Introduction


4. Derek Humphrey and Mary Clement, Freedom to Die: People, Politics, and
the Right to Die Movement 19 (St. Martin’s Griffin 2000). The same demographics of the dying also appear in Britain. See David Field, supra n. 3, at 60.


7. See Stacy L. Mojica and Dan S. Surrell, supra n. 6, at 474–75.


9. Daniel C. Maguire, supra n. 8, at 84; Tracy Nerland, supra n. 5, at 122.

10. Wesley J. Smith, Forced Exit: The Slippery Slope from Assisted Suicide to


13. Ian Dowbiggin, supra n. 10, at 64, 70; Wesley J. Smith, supra n. 10, at 83; N.D.A. Kemp, supra n. 10, at 211 (. . . the British euthanasia movement could not avoid being tarred with the Nazi brush).


18. Felicia Cohn and Joanne Lynn, “Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide,” in The Case against Assisted Suicide: For the Right to End-of-Life Care 240 (Kathleen Foley, M.D., and Herbert Hendin, M.D., eds., Johns Hopkins Univ. Press 2002) [hereinafter “The Case against Assisted Suicide”]; Liezl Van Zyl, Death and Compassion: A Virtue-Based Approach to Euthanasia, 124–25 (Ashgate 2000). See also Ian Dowbiggin, supra n. 10, at 175. (Consistently in the polls one-third support PAS, one-third support PAS in isolated cases but oppose it in general, and one-third oppose PAS under all circumstances. While there is a general endorsement of the abstract right to PAS, people balk when considering the right in specific situations.)


**Issue 1**

1. See Malcolm Parker, supra intro. n. 14, at 530:

   i. For most people, our ultimate preferences and principles, which satisfy our conceptions of the good life, can certainly conflict with others’ preferences and principles, so morality involves both the realization of our individual conceptions and attempts to harmonize them with those of others.

   ii. This kind of theory is naturalistic in that it bases morality in human needs, concerns, attitudes and preferences, but also retains deontological language in its traditional place, to refer to those widely agreed principles of which we approve and which we can commend, setting them apart from just any possibility, and reserving to them a critical edge, as well as their generality and claim to universality.


15. Daniel C. Maguire, supra intro. n. 8, at 111. See also German Grisez, supra n. 12, at 786–87.

16. See Jim Dwyer, Peter Neufeld, and Barry Scheck, Actual Innocence (2000); Edward F. Conners, Thomas Lundregan, Neal Miller, and Tom


17. Ibid.
21. “Submission to the Select Committee of the House of Lords on Medical Ethics by the Linacre Centre for Heath Care Ethics,” in “Clinical Practice,” supra, n. 3, at 126 (such a belief in equality is necessary if we will have “Justice” in our society); Arthur Dyck, “Beneficent Euthanasia and Benemortas: Alternative Views of Mercy,” in “Death-Dying,” supra n. 3, at 359 (no person or community can say who deserves to live or die); Luke Gormally, “Walton, Davies, Boyd, and the Legalization of Euthanasia,” in “Euthanasia Examined,” supra intro. n. 2, at 115 (we protect all by making all equally entitled to justice); Peter Singer, supra n. 7, at 65; Marc Stau, “Causal Authorship and the Equality Principle: A Defense of the Acts-Omission Distinction in Euthanasia,” 26 *J. Med. Ethics* 237, 240 (2000). As was the case with the sanctity of life, the notion that all lives have equal value is a recent one in human history. M.T. Meulders-Klein, supra n. 3, at 35.
uation of persons with disabilities that is present in the United States and the possibility that persons with disabilities will internalize these negative attitudes.

Merope Pavlides, “Whose Choice Is It, Anyway? Disability and Suicide in Four Contemporary Films,” J. Disability Pol’y Studies 46 (2005) (“This review confirms the hypothesis that such films underscore our cultural tendency to view disability and illness as an experience that demands release rather than support”); Darrell W. Amundsen and Gail Taira, “Our Lives and Ideologies: The Effect of Life Experience on the Perceived Morality of the Policy of Physician-Assisted Suicide,” 16 J. Disability Pol’y Studies 53, 55 (2005) (“The very people whose job it was to care for me believed that I would be better off dead”); id., at 56 (“The ableist’s ideology . . . : The unhappiness of ‘those people’ is caused by their impairments, not by the ableist’s own lack of social conscience. This is the social harm caused by ableism and abetted by the assisted suicide movement.”). But see Karen Hwang, “Attitudes of Persons with Physical Disabilities toward Physician-Assisted Suicide: An Exploratory Assessment of the Vulnerability Argument,” 16 J. Disability Pol’y Studies 16, 20 (2005) (the disabled community is not monolithic in its view; some don’t think of themselves as vulnerable and resent the label). But the disabled may be more prone to consider ending their lives because of discriminatory services that make life difficult to live, Paul K. Langmore, “Policy, Prejudice, and Reality: Two Case Studies of Physician-Assisted Suicide,” 16 J. Disability Pol’y Studies 38, 44 (2005); and an unsupportive cultural environment that keeps the disabled from seeing the potential quality and value their lives might have, Richard Radtke, “A Case against Physician-Assisted Suicide,” J. Disability Pol’y Studies 58 (2005).

