given the opportunity to become reconnected to his or her significant other. One study estimates that seventy-five percent of patients who attempted suicide were really ambivalent in their suicide motivation.¹⁵⁶ As Professor Erwin Stengel, one of the most famous to have studied suicide motivations, stated:

Many suicidal attempts and quite a few suicides are carried out in the mood "I don't care whether I live or die," rather than with a clear and unambiguous determination to end life. A person who denies, after what seems an obvious suicidal attempt, that he really wanted to kill himself, may be telling the truth. Most people, in committing a suicidal

indeed, most studies of suicide support the position that a person seeking a suicide is likely suffering from a mental disorder that the psychiatrist or psychologist could help treat. Yet there are a number of responses to the legal position that require the psychiatrist to "diagnose" whether the suicide interest is authentic. First, the state of knowledge about the "rationality" of committing suicide is not clear. See Marzen, *supra* note 14, at 150-53. The question whether suicide is a courageous act of self-sacrifice or a weak, faithless response to the false hopelessness of a person's situation has divided philosophers for centuries. Second, the very notion of hopelessness, which is a very important factor in the suicide's decision, becomes more and more rational with a medical diagnosis that they do not have long to live. Third, competency with respect to a request to end life cannot be subjected to an easy psychological evaluation. The very definition of depression, that someone is not "future-looking," and suffers from prolonged feelings of hopelessness, begs the question of whether they may be rational in hopelessness.

On the other hand, some studies show there is a close association between suicidal intent and mental disorder that can not be underestimated. These studies estimate that at least 90% of patients who desire death during a terminal illness suffer from a treatable mental illness, usually a depressive condition.

In addition, while the request to commit suicide may be reasonable, it may be related to untreated pain. Therefore the involvement of both the treating physician and the psychiatrist is necessary. It follows that there are patients who suffer from undetectable mental illness who need protection from misdiagnosis of the physician and institutional care-provider.

Yet it is also important to recognize that the institutional care-provider, including the psychiatrist, may also be biased in a way that overstates the irrationality and treatability of the patient's condition. There are enormous economic benefits to the medical profession in end-of-life heroic measures. Intensive care and other end-of-life treatment is enormously costly, and supports the huge capital outlays in expensive facilities and equipment. This cost is very real, and continues to grow as technology becomes more and more available to prolong life far beyond any meaningful relationships that can exist between the patient and his or her significant other. See Brian Pollard, *Australia: Protection, Choice and the Common Good*, AGE (MELBOURNE), Apr. 10, 1995, at 13.

156. ERWIN STENDEL, SUICIDE AND ATTEMPTED SUICIDE 71 (1964).

act, are just as muddled as they are whenever they do anything of importance under emotional stress. A study by two psychiatrists in Seattle, Washington of ninety-six suicide attempters revealed that 75 percent of them (71 percent of the men and 77 percent of the women) were ambivalent about their intentions to die. "The ambivalent group," the researchers stated, "are vacillating and confused in intent, but in taking risk of death . . . may test the affection and *care of others*. The serious attempt group are similar to the completed suicide group in their depression, hopelessness, and lack of social interaction." Psychiatrists have long advanced the opinion that underlying a suicidal individual's ostensible wish to die is actually a wish to be rescued, which is manifested by: [A] tendency to give warning of the impending attempt to give others a chance to intervene. . . . In most suicidal attempts, irrespective of the mental state in which they are made, we can discern an appeal to other human beings. This appeal also acts as a powerful threat. We regard the appeal character of the suicidal attempt, which is usually unconscious, as one of its essential features.¹⁵⁷

The suicide attempt is often motivated by attempts to connect with someone, either her doctor or someone with whom she had a significant relationship. The patient's logic may be that her life is not worth living because she can not get anyone to listen to her when she wants to talk about her fears and suffering. Dr. Susan Block, noted Harvard psychiatrist, says "[w]hen patients ask to die, . . . they are often really saying 'Can't you listen to me? . . . And I think good medicine, and in particular good hospice care, can . . . [take care of] a lot of that. When that is done, most requests for euthanasia [go] away."¹⁵⁸

If the great majority of those requesting suicide are "treatable" or ambivalent at best, then why legalize suicide? The answer is that legalizing it, while keeping it in a "care setting" helps bring the patient out of isolation and into relationships that can better treat the hopelessness. The irony is that by prohibiting suicide assistance, the law may increase the patient's isolation and desperation. By allowing for the request, more suicides may be prevented. In any event, a caring conver-

157. *Id.*

158. B.D. Colen, *Doctors Who Help Patients Die*, NEWSDAY, Sept. 29, 1991, at 4.

sation has an excellent chance at not ending in deadlock because the patient feels that someone cares and withdraws his request.

