Physician Assisted Suicide:  
The Historical Legal Debate, the Doctrine of Double Effect, and the Advancement of Palliative Care

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Suicide has been alternately interpreted over the course of history as a virtuous, cowardly, villainous, sacrilegious, and illegal thing to do. In these modern times of ventilators, artificial nutrition and hydration and the consequent ability to keep the terminally ill alive long after they would otherwise have died, new problems have arisen regarding the right one has over one’s own body and one’s own death. With Cruzan v. Director, Mo. Dept. of Health¹, the Supreme Court set an important precedent in this debate by establishing a patient’s constitutionally protected right both to refuse medical treatment and to have any life-saving/life-prolonging treatment removed. This ruling, while establishing an important precedent, also opened the door for further interpretation both of the Constitution (specifically the Fourteenth Amendment) and the ultimate meaning behind the wording of Cruzan. On June 27, 1997 the Supreme Court ruled on two cases that dealt with a question not far removed from that in Cruzan. These two cases, Vacco v. Quill² and Washington v. Glucksberg³, addressed the issue (initially raised in Compassion in Dying v. Washington⁴) of whether there is a “liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician assisted suicide.”⁵ The Courts below, through appeal⁶, ruled that there is such a liberty interest,

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⁵ Washington v. Glucksberg, 521 U.S. at 708. (internal citations omitted).
⁶ The history of this case is a bit convoluted: In January 1994, respondents, along with three terminally ill, pseudonymous plaintiffs (who have since died) and Compassion in Dying (a nonprofit organization that counsels people considering physician assisted suicide) sued the United States District Court, seeking declaration that Wash. Rev. Code 9A.36.060(1) (1994) is, on its face, unconstitutional.
and further, that Washington’s ban on assisted suicide\(^7\) is unconstitutional insofar as it “places an undue burden on the exercise of [that] constitutionally protected liberty interest.”\(^8\) The Supreme Court granted certiorari (in *Washington v. Glucksberg*), but did not agree with the en banc Ninth Circuit Court of Appeals (hereinafter “Court of Appeals”) in its ruling, and accordingly reversed. This paper will begin with an examination of the arguments given by the en banc Court of Appeals (*Compassion in Dying v. Washington*\(^9\)) and the Supreme Court (*Washington v. Glucksberg*), in reaching their rulings; it will then turn to the ramifications these Courts’ rulings have on the importance of the Doctrine of Double Effect and the possible advancement of palliative care.

I. PHYSICIAN ASSISTED SUICIDE AND THE LAW

*Compassion in Dying v. Washington*

In *Compassion in Dying*, the en banc Court of Appeals made two important rulings, first, “that there is a constitutionally-protected liberty interest in determining the time and manner of one’s own death”\(^10\); and second, that “insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own death, it violates the Due Process Clause of the Fourteenth Amendment.” Id. In reaching these rulings, the Court of Appeals had to consider three aspects of the Constitution as it

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\(^7\) Wash. Rev. Code 9A.36.060(1).

\(^8\) *Compassion in Dying*, 850 F.Supp. at 1465; Washington v. Glucksberg, 521 U.S. at 708, 117 S.Ct. at 2262.

\(^9\) 79 F.3d 790.

\(^10\) Id.
applied to the case before them. First, whether there is in fact a liberty interest in choosing the time and manner of one’s death; second, whether this liberty interest overrides the state’s interests; and third, whether Washington’s statue compromises the execution of this liberty interest and thereby violates the Due Process Clause of the Fourteenth Amendment. First, the question of liberty interest.

INDIVIDUAL LIBERTY INTEREST

The Court of Appeals, in examining whether there is a liberty interest in determining the time and manner of one’s death, turned to previous Supreme Court cases in, so called, “right-to-die,” and abortion issues. The court believed that the arguments on both sides of those issues were similar to those in the action before it, and that the rulings in those types of cases could therefore be used as precedent on which the court could base its present ruling. In many respects, according to the Court of Appeals, “the legal arguments on both sides are similar, as are the constitutional principles at issue.” To drive its point home point the court referred to Planned Parenthood v. Casey where the Supreme Court ruled that “[t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to a personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.” Further, to allay the objections that it would no doubt receive concerning the questionable historical basis of a right to suicide, the Court of Appeals stated in Compassion in Dying that “[i]n Casey, the court made it clear that the fact that we have previously failed to acknowledge the existence of a particular liberty interest or even that we have previously prohibited its exercise is no barrier to recognizing its existence”; and even if there is debate as to the historicity of their claim, the Court of Appeals posited that “historical evidence alone is not a

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11 It is important to keep in mind here that the mere discovery of a liberty interest does not necessarily mean that the state can’t prohibit the exercise of that interest, or that it can’t adopt regulations governing the exercise of that right (this will be discussed in-depth, infra, in evaluating whether a state’s interests can override the liberty interest in question).

12 Compassion in Dying, 79 F.3d at 801.


14 Casey, at 851; Compassion in Dying, 79 F.3d at 801.

15 Compassion in Dying, 79 F.3d at 805.
sufficient basis for rejecting a claimed liberty interest.” Unfortunately, as will be seen later, the Supreme Court did not agree with this cavalier attitude toward history.

In previous Supreme Court rulings, it had been put forward that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively “deeply rooted in this Nation’s history and tradition”, and “implicit in the concept of ordered liberty, such that neither liberty nor justice would exist if they were sacrificed.” Accordingly, the Court of Appeals set out to show how the proposed liberty interest is “deeply rooted in this Nation’s history and tradition.”

Like the Court in Roe v. Wade before it, the Court of Appeals began its exegesis from an ancient perspective, citing Jocasta, Oedipus’ mother, whose suicide was portrayed as an “honorable way out of an insufferable situation”; Homer’s apparent acceptance of suicide as being a natural and heroic act; and Libanius’ writing that,

> whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief, abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.