24. Bill Moyers, “Living with Dying,” segment 1 of On Our Own Terms: Films for the Humanities and Science (2000); Darrel W. Amundsen, “The Significance of Inaccurate History in Legal Considerations of Assisted Suicide,” in “The Case against Assisted Suicide,” supra intro. n. 3, at 13; Darrel W. Amundsen, “The Significance of Inaccurate History in Legal Consideration of Physician Assisted Suicide,” in “Expanding the Debate,” supra intro. n. 8, at 91; Stacie L. Mojica and Dan S. Murel, supra intro. n. 6, at 471, 485. This opposition on the part of African Americans, however, may be as much a function of religious belief as concerns about racial bias. Peter G. Filene, supra intro. n. 1, at 213. Dona J. Reese, Robin E. Ahern, Shankar Nair, Joleen D. O’Faire, and Claudia Warren, “Hospice Access and Use by African Americans: Addressing Cultural and Institutional Barriers through Participatory Action Research,” 44 Social Work 549, 553–54 (1999) (barriers to use of hospice include knowledge of service economic restraints, religious views that to not pray for a miracle and fight on demonstrates a lack of faith in God, cultural views about fighting for life and a cure versus accepting palliative care and inevitable death, distrust of nondiverse health care system when a recommendation for palliative care is made).

25. “Social worth” was a central criterion for decisions about who would be given access to kidney dialysis in some programs. Twenty-nine percent of the cen-

An even more vivid sense of the role of social worth criteria in these life and death decisions comes from the recollections of one board member who made such decisions.

“The choices were hard,” Mr. N, a lay member of the committee, told us, “and I wasn’t happy about some of the decisions I made. For example, I remember voting against a young woman who was a known prostitute. I found I couldn’t vote for her, rather than another candidate, a young wife and mother who had proved her responsibility and worth. I also voted against a young man who had been a ne’er-do-well, a real playboy, until he learned he had renal failure. He promised he would reform his character go back to school, and so on, if only he were selected for treatment. But I felt I’d lived long enough to know that a person like that won’t really do what he was promising at the time.”

Id.; see also Paul E. Kalb and David H. Miller, “Utilitarian Strategies for Intensive Care Units,” 261 JAMA 2389 (1989) (“such social considerations as quality of life, family preferences, and potential contribution to family and society were all important factors in physician treatment decisions”). Thus, in making decisions about who would be given dialysis the committee tended to choose people like them, the upper middle class. See Renee C. Fox and Judith P. Swazey, supra n. 25, at 230–31.

[T]hose making microallocation decisions have a strong tendency to prefer patients with whom they identify; if the decision-makers are well-educated and well-to-do professionals, an allocation system in which the patient’s social worth were a factor would be likely to prefer patients with high socio-economic status. Minority groups and the underprivileged might be underrepresented.

(1983) (doctors consciously or unconsciously are influenced by their affinity, or lack thereof, with a patient, including whether the doctor and patient are of the same socioeconomic class).

26. Daniel C. Maguire, supra intro. n. 8, at 88, 132. For a fuller discussion of the Nazi horror, see chapter 4.


28. See Cruzon v. Director, Missouri Dept. of Health, 497 U.S. 261, 302 (1990). This is less surprising when one realizes that on average 80 days of the last year of one’s life are spent in a hospital or nursing home. Peter G. Filene, supra intro. n. 1, at 55. See also Paul J. Zweir, supra intro. n. 5, at 224 (70 percent of these decisions will involve withdrawing treatment); George P. Smith, “Restructuring the Principles of Medical Futility,” 11 J. Palliative Care 9.9 (1995); and Marcia Angell, “Helping Desperately Ill People to Die,” in “Regulating How We Die,” supra n. 7, at 12. A somewhat different estimate (though limited to hospitals) estimates that 50 percent of deaths in hospitals from nonemergency cases result from withdrawing lifesaving treatment. Robert T. Hall, supra intro. n. 15, at 10.

29. Daniel Callahan, “Self-Extinction: The Morality of the Helping Hand,” in “Physician Assisted Suicide” supra intro. n. 11, at 95. If a nonphysician pulled the plug, it would be homicide. Leslie Pickeras Francis, “Assisted Suicide: Are the Elderly a Special Case?” in “Expanding the Debate,” supra intro. n. 8, at 241; Peter Singer, supra n. 7, at 77. See also J.P. Bishop, “Euthanasia, Efficiency, and the Historical Distinction between Killing a Patient and Allowing a Patient to Die,” J. Med. Ethics 220, 220 (2006) (we can’t distinguish between killing and letting die because the modern view of causality wrongly focuses on effect not motives and intent like the older formulation).


31. George P. Smith, supra n. 28, at 10. Smith includes four concepts within the notion of futility: (1) the treatment won’t cure, (2) the treatment is not beneficial, (3) the treatment is unlikely to produce benefits, and (4) the treatment is plausible but not yet validated. See also Robert I. Mishbin, supra intro. n. 5, at 144–45 (no right to use resources if “futile”). Cf. Robert I. Mishbin, supra intro. n. 5, at 127 (on “go slow” codes in hospitals). For the Catholic view on futility, see Kevin D. O’Rourke, O.P., “Pain Relief: Ethical Issues and Catholic Teaching,” in Birth, Suffering, and Death 157, 163 (K.W. Wilder, ed., Kluwer Academic 1992); and “Nutrition and Hydration: Moral and Pastoral Reflections,” 15 J. Contemp. Health Law & Policy 455, 466 (1999) (National Conference of Catholic Bishops Committee for Pro-life Activities) (discusses when providing water is considered futile).

32. James L. Werth, “Concerns about Decisions Relating to Withholding/Withdrawing Life Sustaining Treatment and Futility for Persons with Disabilities,” 16 J. Disability Pol’y Studies 31, 34 (2005) (“If Futility is to be a useful concept in practice, it must have an understandable and acceptable definition and be
applied consistently by physicians. Research indicates that this is not the case, . . . ”); David Rieff, “Illness as More Than Metaphor,” *New York Times Magazine* (Dec. 4, 2005) (in writing about the death of his mother, Susan Sontag, her son notes, “I have found no consensus [regarding the meaning of medical futility] among the oncologists I have spoken with in the aftermath of my mother’s death, and I don’t believe there is one”).