What is clear to me, then, is that the law in a majority of circuits has the opposite effect of what is intended. By prohibiting physician-assisted suicide, individuals are made to take matters into their own hands and attempt suicide. Their decisions are made out of a sense of hopelessness and isolation which is increased by their lack of control over their lives and by the fact that they cannot get anyone to listen to them. By allowing them to ask for help and then engaging them in a caring conversation which might help break their isolation and hopelessness, we might better protect against suicide.¹⁵⁹ It is at least worth a try where a majority of the population in a particular state votes to do so.

The care analysis is not just some pie-in-the-sky utopian solution to real world problems. Many families today describe just such discussions with their loved ones in the end-of-life situations.¹⁶⁰ Some think of the model as the family consensus model of decision-making.¹⁶¹ It has the practical benefit that everyone who is later likely to complain, or even sue, is brought into the decision and has input into it. If anyone does not agree, his or her doubts and fears and grieving must be dealt with in conversations with the patient and other family members.

A version of this consensus-caring process is also being used at the beginning of life in the neonatal units around the country.¹⁶² While such a process of decision-making is of uncertain legality,¹⁶³ having been derived from a profound dissatisfaction with the law and case authority in the area, it seems to "work" in the neonatal unit.¹⁶⁴ At the beginning of life, parents are in

159. See Julia Pugliese, Note, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 HAST. L.J. 1291 (1993).

160. *Id.*; see Michael J. Roth, Note, *A Failed Statute, Geoffrey Feiger, and the Phrenetic Physician: Physician-Assisted Suicide in Michigan and a Patient-Oriented Alternative*, 28 VAL. U. L. REV. 1415 (1994).

161. Pugliese, *supra* note 159, at 1316.

162. See generally *Medical Technology*, *supra* note 111.

163. *Id.*

164. See generally Troyen A. Brennan, *Silent Decisions: Limits of Consent and the*

the hospital and are faced with the intersection of technology and living and dying. In the neonatal units, the parents are the ones in the relationship with the newborn and it is upon them that the decision falls about how much technology ought to be used to support what amount of life. Consider the anencephalic infant with a life expectancy of less than six months. The child may be kept from brain death a lot longer with heavy intensive care cost.¹⁶⁵ Yet the baby may have no chance of ever having a relationship with anyone. The legal approach that is now taken is that the prolonging of life support is the joint decision of the parents, even when the medical team agrees that treatment is futile.¹⁶⁶ Comfort and care is routinely provided, but respiratory, hydration, and nutrition decisions are reached by the combined discussion of the parents and staff. If there is disagreement, the parents make the final call, based on their definitions of life.¹⁶⁷ If there is not unanimity in termination, the state votes to prolong the life.¹⁶⁸

Yet notice of such decisions may carry reverse implications. Where there is agreement that treatment is futile and it is better that aggressive treatment and life support be terminated, then their joint decision should be allowed to stand. This is how it goes in many neonatal units.¹⁶⁹

While the decision is left with those who are in the closest relationship with the child and who presumably care most for the child, the role of the physician is left up in the air. The case law provides that the physician may not contradict the decision of the parents, even where the standard of practice or her sense of ethics is offended by the treatment.¹⁷⁰ The courts

Terminally Ill Patient, 16 LAW, MED. & HEALTH CARE 204 (1988).

165. The Washington Post reports the total cost of maintaining Baby K to be in excess of \$250,000. Marylou Tousignant & Bill Miller, *Death of "Baby K" Leaves a Legacy of Legal Precedents*, WASH. POST, Apr. 7, 1995, at B3.

166. *In re Baby K*, 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994).

167. *Id.*

168. *Id.*

169. See Dixie Snow Huefner, *Severely Handicapped Infants with Life-Threatening Conditions: Federal Intrusions into the Decision not to Treat*, 12 AM. J. LAW & MED. 171 (1986); Carl E. Schneider, *Rights Discourse and Neonatal Euthanasia*, 76 CAL. L. REV. 151 (1988); see also C. Everett Koop, *Life and Death and the Handicapped Newborn*, 5 ISSUES IN L. & MED. 101 (1989).