Similarly, the Stoics looked on suicide as the ultimate act of a pure and free rational will. The Romans, like the Greeks, looked on suicide as a socially acceptable alternative to public humiliation, and historical accounts relate to us how hundreds of Jews killed themselves at Masada in

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16 Id.
17 Washington v. Glucksberg, 521 U.S. at 703.
18 Id. at 721. (internal citations omitted).
20 Compassion in Dying, 79 F.3d at 807.
order to avoid being captured by attacking Roman legions.\textsuperscript{22} In the Old Testament Samson, Saul, Abimelech, and Achitophel all committed suicide in some form, and yet none of them is denounced; in the New Testament, Judas Iscariot’s suicide is treated as an act of repentance for his wrongdoing rather than as a sin. Martyrdom was honored among early Christians, even though it could easily be argued that many of the early martyrs “committed suicide” by placing themselves in situations that could not but lead to their deaths. The Christian church eventually (at the Council of Toledo, in 693 c.e.) decreed that anyone who attempted suicide should be excommunicated, and this view held sway for over 1000 years until philosophers such as Moore and Hume stepped to the fore and supported the right of a terminally ill person to commit suicide and even went so far as to approve the actions of people assisting those who wished to end their lives.\textsuperscript{23}

English common law, largely modeled after Justinian’s Digest, stated that anyone who commits suicide to avoid felonious conviction must forfeit all his property to his lords, but even here “[i]t ought to be otherwise if he kills himself through madness or an unwillingness to endure suffering”; “[i]f a man slays himself in weariness of life or because he is unwilling to endure further bodily pain ... he may have a successor, but his movable goods are confiscated. He does not lose his inheritance [i.e., real property], only his movable goods.”\textsuperscript{24} Sir Edward Coke, writing in 1644, made amendments to the law, but he too included an addendum to the effect that an exception can be granted for someone who “by the rage of sickness or infirmity or otherwise ...[kills himself]... while he is not of compos mentia.”\textsuperscript{25} More often than not, juries found it difficult to convict someone of unlawful suicide, and turned instead to

\textsuperscript{22} When Jerusalem was taken by the Romans in 70 c.e., about 1000 men, women, and children withdrew to the remote mountaintop. Under their leader, Eleazar ben Jair, they withstood a 2-year siege by the Roman Tenth Legion. All but seven killed themselves rather than surrender when the besiegers finally captured the fortress in 73 c.e. (See Masada, Jewish Virtual Library at http://www.jewishvirtuallibrary.org/jsource/Judaism/masada.html, citing JOSEPH TELUSHKIN, JEWISH LITERACY (1991).)

\textsuperscript{23} See, generally, THOMAS MOORE, UTOPIA (Edward Surtz ed., 1964).

\textsuperscript{24} Compassion in Dying, 79 F.3d at 808. (internal citation omitted)(emphasis added).

\textsuperscript{25} Id. at 809.

\textsuperscript{26} Id.
concluding that anyone who killed himself must not, therefore, have been of sound mind.27

English law, along with her people, was exported to the New World. However, by 1768, 6 of the 13 colonies had done away with the penalties for suicide.28 “By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the 37 states is it clear that there were statutes prohibiting assisting suicide.”29 Since the turn of the last century, the majority of states have not criminalized either suicide or attempted suicide: the New Jersey Supreme Court went so far, in 1901, as to say that since suicide was not punishable it should not be a crime. “[A]ll will admit that in some cases [suicide] is ethically defensible ...[as]...when a man curtails weeks or months of agony of incurable disease.”30 Today no state has a statute prohibiting either suicide or attempted suicide.31 Additionally, though the majority of states today do have statues that prohibit assisting in a suicide, there have been very few instances in which a physician has been punished for aiding a patient in hastening his own death. Further, “[a]ccording to a survey by the American Society of Internal Medicine, one doctor in five said he had assisted in a patient’s suicide.”32 Accounts like “It’s Over, Debbie,”33 in publications like the Journal of the American Medical Association, drive home the fact that discussions of this topic are not foreign to the medical community.

Based on these and other historical references, the Court of Appeals found that the liberty interest in question here is in fact, deeply rooted in this nation’s history and tradition.

Next, In an effort to delineate the exact boundaries of the Due Process Clause, the Court of Appeals turned to an examination of two important cases, Casey and Cruzan, that they believed showed that there is

27 Id.
28 Id.
29 Id.
31 Compassion in Dying, 79 F.3d at 810.
32 Id. at 811.
33 259 J. AM. MED. ASSOC. 2 at 272 (1988). (anonymous letter from doctor/author who administered a fatal dosage of morphine to a dying patient who asked for assistance)
“a strong liberty interest in determining how and when one’s life shall end, and that an explicit recognition of that interest follows naturally, indeed inevitably.”\textsuperscript{34}

In \textit{Casey}, the Supreme Court, after having considered prior decisions that granted constitutional protection to personal choices, said, [t]hese 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 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.\textsuperscript{35}

The Court of Appeals found this ruling to be very informative, indeed “almost prescriptive,”\textsuperscript{36} in their ruling on the possible liberty interest of a terminally ill person’s wish to hasten death. Taking the \textit{Casey} ruling (one that concerned itself primarily with the right to abortion) one step further, the Court of Appeals here stated that, [h]ow a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.... Prohibiting a terminally ill patient from hastening his death may have an even more profound impact on that person’s life than forcing a woman to carry a pregnancy to term.\textsuperscript{37}

In \textit{Cruzan}, where the issue was the removal of a comatose, terminally ill patient from life-support, the Court determined that there existed a liberty interest that includes the refusal of artificial provision of life-sustaining food and water. Citing from previous cases\textsuperscript{38} where rulings

\textsuperscript{34} \textit{Compassion in Dying}, 79 F.3d at 812.
\textsuperscript{35} \textit{Casey}, 505 U.S. at 851, 112 S.Ct. at 2807.
\textsuperscript{36} \textit{Compassion in Dying}, 79 F.3d at 813.
\textsuperscript{37} \textit{Id.} at 814.
\textsuperscript{38} \textit{E.g.}, Parham v. J.R., 442 U.S. 584 (1979). (Where the court held that a decision upholding a State's right to permit family decisionmaking, [may not] be turned into a constitutional requirement that the State recognize such decisionmaking.)
had been made to the effect that there is a definite liberty violation when a person is forced to undergo injection of medication against their will, the Court in Cruzan found that a “protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions ... and that the refusal of artificial food and water is encompassed in that liberty interest.” Given the liberty interest found in Cruzan, the Court of Appeals in Compassion in Dying concluded that the Cruzan decision “necessarily recognizes a liberty interest in hastening one’s own death.” In their support, the Court of Appeals here pointed out that Nancy Cruzan was not terminally ill, and as the Court in Cruzan noted, “[m]edical experts testified that she could live another thirty years.” Thus, according to the Court of Appeals here, “the [Cruzan] Court could not have resolved the case as it did by finding a liberty interest only in the terminally ill.” And so the Court of Appeals here found that both Casey and Cruzan provided sufficient precedent to persuade it that “the Constitution encompasses a due process liberty interest in controlling the time and manner of one’s own death — that there is, in short, a constitutionally recognized ‘right-to-die.’”