37. Peter Singer, supra n. 7, at 112; Leizl van Zyl, supra intro. n. 18, at 52; John Harris, “The Philosophical Case against the Philosophical Case against Euthanasia,” in “Euthanasia Examined,” supra intro. n. 2, at 33, 39; “Submission to the Select Committee of the House of Lords on Medical Ethics by the Linacre Centre of Health Care Ethics,” in “Clinical Practice,” supra n. 3, at 139; Robert T. Hall, supra intro. n. 15, at 12; George P. Smith, supra n. 28, at 10.

38. Margaret P. Battin, “Is a Physician Ever Obligated to Help a Patient Die?” in “Regulating How We Die,” supra n. 7, at 41; Lawrence O. Gostin, supra n. 4, at 94. On the other hand, there are authors who say that one cannot easily tell whether or not morphine was the cause of a particular death. Wesley J. Smith, supra intro. n. 10, at 222. There are even some who claim that, properly administered, morphine carries no greater risk of death than aspirin. “Submission to the Select Committee of House of Lords on Medical Ethics by the Linacre Centre for Health Care Ethics,” in “Clinical Practice,” supra n. 3, at 79.


40. Liezl van Zyl, supra intro. n. 18, at 127. See also Alan Donagan, supra n. 39, at 159; Joseph M. Boyle Jr., supra n. 39, at 531–32.

41. Glanville Williams, *The Sanctity of Life and the Criminal Law* 322 (Knopf 1972); Liezl van Zyl, supra intro. n. 18, at 129; Joseph M. Boyle Jr., supra n. 39.

42. Yale Kamisar, “The Reasons So Many People Support Physician Assisted

43. “Submission to Select Committee of House of Lords on Medical Ethics by the Linacre Centre for Health Care Ethics,” in “Clinical Practice,” supra n. 3, at 63. Cf. Robert I. Mishbin, supra intro. n. 5, at 141.

44. Craig Paterson, “On Clarifying Terms in Applied Ethics Discourse: Suicide, Assisted Suicide, and Euthanasia,” 43 Int’l Phil. Q. 351, 351–55 (2003). (“Suicide is to be taken to mean: an act or omission whose proximate effect results in the person’s own bodily death, voluntarily and knowingly undertaken, with the intended objective [whether as an end in itself or as a means to some further end] that one’s bodily life be so terminated.”)


47. David Orentlicher, “The Supreme Court and Terminal Sedation: Rejecting Assisted Suicide, Embracing Euthanasia,” 24 Hast. Const. Q. 947, 953–58 (1997); Id., at 959 (sedation prevents saving a patient who has been misdiagnosed because he or she will die anyway from starvation); John D. Arras, “Tragic View,” in “Expanding the Debate,” supra intro. n. 8, at 300 (author believes that terminal sedation is even worse than PAS); David Orentlicher, “The Supreme Court and Terminal Sedation: An Ethically Inferior Alternative to Physician-Assisted Suicide,” in “Expanding the Debate,” supra intro. n. 8, at 301.

48. Judith A.C. Reitjens et al., supra n. 46, at 752.

Issue 2


9. Paul I. Mishbin, supra intro. n. 5, at 143.


12. Id., at 45; Darrel W. Amundsen, “Suicide and Early Christian Values,” in
“Historical and Contemporary Themes,” supra intro. n. 5, at 127; Daniel C. Maguire, supra intro. n. 8, at 143 (Samson); Darrel W. Amundsen, “The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 24.


16. James F. Childress, “Religious Viewpoints,” in “Regulating How We Die,” supra ch. 1 n. 5, at 125; Beth Spring and Ed Laron, Euthanasia: Spiritual, Medical, and Legal Lessons in Health Care 109 (Multnomah 1988) (Saint Augustine’s position); Joseph Boyle, “Sanctity of Life and Suicide: Tensions and Developments within Common Morality,” in “Historical and Contemporary Themes,” supra intro. n. 5, at 226 (author notes that the phrase “your neighbors” is not added to modify “Thou shall not kill”).


18. Daniel B. Sinclair, “The Interaction between Law and Morality in Jewish Law in the Area of Feticide and Killing of a Terminally Ill Individual,” in Criminal Justice Ethics 76, 80 (summer–fall 1992); H. Tristram Engelhardt Jr., “Death by Free Choice: Modern Variations on an Antique Theme,” in “Historical and Contemporary Themes,” supra intro. n. 5, at 257; Peter Singer, supra ch. 1 n. 7, at 218 (the threat of murder causes fear because humans can see themselves existing over time and the risk of death at the hands of another “threatens the peaceful existence on which our society depends”). See also Carl Wellman, “A Moral Right to Physician-Assisted Suicide,” 38 Am. Phil. Q. 271, 273 (2001) (murder also harms the family and friends of the victim).

19. Daniel C. Maguire, supra intro. n. 8, at 6; Glanville Williams, supra ch. 1 n. 41, at 313–14; Karen Labacqz and H. Tristram Engelhardt Jr., M.D., “Suicide,” in “Death-Dying,” supra ch. 1 n. 8, at 695.

20. Glanville Williams, supra ch. 1 n. 41, at 256. Cf. also Karen Labacqz, Ph.D., and H. Tristram Engelhardt,” supra ch. 1 n. 6, at 686. (“Murder . . . is the violation of a person’s ‘right to life.’ In suicide, there is no violation of someone’s right to life, because the act is not against the victim’s will.”)

21. James F. Childress, “Religious Viewpoints,” in “Regulating How We Die,” supra ch. 1 n. 7, at 26 (author goes through Aquinas’s “metaphors,” i.e., gifts, loans, and such); Fr. Robert Barry, O.P., supra, intro. n. 5, at 476; Beth Spring and Ed Laron, supra n. 16, at 122.