170. *In re Baby K*, 16 F.3d 590, 596-98 (4th Cir. 1993). The court claimed it was interpreting the EMTALA (Emergency Medical Treatment and Active Labor Act, 42

then treat the issue as a question of rights under a statute rather than as a matter of balancing the interests of the ones caring and ones cared for.¹⁷¹ So the decision is driven out of the court and into a form of consensus decision-making. The law forces the parents who do not want treatment for their child to enter into a quiet conspiracy with the physician to turn off the respirator. The physician and hospital, driven by the fear of a lawsuit, engage in consensus building with the parents about what they want to happen. The physician gives his recommendation in the face of the uncertainty that the parents express about the prognosis. When everyone is in agreement both medically and ethically, a decision to end life support can be, and often is, reached.

Those who do not have the fortitude to ask that this be done go on paying for treatment or forcing the state to provide the resources where the treatment is beyond the standard of medical practice. Yet the law can only go so far in enforcing a right-to-life morality. As long as the physicians give parents the option to withdraw or withhold treatment, while providing comfort care, the law will not be able to prevent the termination of life support: who is to know? Who will sue?

The obvious difference at the end of life where adults are involved is that the circle of those in relationships with the patient has broadened and changed. There is no automatic hierarchy of persons who have the claim to care sufficiently for the patient. The patient could be best loved and cared for by a friend, a spouse, a sibling, a nephew, a nurse, or a grandchild. The physician's ability to develop a consensus will then vary greatly, depending on the physician's ability to determine who should be consulted and whose decisions count. The physician is not as helpless as in the neonatal situation in determining the best interests of the fetus or child. In the physician-assisted suicide case, the patient can be consulted concerning those who ought to be brought into the decision. Once some persons are

U.S.C. § 1395dd (1992)) and was bound by its plain language to require the physician to provide respiratory care when the parents sought it. *See also Medical Technology*, *supra* note 111, at 1591-94 (describing the competing laws and the competing values in these treatment decisions).

171. The court's advice to amend the EMTALA is of little solace. *In re Baby K*, 16 F.3d at 598.

brought in, they can be asked to identify other persons who have a caring relationship with the patient.

The physician or nurse might complain that he or she is placed in a difficult and time consuming process. After all, developing a consensus takes time. Each person may have a different opinion concerning the legitimacy of the suicide. Yet in a group setting, with the patient present, the various opinions must be weighed against the expressions of autonomy by the patient. If the patient is not able to convince a person the group thinks has a significant claim of relationship on the patient, then the decision to end life must wait, or the patient must take the decision upon himself and act alone.¹⁷²

While some care-providers may not want to be bothered with such a lengthy and drawn-out process, other physicians or nurses who empathize with the patient's pain and concern may be enlisted in the process. And it is this involvement in the life of the patient, including his relationships, that guards against a biased and hasty decision to terminate one's life.

IV. CONCLUSION

Should the law explicitly provide for a limited "right" to physician-assisted suicide or should the physician-assisted suicide situation of the adult be handled "illegitimately," as in the neonatal units? It is my position that physician-assisted suicide should be made available to those who go through the care model of decision-making. If there is consensus among physi-

172. Some might argue that this gives too much power to a single family member or person in a significant relationship to the patient. Shouldn't there then be a right to appeal? The problem is determining to whom they would appeal. If the appeal is to the court, the judge, or a stranger, this imports yet another set of values into the discussion. If the appeal is to some public health board, then its values are called into question, and it has no investment in the care of the patient. In addition, the problem with any appeal is that it may turn the initial discussion into an adversarial warmup for the appeal. It is better to leave the decision with the group that has been led in a caring discussion as a result of the patient's situation and request. If this caring group cannot persuade the one vetoer, then, just as a lone juror can deadlock a jury in a murder case, one lone care-provider should be able to deadlock the physician-assisted suicide. After all, what is sought is limited access to suicide. If the patient is ultimately blocked and feels strongly enough about it, they can still commit suicide on their own.

cian, nurse, patient, and those who are in significant relationships with the patient, then the physician should be able to provide life-ending assistance. The physician should be protected by a written agreement from the group that termination is desired by the patient and is the caring thing to do. Without such a consensus, the physician should not provide life-ending support. Yet the opposite should also be true: where there is a consensus that caring requires assistance, then assistance in suicide should be provided. The law can legislate morality by providing for a decision-making community that can be taught to care about the patient and do the right thing for them. Otherwise, the state's "all or nothing" rights-based approach has the potential of either prematurely encouraging suicide or of instead imprisoning a patient in their own suffering, taking away what little dignity they might have left, and thereby increasing the chance that the patient may commit suicide on his own.¹⁷³

173. My position is that we do what we have done in other areas where the valuing question is too difficult, so we take the position that it is none of the state's business. But this does not mean that it is only the individual's business. Why not go the route of the corporate decision-making model and make the issue one of a group or a community of individuals in relationship with the patient and charge them with taking a caring approach to the issue?