The State’s Interest

Now that the Court of Appeals had shown what it believed to be a protected liberty interest, it had to discern whether the Washington statute and its attempt to curtail the practice of that interest was constitutionally warranted. In order for the state’s statute preventing assisted suicide to be constitutionally justified, it must be shown that the state’s interests override the individual’s liberty interest. Those state interests the Court of Appeals considered were:

1) the importance of the various state interests, both in general and in the factual context of the case; 2) the state’s more specific interest in preventing suicide; 3) the state’s interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence;

39 Cruzan, 497 U.S. at 288. See also, Id. at 278; 110 S.Ct. at 2851.
40 Compassion in Dying, 79 F.3d at 816.
41 Id. at 816 n. 69., citing Cruzan, 497 U.S. at 266 n.1.
42 Compassion in Dying, 79 F.3d at 816 n. 69.
43 Id. at 816.
4) the state’s interest in protecting family members and loved ones; 5) the state’s interest in protecting the integrity of the medical profession; and 6) the state’s interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional.\textsuperscript{44}

Briefly, under \textit{Cruzan} it was held that the state is able to assert an unqualified interest in preserving the lives of its citizens, and further that “quality” of life issues needn’t make any difference in the degree of the state’s interest.\textsuperscript{45} Accordingly, the State is able to assert its interest in preserving the lives of the those terminally ill, competent adults in this case who wish to hasten their own deaths. However, In Washington’s Natural Death Act\textsuperscript{46}, the state said that its interest gives way in the case of competent, terminally ill adults dependent on medical treatment to stay alive. In effect, we see Washington saying, through this Act, that its interest is not so weighty as to completely deprive competent, terminally ill adult patients of some control over their deaths:

\begin{quote}
The legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.\textsuperscript{47}
\end{quote}

Thus the first conflict with a state interest is solved\textsuperscript{48}. The second interest, that of preventing suicide, is a bit more complex. The mere fact

\textsuperscript{44} Id.

\textsuperscript{45} “We think a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life...” \textit{Cruzan}, 497 U.S. at 281.

\textsuperscript{46} Wash. Rev. Code 70.122.020 et seq.

\textsuperscript{47} \textit{Compassion in Dying}, 79 F.3d at 818.

\textsuperscript{48} Judge Beezer, dissenting from the majority in this case stated that, [i]t may be tempting to extrapolate... a principle that terminally ill patients seeking to commit physician-assisted suicide fall within the zone where the state’s interest in preserving life is weakened. Such an extrapolation would be improper. The state’s interest is weakened only where continued medical treatment would do nothing more than postpone death. This is the [elsewhere], and it matches the line...
that there is no law on the books in Washington against suicide or attempted suicide *per se*, does not entail that there is not a state interest in preventing the act. Constraints of space preclude a detailed discussion of this issue; suffice it to say that “[w]hile the state has a legitimate interest in preventing suicides in general, that interest, like the state’s interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die.”\(^{49,50}\) Further, the state’s interest has already been shown to give way when confronted with competent terminally ill adults; similarly, the state’s interest in preventing suicide can be seen to be overridden in a number of contexts already in place, *e.g.*, the widespread and accepted use of the Doctrine of Double Effect, where, according to the American Medical Association,

> the intent of palliative treatment is to relieve pain and suffering, not to end the patient’s life, but the patient’s death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.\(^{51}\)

The Court of Appeals in *Compassion in Dying* took a rather large step (*i.e.*, toward legitimizing physician assisted suicide) beyond what previous Courts had ruled. It was this step that was one of the points that ultimately the Supreme Court took exception to.

Nevertheless, we do not believe that the state’s interest in preventing that additional step is significantly greater than its interest in preventing the other forms of life-ending

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\(^{49}\) *Id.* at 820.

\(^{50}\) In his dissenting opinion, Judge Beezer opined that “the state interest in preventing suicide runs directly contrary to any claimed right to physician-assisted suicide” *Id.* at 854; and, further, that “the state’s interest in preventing suicide is distinct from its interest in preserving life, and it does not diminish with the onset and advancement of terminal illness.” *Id.*

medical conduct that doctors now engage in regularly. More specifically, we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient’s life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor’s pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life.... In sum, we find the state’s interests in preventing suicide do not make its interest substantially stronger here than in cases involving other forms of death-hastening medical intervention.  

52 Compassion in Dying, 79 F.3d at 824.

53 It is this step, that of equating double effect, with single, and “pulling the plug” to prescription of death-hastening medication, which caused the most uproar among the groups submitting amici briefs to the Supreme Court.

Some pointed out that

[p]roviding medication to control pain has always been a legitimate and lawful medical act, even if death or suicide is risked. Most invasive medical interventions carry the risk of death or disability. But if a patient dies during surgery, the surgeon is not guilty of homicide. This is because there is a real difference between an intended result and an unintended but accepted consequence of medical care where the goal is to benefit the patient.


Similarly, Judge Kleinfeld, in his dissenting opinion in the Court of Appeals of appeals ruling points out that,

[w]hen general Eisenhower ordered American soldiers onto the beaches of Normandy, he knew he was sending many American soldiers to certain death.... His purpose, though, was to... liberate Europe from the Nazis. The majority’s theory of ethics would imply that this purpose was legally and ethically indistinguishable from a purpose of killing American soldiers.

Compassion in Dying, 79 F.3d at 858. (Kleinfeld, J. dissenting).

More will be said about the Doctrine of Double Effect in part II of this paper.
The consideration of the third state interest, that of the “state’s interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence,” starts with the belief that the current statute is necessary to protect indigent, minorities, and the disabled from exploitation. The argument basically states that it would be too easy for the poor to be disproportionately persuaded to undergo physician-assisted suicide. However,

as with abortion, there is far more reasons to raise the opposite concern: the concern that the poor and the minorities, who have historically received the least adequate health care, will not be afforded a fair opportunity to obtain the medical assistance... that would allow them to end their lives with a measure of dignity. The argument that the disadvantaged persons will receive more medical services than the remainder of the population in one, and only one area — assisted suicide — is ludicrous on its face.

In addition to the poor and minorities, however, there is the understandable concern that the elderly and infirm would come under indecorous pressure to end their lives, be it from family members who are having trouble paying for medical expenses for the infirm, or simply self-interested relatives due to inherit. Similarly, terminally ill patients may well feel pressured to hasten their own deaths out of fear of leaving enormous medical bills and debt to their heirs. Though the Court did recognize these dangers, it also felt that “[w]hile state regulations can help ensure that patients do not make rash, uninformed, or ill considered decisions, we are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration.”

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54 See supra note 43.

55 This same argument was used in past abortion cases, where it was posited that the poor and minorities would be either persuaded or forced against their will to have abortions. However, “[t]he fact is that the poor and minorities have been disproportionately deprived of the opportunity to have abortions...” Compassion in Dying, 79 F.3d at 825 n. 99.