23. Paul I. Mishbin, supra intro. n. 5, at 169; Baruch A. Brody, “A Historical Introduction to Jewish Casuistry on Suicide and Euthanasia,” in “Historical and


28. Paul I. Mishbin, supra intro. n. 5, at 173; “The Conditions of Our Stewardship,” in “Clinical Practice,” Book One, “Euthanasia and Clinical Practice: Trends, Principles, and Alternatives (Working Party Report, 1982),” supra ch. 1 n. 3, at 53; Peter Asili, supra ch. 1 n. 33, at 65. But see Glanville Williams, supra ch. 1 n. 41, at 250 (author considers a conundrum: How can you return your soul if it is destroyed at death? Yet, if it’s not destroyed, God gets it back).


30. Daniel C. Maguire, supra intro. n. 8, at 61, 142.


Issue 3


7. Id.


9. Derek Humphrey, Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying xv (published by Hemlock Society; distributed by Carol Pub. 1991); Katy Redfield Jamison, supra intro. n. 6, at 24; John Wesley Smith, supra intro. n. 6, at xvi.

10. Kay Redfield Jamison, supra intro. n. 6, at 24.


13. David Lester, “Suicide among the Elderly in the World: Covariation with Psychological and Socio-economic Factors,” in Suicide and Euthanasia in Older Adults: A Trans-cultural Journey 7, 12 (Daniel DeLeo, ed., Horgrefe and Huber 2001) [hereinafter “Older Adults”].


15. Harvey Max Chochinov, M.D., and Keith G. Wilson, Ph.D., “The Euthanasia Debate: Attitudes, Practices, and Psychiatric Considerations,” 40 Can. J. Psych. 593, 598–99 (25 percent of cancer patients show depressive symptoms, with 6 to 10 percent exhibiting “major” depression, which is significant because of
the correlation between depression and the desire for death); Linda Ganzini and Melinda A. Lee, “Psychiatry and Assisted Suicide in the United States,” 36 New Engl. J. Med. 1824, 1825 (1997) (80 percent of cancer patients who killed themselves had “depressive syndrome”); Harvey M. Chochinov, M.D., Ph.D., and Leonard Schwartz, LL.B, LL.M, M.D., “Depression and the Will to Live in the Psychological Landscape of Terminally Ill Patients,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 261, 264; Robert G. Twycross, “Where There Is Hope, There Is Life: A View from Hospice,” in “Euthanasia Examined,” supra intro. n. 2, at 145; Leslie Pickering Frances, “Assisted Suicide: Are Elderly a Special Case?” in “Expanding the Debate,” supra intro. n. 8, at 82–83 (depression can affect choices); Michael Teitelman, “Not in the House: Arguments for a Policy of Excluding Physician-Assisted Suicide from the Practice of Hospital Medicine,” in “Expanding the Debate,” supra intro. n. 8, at 208–9 (it is difficult to evaluate depression in the terminally ill). Cf. also Kay Redfield Jamison, supra intro. n. 6, at 81 (the overwhelming majority of suicides are linked to psychological illness [the book focuses on those under 40]).

However, “interest” in suicide and the “desire for hastened death” were better correlated with hopelessness than depression. Zeehan A. Butt, James C. Overholser, and Carla Kmett-Danielson, “Predictors of Attitudes towards Physician-Assisted Suicide,” 47 Omega 107, 114 (2003); Malcolm Parker, supra intro. note 14, at 524; Barry Rosenfeld, supra intro. n. 12, at 86.


18. Harry M. Chochinov, M.D., Ph.D., and Leonard Schwartz, LL.B, LL.M, M.D., “Depression and the Will to Live in the Psychological Landscape of Terminally Ill Patients,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 268 (the correlation between suicidal ideation and hopelessness was greater than that between suicidal ideation and depression). But see N. Gregory Hamilton, M.D., and Catherine A. Hamilton, M.A., “Competing Paradigms of Response to Assisted Suicide Requests in Oregon,” 162 Am. J. Psych. 1060, 1060 (2005) (“Although physical illness may be a precipitation cause of despair, these patients usually suffer from treatable depression and are always ambivalent about their desire for death”).


supra ch. 1 n. 4, at 73; Wesley J. Smith, supra intro. n. 10, at 166; “Canada,” ch. 1 n. 34, at 46; Gerald A. Larue, supra ch. 2 n. 10, at 16; Kathy Doyle and Alex Carroll, “The Slippery Slope,” 146 New Law J. 759 (May 1996) (story of a patient who recovered after being diagnosed as PVS).


24. Peter G. Filenes, supra intro. n. 1, at 39 (would it have been worth it to keep Karen Ann Quinlan alive if the chances for her recovery were “one in a million”?).


30. Margaret Somerville, supra ch. 1 n. 10, at 262; Jos M.V. Welie, In the Face
of Suffering: The Philosophical-Anthropological Foundations of Clinical Ethics 163 (Creighton Univ. Press 1998); Liezl van Zyl, supra intro. n. 18, at 181 (the paradigm 1850s American masculine view was that you must be tough in the face of pain and indifferent to suffering).


33. John Keown, supra ch. 1 n. 4, at 276; Helga Kuhse, supra n. 25, at 166. Cf. also the concern that the “right to die” may become perceived as a “duty to die” on the part of the patient. Liezl van Zyl, supra intro. n. 18, at 43; David J. Mayo and Martin Gunderson, “Physician Assisted Suicide and Hard Choices,” in “Legal Euthanasia: Ethical Issues in an Era of Legalized Dying,” 18 J. Med. & Phil. 329, 335 (1993) (Margaret P. Battin and Thomas J. Bole III, issue eds.).


Issue 4

1. See Amicus Brief of Surviving Family Members in Support of Oregon’s Death with Dignity Act, filed in Oregon v. Ashcroft (No. CV01–1647–JO); Liezl van Zyl, supra intro. n. 18, at 57; Timothy E. Quill, M.D., Death and Dignity: Making Choices and Taking Charge (Norton 1994); Phil Such, “Why I’m Starving Myself to Death,” Daily Mail (Feb. 21, 2002). Cf also Derek Humphrey (with Ann Wickets), Jean’s Way (Hemlock Society 1978); and Juliet Cassuto Rothman, Saying Goodbye to Daniel: When Death Is the Best Choice (Continuum 1995) (withdrawal of life support).

2. Liezl van Zyl, supra intro. n. 18, at 47.

6. Debra M. Bryan, “It’s My Body and I’ll Die if I Want to: A Plan for Keeping Personal Autonomy from Spinning out of Control,” 8 J. Med. & Law 45, 53 (2004); Mary A. Fisher, “To Live or to Die,” Reader’s Digest 107, 112 (May 2003). See also “Assisted Suicide and Euthanasia, Part I,” Testimony to Senate Judiciary Committee on Civil Rights, Constitutional and Property Rights, Congressional Testimony of Wesley J. Smith, Senior Fellow, Discovery Institute, at 6 (May 26, 2006, congressional testimony) (Smith “extrapolates” from the Dutch experience that if PAS were legalized in the United States there would be 170,000 instances of it each year, with 85,000 being involuntary).
7. Daniel C. Maguire, supra intro. n. 8, at 140–41.
9. Gerald Dworkin, R.G. Frey, and Sissela Bok, supra ch. 3 n. 25, at 45.
11. Wesley J. Smith, supra intro. n. 10, at 75 (350,000 people).
12. Wesley J. Smith, supra intro. n. 10, at Id. 78–79 (this eventually resulted in 275,000 deaths). See also Leo Alexander, M.D., “Medical Science under Dictatorship,” in “Death-Dying,” supra ch. 1 n. 3, at 574.
15. Id., at 7; Leo Alexander, M.D., “Medical Science under Dictatorship,” in “Death-Dying,” supra ch. 1 n. 3, at 571.
17. Wesley J. Smith, supra intro. n. 10, at 78.
18. Id., at 79.
19. Daniel C. Maguire, supra intro. n. 8, at 133; Robert I. Mishbin, supra intro. n. 5, at 18–19.
20. Karl Binding and Alfred Hoche, M.D., “Permitting Destruction of Life Not Worth of Life: Its Extent and Form” (Liepzig 1920), reprinted in 8 Law & Med. 23 (1992); Ian Dowbiggin, A Concise History of Euthanasia 77–80 (Rowman and Littlefield 2005) (author places Binding and Hoche in their historical con-
text); David C. Thomasama, supra n. 13, at 191; Wesley J. Smith, supra intro. n. 10, at 73.


22. Robert I. Mishbin, supra intro. n. 5, at 49.

23. Derek Humphrey and Mary Clement, supra intro. n. 4, at 21; Robert I. Mishbin, supra intro. n. 5, at 33. See also *The Reference Shelf: Suicide* 129 (Robert Emmett Long, ed., H.W. Wilson 1995) (doctors are revolted by death and leave it to nurses). In fact, it has only been since the beginning of the twentieth century that doctors could really heal. See Peter G. Filenes, supra intro. n. 1, at 20.


25. John Keown, supra ch. 1 n. 4, at 165.

26. Daniel Callahan, supra intro. n. 1, at 58, 72.


29. Annette E. Clark, supra intro. n. 15, at 88.


34. Robert I. Mishbin, supra intro. n. 5, at 33–34; David C. Thomasama, supra n. 13, at 193. But see Robert T. Hall, supra intro. n. 15, at 16 (patients are more likely to trust a doctor if they know that the doctor will stay to the end, help them die); “Euthanasia Wouldn’t Kill Patients’ Trust, Survey Says,” *Akron Beacon Journal* (Ohio) (Dec. 6, 2005) (in a survey by Wake Forest University researchers interviewees were asked if they agreed or disagreed with the statement “If doctors were allowed to help patients die, you would trust your doctor less.” Fifty-eight percent of the adults questioned disagreed with the statement.). The outcome of a patient survey may be different, however, in the managed care/HMO environment, where a patient may wonder whether a doctor’s suggestion of PAS is motivated by concern for the patient or for his or her employer’s bottom line. See Steve

35. Gary P. Stewart, ed., Basic Questions on Suicide and Euthanasia: Are They Ever Right? Bio Basics Series 61 (Kregel 1998) (patients indicated that they would lose trust if a doctor brought up PAS). But see Margaret P. Battin, “Is a Physician Ever Obligated to Help a Patient Die?” in “Regulating How We Die,” supra ch. 1 n. 7, at 40 (patients who believe that doctors will help them die tend to hold on to the end); and Paul Van Der Maas and Linda L. Emanuel, “Factual Findings,” in “Regulating How We Die,” supra ch. 1 n. 7, at 168 (most patients would not lose trust if they knew their doctor was involved in PAS or euthanasia).

36. “The possibility that persons may get comfort from having the medication (and never using it) should not be minimized. . . . In fact, this may be one of the most important findings from the Oregon experience and is consistent with the data showing that control is one of the key factors in why people want to use the Act.” Howard Weinberg and James L. Werth Jr., “Physician-Assisted Suicide in Oregon: What Are the Key Factors?” 27 Death Studies 501, 512–13 (2002). Cf. Linda Ganzini and Steven K. Dobscha, supra ch. 3 n. 29, at 120 (only one out of 100 patients who consider PAS die after ingesting a lethal prescription); Noelle Knox, “An Agonizing Debate over Euthanasia,” USA Today (Nov. 23, 2005) (“In Europe, Physicians and others have found that many people ask about euthanasia or assisted suicide but don’t pursue the option. The reason may be more effective pain medications and peace of mind that comes from knowing euthanasia is an option.”).