56 Id. 79 F.3d at 825.

57 Id. at 826.
This subject, that of essentially passing judgment on the quality of life for the end-stage, terminally ill patient, has prompted many objections. The amici curiae brief of Not Dead Yet and American Disabled for Attendant Programs Today outlines several of these concerns. In this brief, the amici contend that there is a documented history of unequal treatment of people with disabilities, despite several court rulings declaring such discrimination illegal:

Given the history of purposeful unequal treatment to which people with disabilities are subjected and the continuing existence of unfair... discrimination and prejudice, adequate assisted-suicide safeguards cannot and will not prevent abuse against people with disabilities.... As long as society, including the medical profession, demonstrates ignorance and prejudice regarding the lives of people with disabilities, no safeguards can be trusted to contain the torrent of discrimination that will be unleashed by lifting the ban on assisted suicide.


Expounding on this unequal treatment theme, the New York State Task Force on Life and the Law wrote,

[i]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society — only that they are not exempt from the prejudices manifest in other areas of our collective life.


And further, that

[many patients] in large, overburdened facilities serving the urban and rural poor... will not have the benefit of skilled management and comfort care. Indeed, a recent study found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain. Many patients will also lack access to psychiatric services.

Id.
The fourth relevant state interest concerned the effect physician-assisted suicide might have on children, other family members, and loved ones.\textsuperscript{59} The Court of Appeals believed that the admitted state interest in safeguarding minor children and other family members “is of almost negligible weight when the patient is terminally ill and his death is imminent and inevitable.”\textsuperscript{60} In fact, the state held that forcing the innocent third parties considered here to witness a loved one’s slow and painful death “is more likely to harm than further the interests of innocent third parties.”\textsuperscript{61}

The AMA Code of Ethics section 2.211 condemns both euthanasia and physician-assisted suicide in similar language to those objections seen above:

The poor, the elderly, the disabled and minorities are all at risk from undue pressure to commit physician-assisted suicide, either through direct pressure or through inadequate treatment of their pain and suffering. They cannot be adequately protected by procedural safeguards.... The only way to achieve adequate protection for these groups is to maintain a bright-line rule against physician-assisted suicide.


Conversely, in the brief by the B.C. Civil Liberty Association in regards to the Canadian rulings on this same issue, the BCCLA stated that,

[w]e must also be careful not to exaggerate the susceptibility of persons. Persons who are competent to make legally binding death-requests will also typically be able to resist the pressures in question; if they cannot do the latter, they will not typically be able to do the former.... [If such pressures can be controlled] it would certainly be more appropriate to so control them, for we do not thereby deprive everyone of the right to death in order to protect a few who could be protected in some other way.


\textsuperscript{59} See supra, note 43.

\textsuperscript{60} \textit{Compassion in Dying}, 79 F.3d at 827.

\textsuperscript{61} Id.
The fifth state interest, that of protecting the integrity of the medical profession, received quite a bit of attention, not only from the Court of Appeals here, but also from the amici curiae in their briefs to the Supreme Court. The Court of Appeals did not believe that the integrity of the medical profession would be imperiled in any way by the upholding of the liberty interest being considered. The Court of Appeals based its decision largely on its belief that the assertion that the legalization of physician-assisted suicide will wear away at the commitment of doctors to their patients rests both on an ignorance of what numbers of doctors have been doing for quite some time, and on a misconception of the role of physician. Perceiving the apparent similarity between what physicians are now permitted to do and what the plaintiffs assert they should be permitted to do (i.e. not assist in the killing of a patient), the Court of Appeals saw no risk at all to the integrity of the medical profession.

The final state interest considered was that of fear of adverse consequences. Here is where we see the “slippery slope” or “wedge” arguments that plague questions such as this one. Another analogy, that is perhaps more vivid than any kind of slope or wedge, says that if you let the a camel’s nose into your tent, you’d best be prepared for the rest of it to follow shortly behind. The argument posits that, once a liberty interest in hastening one’s death is declared, that interest will open the door for

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62 See supra, note 43.

63 “They may terminate life-support systems, withdraw life-sustaining gastronomy tubes, otherwise terminate or withhold all other forms of medical treatment, and, may even administer lethal doses of drugs with full knowledge of their ‘double effect’” Compassion in Dying, 79 F.3d at 828.

64 In his dissenting opinion, Judge Beezer wrote that,

[p]hysician assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

... Because it is contrary to Washington statutory law, reinforced by the AMA Code of Ethics, it would violate the state’s interest in maintaining the ethical integrity of the medical profession to allow physicians to participate in physician assisted suicide.

Id. at 855.
others, and “sweep away all restrictions in its wake.” If this interest is declared, the argument continues, it will only be a matter of time before Courts will find it permissible to put people to death based not on terminal illness or even the individual’s desire, but because the people in question pose too much of a burden on society, or whose lives are deemed “not worth living” (e.g. the poor, lower classes, minorities, prisoners, severely handicapped, the elderly, etc.). Those advocating not recognizing a liberty interest here often cite the experience in the Netherlands where physician aid-in-dying is permitted in certain circumstances, and where there have been documented instances of not only active, voluntary euthanasia, but also, more alarmingly, active, non-voluntary euthanasia as well. However, the Court of Appeals made the point that reports on the medical practices in Holland are so varied that it is incredibly difficult to draw any conclusions from them. Similarly, even were the figures from Holland reliable, it would be difficult to say just how directly practices in the Netherlands can be compared to possible practices in the United States; cultural, legal and psychological variables differ so greatly between the two countries that any comparison would be problematic.

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65 Id. at 830.

66 Figures on the Netherlands experience differ depending on whose report one reads. The official Remmelink Report states that the ideas circulating in society as to the “excessive” scale of euthanasia in the Netherlands and to the charge that it is being used as a substitute to good palliative care are grossly out of line with reality:

According to the [Remmelink] commission, the assumption [that euthanasia is being used as a substitute to good palliative care] is not only disproved by the self-evident number of 2,300 cases a year, but also by the fact that doctors in the Netherlands are faced with about 9,000 requests for the termination of a patient’s life. In other words: it happens more often that a doctor does not comply with a request for the termination of a life... than that he actually carries out euthanasia.