38. Yale Kamisar, supra ch. 1 n. 42, at 114.

41. David Orentlicher, supra ch. 1 n. 47, at 453–54.

42. “Introduction,” in “Expanding the Debate,” supra intro. n. 8, at 4; Margaret P. Battin, “Is a Physician Ever Obligated to Help a Patient Die?” in “Regulating How We Die,” supra ch. 1 n. 7, at 24; Paul Van Der Maas, “Factual Findings,” in “Regulating How We Die,” supra ch. 1 n. 7, at 157 (10 percent of cancer patients are in “untreatable pain”); Derek Humphrey and Mary Clement, supra intro. n. 4, at 57 (10 percent of cancer patients in untreatable pain). But see Ira R. Byock, “Physician-Assisted Suicide Is Not an Acceptable Practice for Physicians,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 115 (author cites authorities that some pain cannot be controlled but disagrees with these authorities, though recognizes that in the current reality pain is not controlled).


44. Forty-two percent of U.S. hospitals offer a formal pain management program, and 23 percent offer formal hospice programs. Debra M. Bryan, “It’s My Body and I’ll Die if I Want to: A Plan for Keeping Personal Autonomy from Spinning out of Control,” 8 J. Law & Med. 45, 62; Margaret P. Battin, “Safe, Legal, Rare? Physician-Assisted Suicide and Cultural Change in the Future,” in “Older Adults,” supra. ch. 3, n. 13 “. . . about 50% of dying hospitalized patients were reported to have experienced moderate to severe pain at least 50% of the time in their last three days of life”); id., at 203, 204 n. 1. Most studies have failed to find a significant relationship between pain and requests for PAS. See Barry Rosenfeld, supra intro. n. 12, at 96, 98. However, this may be misleading:

Although a superficial reading of this literature might lead one to conclude that pain is not a significant predictor of interest in assisted suicide (because the two were significantly associated in only one of five published studies), several alternative explanations also exist. First, as noted earlier in this volume (chap. 4), there is ample reason to believe that pain would be more relevant as a predictor of interest in assisted suicide in some medically ill populations than in others. Pain may be a less salient factor in patients with HIV/AIDS, MS, or ALS, compared to patients with cancer. Thus, the failure to observe a relationship between pain and interest in assisted suicide might reflect the populations studied, not the importance of pain as a trigger. Only one of the studies described above focused squarely on cancer-related pain (M. Sullivan et al., 1997), although most of the patients studied by E.J. Emanuel et al. (2000) also had a primary diagnosis of cancer. Thus, in both studies of cancer patients, some relationship between pain (either expectancies or severity) has been noted, and the strongest relationship by far was observed in Emanuel et al.’s much larger, and far more methodologically sound study. (Id., at 98–99)

46. Derek Humphrey and Mary Clement, supra intro. n. 4, at 63; Liezl van Zyl, supra intro. n. 18, at 33; Annette E. Clark, supra intro. n. 15, at 105. But see lawsuits in civil cases for not relieving pain. Liezl van Zyl, supra intro. n. 18, at 184; Anne Helm, “Voluntary Euthanasia: An International Perspective,” 17 Law/Technology 300, 302 (1984).

47. Derek Humphrey and Mary Clement, supra intro. n. 4, at 63 (fear of prosecution); Kathleen Foley, M.D., “Compassionate Care, Not Assisted Suicide,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 304 (fear of a Drug Enforcement Administration investigation and license revocation). See, also Professor Sandra Johnson, Saint Louis School of Law, “End of Life Decisions,” speech delivered at the Seattle University School of Law, Seattle, Washington (Oct. 7, 2002).


49. Derek Humphrey and Mary Clement, supra intro. n. 3, at 63–65; Anne Helm, supra n. 46, at 302.

50. Derek Humphrey and Mary Clement, supra intro. n. 4, at 65.


(Margaret P. Battin and Thomas J. Boyle III, issue eds.); Kathleen Foley and Herbert Hendin, “Conclusion: Changing the Culture,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 311.


55. Noelle Knox, supra note 36 (“Kimsa, the family doctor in the Netherlands who has helped people end their lives, said he found the experience ‘shattering’”); Steven K. Dobscha, M.D., Ronald T. Heinz, M.D., Nancy Press, Ph.D., and Linda Ganzini, M.D., M.P.H., “Oregon Physicians’ Responses to Requests for Assisted Suicide: A Qualitative Study,” 7 J. Palliative Med. 451, 453–54 (2004) (“Requests for assisted suicide carried both apprehension and discomfort”). Yet, “[d]espite discomfort at many levels, physicians reported that going through the assisted suicide decision making process had a positive impact on them personally, and on their ability to speak with patients about the end of life” (id., at 459).


57. Mary Clement and Derek Humphrey, supra n. 36, “High Cost of Dying,” supra intro. n. 3, at 38; Margaret Somerville, supra ch. 1 n. 10, at 233.


59. Noelle Knox, supra. n. 36 (“As members of the baby boom generation age, their increasing frailty will strain health care and welfare systems, not to mention their families”).

60. Beth Spring and Ed Laron, Euthanasia: Spiritual, Medical, and Legal Lessons in Terminal Health Care 23 (Multnomah 1988). We spend three and a half times more on their health care than the remainder of the population. See The Reference Shelf: Suicide 95 (Robert Emmet Long, ed., H.W. Wilson 1995).