**The Remmelink Report: Medical Practice with Regard to Euthanasia and Related Medical Decisions in the Netherlands.**

Further, the Remmelink Commission reports that of Holland’s 130,000 deaths in 1990, 0.8% (1000) cases were as a result of active non-voluntary euthanasia. Paul J. van der Maas, Johannes J. M. val Delden, Loes Pijnenborg, Caspar W. N. Looman, *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 THE LANCET 87686, 69-74 (Sept. 14, 1991).
As to the slippery slope argument, the Court of Appeals stated that, [r]ecognition of any right creates the possibility of abuse. The slippery slope fears of Roe’s opponents have, of course, not materialized. The legalization of abortion has not undermined our commitment to life generally; nor, as some predicted, has it led to wide spread infanticide. Similarly, there is no reason to believe that legalizing assisted suicide will lead to the horrific consequences its opponents suggest. 67

THE STATE’S INTEREST VERSUS AN INDIVIDUAL’S LIBERTY INTEREST

Now, once all of the relevant state’s interests had been outlined, the Court of Appeals had to weigh the state’s interests and the liberty interest of the individual and decide the strength of the state’s interests and the fairness of the means by which the state furthers those interests (i.e., the statute prohibiting assisted suicide). Here the Court of Appeals found that by prohibiting physician-assisted suicide, Washington State was putting a ban on the only agreeable, and practical way many terminally ill people have to end their lives. By prohibiting the use of physician-assisted suicide, the state is in effect, forcing those competent, terminally ill adults who are determined to end their lives, to do so by their own means; often leaving family members and loved ones to clean up the mess, or, worse yet, botching the job and surviving, but in an even worse situation: with severe brain damage or a bed ridden existence in a persistent vegetative state (two common occurrences with individuals who improperly judge the amount or type of medication needed to end their lives). Thus, for many terminally ill patients, the Washington statute is effectively a prohibition. While technically it only prohibits one means of exercising a liberty interest, practically it prohibits the exercise of that interest as effectively as prohibiting doctors from performing abortions prevented women from having abortions in the days before Roe. 68

67 Compassion in Dying, 79 F.3d at 831.

68 Id. at 832.
In the end, the Court of Appeals found that no matter how strong the state’s interest may be, it is “insufficient to outweigh the terminally ill individual’s interest” in determining when and how to end her life.\textsuperscript{69} Finally, turning the slippery slope argument to their favor, the Court of Appeals wrote that if general state policies could be used to deprive a terminally ill individual of her right to make decisions about her own death and have them honored, “it is hard to envision where the exercise of arbitrary and intrusive power by the state can be halted.”\textsuperscript{70}

Accordingly, since it felt that the Washington statute placed an “undue burden” and a “substantial obstacle” in the path of terminally ill, competent adults who wish to choose the manner of their own deaths, the Court of Appeals held that “the ‘or aids’ provision of Washington State RCW 9A.36.06, prohibiting assisted suicide, is unconstitutional as applied to terminally ill competent adults who wish to hasten their own deaths with medication prescribed by their physicians.”\textsuperscript{71}

\textit{Washington v. Glucksberg}

The Supreme Court, in their examination of the Ninth Circuit Court of Appeals’ decision in \textit{Compassion in Dying}, first took issue with that Court’s historical exegesis. While the Supreme Court agreed that “the primary and most reliable indication of [a national] consensus is... the pattern of enacted laws,”\textsuperscript{72} it also contended that opposition to and condemnation of suicide (and thereby of assisted suicide) are consistent themes of the “philosophical, legal, and cultural heritages”\textsuperscript{73} of our nation. The Supreme court focused more on the specific history of the United States\textsuperscript{74} — and not on more ancient sources as the Court of Appeals had—

\textsuperscript{69} Id. at 837.

\textsuperscript{70} Id.

\textsuperscript{71} Id.


\textsuperscript{73} \textit{Glucksberg}, 521 U.S. at 711, 117 S.Ct. at 2263.

\textsuperscript{74} Space prohibits such a discussion here, but for an excellent survey of how other democratic countries have addressed the question of physician-assisted suicide, \textit{see} Raphael Cohen-Almagor, \textit{Euthanasia And Physician-Assisted Suicide In The Democratic World: A Legal Overview}, 16 N.Y. INT’L L. REV. 1 (2003).
insisting that for “over 700 years, the Anglo-American common-law tradition has punished or otherwise disapproved of both suicide and assisting suicide.”

In 13th century England, as the Court of Appeals pointed out, if individuals killed themselves, their property was forfeit to the king, unless “a man slays himself in weariness of life or because he is unwilling to endure further bodily pain” in which case only his movable goods were confiscated. Here we see the suicide of a sane person, no mater the reason, declared as a punishable felony. Sir William Blackstone (whose commentaries on English law would become the primary authority for 18th and 19th century American Lawyers), centuries later, in his condemnation of the Stoics, wrote that suicide is “the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure....”

In the Providence Plantations (now Rhode Island), legislators declared in 1647, that,

[spell murdered is by all agreed the most unnatural and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor: ... his goods and chattels are the king’s custom, but not his debts or his lands; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing.]

The rather harsh common law penalties were eventually abolished, but this movement away from the harsh proscriptions did not necessarily

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75 Id.
76 Id.; Cf., Compassion in Dying, 79 F.3d at 809. (internal citations omitted).
77 Note here that the same passage was cited by the Ninth Circuit and Supreme Courts to make dichotomous points. This is a problem not infrequently encountered when one tries to find historical precedent for any action. If you are willing to look hard enough and interpret creatively, there is very little precedent you cannot find with which to justify yourself.
78 Glucksberg, 521 U.S. at 712, citing 4 W. BLACKSTONE, COMMENTARIES 189.
represent any sort of acceptance of suicide by the legislatures of the time. Rather, it reflected the general belief that to punish the surviving family members for the acts of their loved ones was unjust. That suicide was not as terribly punishable did not, however, have any impact on the restriction against assisting suicide. On the contrary, Chief Justice Swift, in his 1823 work on the laws of Connecticut, wrote that “[i]f one counsels another to commit suicide, and the other by reason of the advice kills himself, the advisor is guilty of murder as principle.” Five years after the publication of Swift’s treatise, New York (with the Act of Dec. 10, 1828, ch. 20 §4) outlined the first explicit United States law outlawing assisting suicide. The commission, led by Dudley Field defined and prohibited aiding a suicide as “furnish[ing] another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life.” By the time the Fourteenth Amendment was ratified, it was officially a crime to assist in suicide in most states. From then to now, though the bans on assisted suicide have been closely reexamined, they have been, generally, reaffirmed in all cases. More recently, on 30 April, 1997, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, which officially prohibits the use of federal funds in support of physician assisted suicide.

In historical summation, the Supreme Court stated that,

[a]ttitudes toward suicide itself have changed since [the 13th century], but our laws have consistently condemned... assisted suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end of life decisionmaking, we have not retreated from this prohibition.

In examining the Court of Appeals’ constitutional claim, the Supreme Court noted that, “we have always been reluctant to expand the concept of substantive due process because guideposts for responsible


82 Glucksberg, 521 U.S. at 715.

83 42 U.S.C. § 14401 et seq.

84 Glucksberg, 521 U.S. at 719.
decisionmaking in the uncharted area are scarce and open ended.”

Accordingly, The Court was also reluctant to extend constitutional protection to an asserted liberty interest, because such protection would remove discussion of the matter from the public arena, placing it purely under the control of legislative action. The Supreme Court therefore believed that it is of the greatest importance to “exercise the utmost care whenever we are asked to break new ground in this field, lest the liberty interest protected by the Due Process Clause be subtly transformed into the policy preferences of the members of this Court.”