62. “Thus, when one couples America’s aging population with the fact that Medicare enrollment in managed care organizations is rapidly rising, a conflict is brewing that will directly determine the amount of (and whether) care will be given to chronically ill, elderly patients in the future. This problem is particularly acute given that 40 percent of total Medicare expenditures come in the last few months of life, making it fertile area in which HMO’s will try desperately to slash
costs, perhaps even encouraging P.A.S. to inappropriate candidates.” Steve P. Calandrillo, supra n. 34, at 74 [nn. omitted]).

63. Wesley J. Smith, supra intro. n. 8, at 141, 147–48; John Keown, supra ch. 1 n. 4, at 275–76; Paul Starr, supra n. 56, at 447–48 (doctors are losing their “professional autonomy” and becoming tied to “profit centers”). Cf. id., at 448 (77 percent of nursing homes are proprietary). But see those contending that, in fact, the cost savings from PAS for hospitals and nursing homes would be far less than people believe. “Notes,” in “Regulating How We Die,” supra ch. 1 n. 7, at 266, note 9; Paul Starr, supra n. 56, at 171 (less aggressive life sustaining would only save 3.3 percent of the health care budget); Felicia Cohn and Joanne Lynn, “Vulnerable People: Practical Rejoinders to Claims in Favor of Assisted Suicide,” in The Case against Assisted Suicide, supra intro. n. 18, at 240; Merrill Matthews Jr., “Would Physician-Assisted Suicide Save the Healthcare System Money? (or, is Jack Kevorkian doing us all a favor),” in Expanding the Debate, supra intro. n. 8, at 320–21.

64. Steve P. Calandrillo, supra n. 34, at 44 (“HMOs know all too well that elderly and terminally ill patients run up huge medical bills in their last months of life [40 percent of Medicare expenditures are made in the last year of life], and it is not unimaginable that PAS—in the absence of regulation—will be introduced as one very haunting method to control those costs”); id., at 73–74, 75 (“Put simply, managed care organizations have a direct financial incentive to limit care and control costs because every dollar patients pay into the plan that is not spent on care [or on administrative costs] remains in the plan’s coffers”). See also Steve Zanskas and Wendy Coduti, supra intro. n 5, at 31–32 (authors discuss PAS and the economics of managed care). One gets little solace from the revelation that an organization that supports Kaiser Permanente and lobbies for “groups practicing in the managed care model” have strongly advocated to the California legislature in support of passing an assisted suicide bill. See “Flashback 2002; Kaiser Shops for Doctors Willing to Prescribe Assisted Suicide Drugs in Oregon,” Obesity, Fitness and Wellness Week (April 14, 2007).

65. See Herbert Hendin, supra n. 24, at 19; Dr. Timothy E. Quill, M.D., supra ch. 4 n. 1, at 122–24; David Rieff, “Illness as More than Metaphor,” New York Times, supra ch. 1, n. 32 (“. . . the doctor’s power to influence those [terminal] patients, one way or the other, is virtually complete.”); Steve P. Calandrillo, supra n. 34, at 83 (“There is abundant empirical evidence indicating that physicians exert a great deal of control over the ‘independent’ choices of their patients merely by presenting them with information and suggestions”).


67. See supra intro. n. 28. See also Yale Kamisar, supra ch. 1 n. 42, at 125.


70. Julia Belian, supra n. 69, at 259.

71. Wesley J. Smith, supra intro. n. 10, at 95; John Keown, “Some Reflections on Euthanasia in the Netherlands,” in “Clinical Practice,” supra ch. 1 n. 3, at 211 (author questions leaving legal decision to the standards of practice of the medical profession); Julia Belian, supra n. 69, at 262.

72. Wesley J. Smith, supra intro. n. 10, at 95.


76. Julia Belian, supra n. 69, at 265–69.

77. Wesley J. Smith, supra intro. n. 10, at 96.

78. Julia Belian, supra n. 69, at 255.

79. Id.

80. See Raphael Cohen-Almager, supra n. 69, at 58.


82. Bert Gordijn, “Pragmatic Tolerance,” supra n. 81, at 229.

83. Id., at 232 (concept arose in the sixteenth century); Herbert Hendin, M.D., *Seduced by Death: Doctors, Patients, and Assisted Suicide* 163 (Norton 1998) [hereinafter “Seduced by Death”].


87. Carlos F. Gomez, M.D., supra n. 73, at 122; John Keown, supra ch. 1 n. 4, at 132.

89. See David C. Thomasama et al., “Asking to Die,” supra n. 88, at 275, 290. Cf. also id., at 317 (author discusses those working in a hospital that does not approve of VAE); John Keown, supra ch. 1 n. 4, at 132. Cf. Jurgen Woretschafer and Matthias Borgers, “The Dutch Procedure for Mercy Killing and Assisted Suicide by Physicians in a National and International Perspective,” 2 Maastricht J. European and Compar. Law 4, 17 (1995) (authors discuss the international law analogue to our Fifth Amendment, nemo tenetur).

90. Julia Belian, supra n. 69, at 278–79 (e.g., five-month suspended sentence and such).

91. John Keown, supra ch. 1 n. 4, at 133.

92. Id., at 85.

93. Id., at 85–86; Bert Gordijn, “New Developments,” supra n. 74, at 302, 303.

94. Carlos F. Gomez, M.D., supra n. 73, at 117 (2 percent, 2 to 4 percent, 6 percent).

95. Id., at 130.

96. John Keown, supra ch. 1 n. 4, at 144.


98. Id., at 303.

99. Id., at 305.

100. Carlos F. Gomez, M.D., supra n. 73, at 96.

101. Id., at 130; Herbert Hendin, M.D., “Seduced by Death,” supra n. 83, at 136; John Keown, supra ch. 1 n. 4, at 83; Wesley J. Smith, supra intro. n. 10, at 83.