The Supreme Court began as the Court of Appeals had, by examining whether the liberty “specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so.” In their historical examination, the Supreme Court found themselves confronted with an “almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it even today.” Consequently, for the Supreme Court to affirm the Court of Appeals’ ruling, they felt they would have to “reverse centuries of legal doctrine and practice” and undermine the practices of almost every state.

In addition to the historical precedent that the Supreme Court held to be most relevant, they accused the lower Court of confusing the issue in both Cruzan and Casey, and basing their ruling on the embellishment of statements taken out of their context. In Cruzan, the Supreme Court contends that it considered whether Nancy Cruzan “[h]ad a right under the United States Constitution which would require the hospital to withdraw life sustaining treatment” at her parents request. And after long deliberation, the Supreme Court held that within the concept of informed consent is encompassed the right of a competent person to refuse medical treatment. They then determined that the Court’s prior rulings confer a liberty interest in refusing unwanted medical treatment in that case.

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85 Id. (internal citations omitted.)
86 Id. at 720.
87 Id. at 723.
88 Id.
89 Id. at 723.
90 Id. at 724, citing Cruzan, 497 U.S. at 269.
91 The Supreme Court in Cruzan also held that “notwithstanding this right, the Constitution permit[s] Missouri to require clear and convincing evidence of
However, the Court of Appeals asserted that in *Cruzan* the Supreme Court “acknowledged that competent, dying persons have a right to direct the removal of life sustaining medical treatment and thus hasten death...[and that]...the constitutional principle behind recognizing the patient’s liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication.” 92 From this, the Court of Appeals concluded that “*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life sustaining food and water, necessarily recognize[d] a liberty interest in hastening one’s own death.” 93 According to the Supreme Court, though, the right assumed in *Cruzan* was “not simply deduced from abstract concepts of personal autonomy.” 94 Rather, the Supreme Court’s *Cruzan* decision was completely in line with the Nation’s history and practices. The decision to commit suicide with the assistance of a physician, conversely, has “never enjoyed similar legal protection” 95 and though the decision to do the one is just as profound as to do the other, the two acts are

widely and reasonably regarded as quite distinct.... In *Cruzan* itself we recognized that most States outlawed assisted suicide... and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide. 96

The Court of Appeals’ use of *Casey* was equally suspect. According to the Court of Appeals: “[I]ke the decision of whether or not to have an abortion, the decision how and when to die is one of ‘the most intimate and personal choices a person may make in a lifetime,’ a choice ‘central to personal dignity and autonomy.’” 97 However, according to the Supreme Court, the mere fact that many of the liberties protected under


92 *Glucksberg*, 521 U.S. at 725.
93 *Id.* (internal citations omitted.)
94 *Id.*
95 *Id.*
96 *Id.* at 725-726.
97 *Id.* at 726, *citing Compassion in Dying*, 79 F.3d, at 813-814.
the Due Process Clause make their case in personal autonomy, does not mean that the Court of Appeals can come to the sweeping conclusion that “any and all important, intimate and personal decisions are so protected.”\textsuperscript{98} And so, the Supreme Court held that,

\begin{quote}
[t]he history of the law’s treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.\textsuperscript{99}
\end{quote}

Let us now turn to the Supreme Court’s examination of whether Washington’s assisted suicide ban is rationally related to that State’s interests. Despite The Court of Appeals’ citing of the Natural Death Act in support of its claim that the State’s interest loses strength when confronted with competent, terminally ill adults, it failed to note, as the Supreme Court observed, that Washington had previously rejected this “sliding scale” approach to its interest in the preservation of life, and that Washington, “through its assisted suicide ban, insists that all persons’ lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law.”\textsuperscript{100}

Likewise, the Supreme Court also recognized the State’s interest in protecting the integrity and ethics of the medical profession. They argued that physician assisted suicide could undermine the trust that is essential to the doctor—patient relationship by “blurring the time-honored line between healing and harming.”\textsuperscript{101,102} The Supreme Court also found that

\textsuperscript{98} Glucksberg, 521 U.S. at 728. (internal citations omitted.)
\textsuperscript{99} Id.
\textsuperscript{100} Id. at 729.
\textsuperscript{102} On the other hand, The ACLU wrote in their brief to the Court that, since safeguarding of the right at issue here will permit and encourage candid discussions of all available options between the terminally ill and their physicians instead of criminalizing the provision of medical assistance to patients in need, recognizing the right of the terminally ill to obtain the relief they seek from doctors
the State had substantial interest in protecting innocent third parties from abuse and the various slippery slope arguments for essentially the same reasons outlined, *supra*, in note 58.

The Supreme court, in lieu of these State interests, held that,

[w]e need not weigh exactlying the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington’s ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code §9A.36.060(1) does not violate the Fourteenth Amendment, either on its face, or as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors.¹⁰³

**Summary of Part I**

In order for a liberty interest to be admitted, the practice in question must first be shown, conclusively, to be a part of our nation’s history and tradition. This is not the case with assisted suicide. It is truly unfortunate that the petitioners in the initial case felt it necessary to formulate their case as they did. From a careful look at the precedent and the history of the United States, it is clear that a liberty interest cannot be formed instead of eroding public confidence in the medical profession.


Similarly, Stevens, in his concurring opinion noted that,

[f]or some patients, it would be a physician’s refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role.... Furthermore, because physicians are already involved in making decisions that hasten the death of terminally ill patients — through termination of life support, withholding of medical treatment, and terminal sedation — there is in fact significant tension between the traditional view of the physician’s role and the actual practice in a growing number of cases.


¹⁰³ *Glucksberg*, 521 U.S. at 735.
inferred. However, even though the choice of *Cruzan* and *Casey* and the overly inflated role the Court of Appeals chose for them to play in its arguments for its ruling, it may not have hit too terribly far from the mark. Justice Stevens, in his concurring opinion in *Glucksberg* makes a very poignant remark, no doubt meant to spur further discussion in future cases similar to this one:

> While I agree with the Court that *Cruzan* does not decide the issue presented by these cases, *Cruzan* did give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death. Although there is no absolute right to physician assisted suicide, *Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State’s interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in deciding how, rather than whether, a critical threshold shall be crossed.¹⁰⁴

II. CONSEQUENCES OF THE COURT’S RULING

The Supreme Court’s ruling in *Glucksberg* categorically denied an individual liberty interest in obtaining physician assisted suicide. However, in reaching this ruling, the Court unanimously held that state laws could distinguish between proscribing physician behavior that *intentionally* hastens a patient’s death, and allowing actions which may *foreseeably* hasten death but which are intended for some other aim (e.g., the relief of pain). This allowance has powerful implications for the application of the doctrine of double effect, and by extension the more broad use of acute palliative care. The second portion of this paper will focus on the doctrine of double effect and its implications for palliative care options at the end of life.

THE DOCTRINE OF DOUBLE EFFECT

¹⁰⁴ *Glucksberg*, 521 U.S. at 745. (Stevens J. concurring).
The Ninth Court of Appeals stated that they saw “little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient’s life.”\textsuperscript{105} The Court there was drastically out of keeping with the mainstream understanding of the doctrine of double effect and why it is such an important tool for physicians.

The doctrine of double effect (hereinafter, “DDE”) can be formulated as follows: an action with two possible effects, one good and one bad, is morally permitted if the action

1) is not itself immoral,
2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect even though it may be a foreseen consequence,
3) does not bring about the possible good effect by means of the possible bad effect,
4) is undertaken for a proportionately serious reason.\textsuperscript{106,107,108,109,110,111}

The primary importance of the DDE, as it pertains to the present discussion, is that it provides a way for those physicians who are morally (as well as legally) indisposed toward euthanasia or assisted suicide to

\textsuperscript{105} Compassion in Dying, 79 F.3d at 824.

\textsuperscript{106} Ann Alpers and Berlard Lo, The Supreme Court Addresses Physician-Assisted Suicide: Can its Rulings Improve Palliative Care?, 8 ARCH. FAM. MED. 200-201 (May/June 1999).

\textsuperscript{107} Camillo C. Bica, Another Perspective on the Doctrine of Double Effect, 13 PUBLIC AFFAIRS QUARTERLY 2 133 (April 2000).

\textsuperscript{108} C.E. Kendall, A Double Dose of Double Effect, 26 JOURNAL OF MEDICAL ETHICS 204 (2000).


\textsuperscript{111} Daniel P. Sulmasy, The Rule of Double Effect: Clearing Up the Double Talk, 159 ARCH. INTERN. MED 545 (Mar 22, 1999).
provide adequate pain relief without fear of “wrongfully” killing their patient. According to the DDE, palliative use of, say, morphine is morally permissible even though euthanasia and assisted suicide are illegal, and possibly morally repugnant to the individual physician.

Moving away from the legal status of euthanasia—which may or may not be in accord with its moral status—let us now examine the application of the DDE and its efficacy in morally absolving an individual of responsibility for the death of an innocent human being. According to the DDE, even if the end result of an action is the death of an innocent person, so long as that end was not the intention of the act or the performing agent, the act itself and the agent performing that act are morally absolved of any responsibility for the resultant death. This particular argument has been espoused by countless practitioners since the dawn of medicine and theology; even an action as simple as prescribing an antibiotic for an infection, already presupposes a great deal about the importance of intention and is thus also an application of the DDE. However, though the DDE has had many and powerful proponents, it has also had its critics: those who oppose the DDE on theoretical grounds, and those who, while they may agree with the DDE in certain settings, are dubious of its role in end-of-life decision making.

In analyzing the moral efficacy of the DDE, it is helpful to adopt the view of its outspoken opposition, and operate on the following null-hypothesis, as espoused by Camillo C. Bica:

\[ (H_0) \text{[I]n cases where the death of an innocent right bearer is the foreseen though unintended effect of an act and as probable an occurrence as is the intended effect, despite the application of the DDE, the moral rights of the victim are violated and the agent is negligent in his obligation to respect those rights.} \]

According to this null-hypothesis, then, it matters not what the intended effect may be; if the action ends with the death of an innocent

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112 “For instance, when physicians treat streptococcal pharyngitis with penicillin, they foresee the possibility that the patient might develop an anaphylactic reaction and die. But they only intend to kill the bacteria, not to kill the patient. The death of the patient is not the cause of the death of the bacteria, and the rarity of anaphylaxis and the harm of not treating makes the risk proportionate and worth taking.” Sulmasy, supra, note 111 at 548.

113 Bica, supra, note 107 at 131.
person, the acting agent is morally culpable. It must be noted here that this view takes for granted the Hohfeldian view that a right is a claim against others, and that there is a correlative duty against others to respect that right.\(^{114}\) Also taken for granted is that among those rights enjoyed by human beings is the right to life, with the correlative duty against others not to wrongfully deprive an innocent individual of life; this particular right is absolute, however, and cannot be waived by the right holder.

In cases of terminal palliative care, this view holds that, while the administration of high doses of morphine—for the control of intense pain—leading to the death of a patient may be allowed by the DDE, the action itself is morally unacceptable as it is in essence an act of violence against an innocent person. It might be argued, contra Bica, that the patient absolves the physician of moral wrongdoing by taking part in the informed consent process and waiving the right to life. However, since Bica believes that there is an unconditional prohibition against individuals waiving their right to life, “the fact that the patient (or his surrogate) gives informed consent is morally irrelevant.”\(^{115}\) Further, she believes that the bad effect (i.e., the patient’s death) is knowingly brought about and not simply accidental; the bad effect is a probable occurrence (indeed equally as probable as the good effect) and not merely a possible one.\(^{116}\) And so, put simply, given that there is an absolute prohibition against killing innocent human beings, and further, given that it is impossible for individuals to waive their right to life—e.g. through an informed consent procedure—the physician “is not absolved of responsibility for the death of the innocent human being nor is the act morally permissible.”\(^{117}\)

Two important aspects of this position are flawed. First, it takes for granted, as one of its premises, that an innocent person’s right to life, and the correlative duty against others not to deprive that person of life, is absolute and unwaivable. Contrary to this view, Allen Buchanan has argued convincingly that the very aspect of what distinguishes rights from other non-rights-based principles is the former’s waivability.\(^{118}\)


\(^{115}\) Bica, *supra*, note 107 at 137.

\(^{116}\) *Id.*

\(^{117}\) *Id.* at 138

Generally speaking, also takes for granted the waivability of the patient’s right to life with the wide acceptance of advance directives and living wills. These documents implicitly accept the premise that the right to life is capable of being waived. Second, and perhaps more importantly, Bica’s argument confuses the importance of intent to the moral efficacy of the DDE. She maintains that the bad effect (i.e. the patient’s death) is knowingly brought about and not simply accidental. Based on this premise she concludes that the DDE is fundamentally inadequate as a means of conferring moral acceptance on an act. However, she ignores the example outlined in note 112, supra, where a patient dies as a result of anaphylactic shock brought on by the administration of penicillin to treat a dangerous infection. Clearly, in that case, the result is not “knowingly” brought about; indeed the chances of this bad result are so slim as to render the administration of penicillin in such cases routine. Granted, there exists the possibility of death by anaphylactic shock, but this mere possibility is not nearly strong enough to warrant withholding administration of the medication. There is a fundamental difference here between the actualization of a possible negative effect and knowingly bringing about that effect. To conflate these two is to misunderstand the importance of intent on a very fundamental level. Another excellent example of this point, taken from outside the medical field, has been pointed out by Daniel P. Sulmasy:

> [c]areful distinctions are also drawn, for instance, between man-slaughter, murder in the first degree, and so forth, purely on the basis of judgments about human intentions. What is done with “malice aforethought” is deemed far more troubling morally than what is done unintentionally.\(^{119}\)

It appears, then, that it is not unreasonable to believe that it is possible both for individuals to waive their right to life, and that the intent of an act is vitally important to the moral designation of that act. Based on the preceding, there is reason to believe that the DDE does in fact play a role in determining the morality of actions which can have two effects, one intended and one not.

Having shown that it is not unreasonable to employ the DDE generally speaking, let us now return to the Supreme Court’s ruling and

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\(^{119}\) Sulmasy, supra, note 111 at 548.
the implications it, taken along with the DDE may have for the advancement of palliative care for the terminally ill.

**IMPLICATIONS FOR PALLIATIVE CARE**

The majority opinion in *Glucksberg* was that the DDE provides a constitutional basis for states to permit narcotics given in high dosages for pain relief in the terminally ill, while proscribing assisted suicide. “Thus, the majority opinion delineates an acceptable justification for aggressive palliative care.”¹²⁰ Just how aggressive palliative care can be strengthened by the Supreme Court’s ruling is not immediately clear; to fully understand the support for palliative care supplied by the Court, we must first examine the conflict within a physician who is morally opposed to assisted suicide (regardless of its legal classification), and yet has the commendable (indeed, professionally mandated) desire to provide adequate pain relief to patients in intense pain at the end of life.

Generally speaking, most people would agree that if pain can be relieved by administration of medicine, then it ought to be; else why bother having the medicines available? The conflict arises when physicians who are morally opposed to assisted suicide—or who fear litigation should they inadvertently cause the death of their patients—are placed in the position of either possibly causing the death of their patients or forcing those patients to endure unreasonable amounts of pain. In lieu of the prohibition of assisted suicide upheld by the Supreme Court, the danger of such forced pain endurance looks quite real. However, the Supreme Court’s understanding permits individual states to treat pain management as substantively different from assisted suicide. Indeed, it has been pointed out that the Court’s ruling could imply a possible constitutional right to palliative care.¹²¹ Given this allowance for aggressive palliative care, those physicians who might have feared legal repercussions even with the DDE, should have at least some of their fears allayed.¹²²

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¹²⁰ Alpers, *supra*, note 106 at 201.

¹²¹ Burt, R. The Supreme Court Speaks: not assisted suicide but a constitutional right to palliative care. 337 NEW ENGLAND JOURNAL OF MEDICINE 1234-1236 (1997).

¹²² See *e.g.*, Cooley v Granholm, 291 F.3d 880, 882 (6th Cir. 2002) where it was held that Michigan law does not prohibit doctors from prescribing medication which has the ‘double effect’ of relieving pain while also hastening
Far more could be said on the topic of the DDE and its implications on palliative care (e.g., the various implications of voluntary euthanasia, assisted suicide, and terminal sedation; the difficulty determining intent; the possibility of criminal charges for federal drug violations\(^\text{123}\), or for murder or manslaughter\(^\text{124}\), etc.) but in the interest of space I will end my discussion here.

death or substantially increasing the risk of death. The Michigan Dignified Death Act, expressly provides that a physician is immune from civil or administrative liability for prescribing a narcotic drug in good faith an with the intention to alleviate a patient’s pain.

The _Cooley_ court declined to address the question of whether the statute itself violated substantive due process because the question was seen as moot, in part due to the fact that the Doctor Plaintiffs in that case could not “clearly identify[y] any current patient or any future patient who is terminally ill and ‘suffering irremediable pain’ and whose death may not be hastened legally by withdrawing artificial life support or by administering morphine or other pain medication.” _Id._

\(^{123}\) For recent developments regarding a physician’s possible liability for prescribing medication for the purpose of assisting in a patient’s suicide, see _e.g._, Oregon v. Ashcroft, 368 F.3d 1118 (9th Cir. 2004), where the Court addressed the question of whether the Attorney General exceeded his authority in adopting a directive declaring that physician assisted suicide violates the Controlled Substances Act (CSA). The court eventually held that “the Ashcroft Directive interferes with Oregon's authority to regulate medical care within its borders and therefore ‘alter[s] the ‘usual constitutional balance between the States and the Federal Government.’” _Id._ at 1124.(internal citations omitted). And further, that since “[p]hysician assisted suicide is an unrelated, general medical practice to be regulated by state lawmakers in the first instance,” _Id._ at 1126, the Attorney General’s directive (which exposed physicians to federal prosecution) “exceeds the CSA’s limited mandate to combat prescription drug abuse and addiction.” _Id._ at 1129.

\(^{124}\) See, _e.g._, Sampson v. State, 31 P.3d 88 (Alaska 2001), where the court held that:

the right to physician-assisted suicide is not implicit in text, context, or history of the Alaska Constitution's liberty and privacy clauses. While these guarantees encompass a broad range of autonomy, they do not require an exemption to Alaska's manslaughter statute that would provide for physician-assisted suicide. As another court said in reaching the same conclusion: ‘By broadly construing the privacy amendment to include the right to assisted suicide, we would run the risk of arrogating to ourselves
III. CONCLUSION

The Supreme Court’s ruling in Glucksberg categorically denied an individual liberty interest in obtaining physician assisted suicide. What remains to be seen, however, are the exact ramifications of this ruling on the acceptance and practice of the DDE and palliative care generally. It is possible that, in the absence of a permissible means of assisted suicide, so minded physicians my resort to overly loose interpretations of the DDE, employing it to excuse the use of medications in doses which can hold little doubt that their intended purpose was in fact the patient’s death, not alleviation of pain *per se*. However, this apprehension is not any more, nor less plausible than the earlier fear that, in the absence of a ban on abortion practices, the incidence of abortion would skyrocket. It may well turn out that the Supreme Court’s upholding Washington’s ban on assisted suicide will lead to better management of pain, and better application of the DDE. It must not be forgotten, however, that merely because the Court declares an action legal or illegal says nothing whatever regarding that action’s *moral* status. In the absence of a clear understanding of the ultimate morality of assisted suicide and the physician’s role therein, the law will have to suffice; once a better understanding is reached, the law may well have to yield to a new conception of morality and the role of the physician.

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those powers to make social policy that as a constitutional matter belong only to the legislature.”

*Id.*, at 98, *citing* Krischer v. McIver, 697 So.2d 97, 104 (Fla.1997).

*See also, People v. Kevorkian, 248 Mich. App. 373, 639 N.W.2d 291 (2001), upholding second-degree murder and delivering a controlled substance convictions where the defendant administered a lethal dose.*