102. John Keown, supra ch. 1 n. 4, at 83.


104. John Keown, supra ch. 1 n. 4, at 109; Robert I. Mishbin, supra intro. n. 5, at 72–73; Julia Belian, supra n. 69, at 297 (discusses Dr. Chabot). But see Stephanie van den Berg, “Dutch Supreme Court Rules against Widening Euthanasia Guidelines,” Agence-France Presse (Dec. 4, 2003) (Dutch Supreme Court upheld the conviction of a doctor who euthanized a healthy 86-year-old
patient solely because patient was “sick of living”); Raphael Cohen-Almager,
supra n. 69, at 167.

105. John Keown, supra ch. 1 n. 4, at 85, 88–89.

106. Id.

Johanna H. Groenewould et al., “Physician Assisted Death in Psychiatric Practice
requests for AVE, but “very few” are granted).

108. John Keown, supra ch. 1 n. 4, at 91, 125.

Assisted Suicide,” supra intro. n. 18, at 103; Wesley J. Smith, supra intro. n. 10, at
101.

110. Herbert Hendin, “The Dutch Experience,” in “The Case against Assisted
Suicide,” supra intro. n. 18, at 103. When physicians report VAE, 99 percent of
the doctors reporting say that they have engaged in consultation; among those not
reporting, only 18 percent consult with another doctor. John Keown, supra ch. 1
n. 4, at 132. Moreover, when death is the result of nonvoluntary active euthanasia
(NVAE), 97 percent do not consult with another doctor. Herbert Hendin, “The
Dutch Experience,” in “The Case against Assisted Suicide,” supra intro. n. 18, at
103; John Keown, supra ch. 1 n. 4, at 132.

111. Herbert Hendin, “The Dutch Experience,” in “The Case against Assisted
Suicide,” supra intro. n. 18, at 111.

112. John Keown, supra ch. 1 n. 4, at 87.

for Consultation of Another Physician in Cases of Euthanasia and Assisted Su-

114. See Raphael Cohen-Almager, supra n. 69, at 170.

115. Herbert Hendin “The Dutch Experience,” in “The Case against Assisted
Suicide,” supra intro. n. 18, at 102: Rein J.P.A. Janssen, Henk A.M.J. Tenhave,
and Zbigniew Zylicz, “Hospice and Euthanasia in the Netherlands: An Ethical
in the Netherlands was “in its infancy”).

Suicide,” supra intro. n. 18, at 121 (“. . . the Dutch experience suggests that engag-
ing physicians in palliative care is much harder when the easier option of euthana-
sia is available. . .”).

Palliative Care: New Developments in the Netherlands,” 41 Patient Educ. &
Counseling 35, 38 (2000); Bert Gordijn and Adraan Visser, “Issues in Dutch Pal-
liative Care: Redefining a Distorted Image,” 41 Patient Educ. & Counseling 3
(2000).

119. Herbert Hendin, “The Dutch Experience,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 120–21. Cf., for example, E.P. Tross, “Too Big for Their Wooden Shoes,” 27 Human Life Rev. 53 (2002) (formerly pro-euthanasia physicians said in an interview that if they had been familiar with palliative care they would not have killed some of the patients they euthanized).

120. Herbert Hendin, “The Dutch Experience,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 120–21. Still, the critics do not believe the care is good at this point of time. See id., at 123, 143; and John Keown, supra ch. 1 n. 4, at 112, 141.

121. Robert I. Mishbin, supra intro. n. 5, at 62; John Keown, supra ch. 1 n. 5, at 112 (the commission characterized this large-scale NVAE as “care for the dying”).

122. Robert I. Mishbin, supra intro. n. 5, at 62. Yet it is common for the seriously ill to ask for VAE one day and wish to live the next. Herbert Hendin, M.D., “Seduced by Death,” supra n. 83, at 34–36, 159. See also Margaret Sommerville, supra ch. 1 n. 10, at 123 (even if patients say they want to die, that does not mean they are asking to be killed).

123. Robert I. Mishbin, supra intro. n. 5, at 62.


125. John Keown, supra ch. 1 n. 4, at 105.


128. Id. (87 percent); Robert I. Mishbin, supra intro. n. 5, at 62 (70 percent).

129. Robert I. Mishbin, supra intro. n. 5, at 62; John Keown, supra ch. 1 n. 4, at 105.

130. John Keown, supra ch. 1 n. 4, at 105.

131. Id., at 126. See, generally, Liezl van Zyl, supra intro. n. 18, at 60 (the practice of NVAE may be more widespread than believed since the society as a whole is valued over the individual).

132. John Keown, supra ch. 1 n. 4, at 96.

133. Id., at 96, 97–98, 106. A total of 6,250 were given drugs with the partial intent of causing death, 5,000 without a specific patient request. Id., at 96, 97–98.

134. Id., at 126.

135. David C. Thomasama, supra ch. 4, n. 13, at 185. Note that in the United States, in cases in which life-sustaining treatment was withdrawn, 35 percent was without the patient’s consent. Annette E. Clarke, supra intro. n. 15, at 119.

136. Helga Kubse, “Killing a Poor Philosophical Argument against Euthanasia,” Aust. Finan. Rev. 16 (Mar. 28, 1995). See also Peter Singer, supra ch. 1 n. 7, at 153; and David C. Thomasama et al., “Asking to Die,” supra n. 88, at 58 (no evidence that NVAE is on the rise). But see John Keown, “Euthanasia in the Netherlands: Sliding down the Slippery Slope?” in “Euthanasia Examined,” supra intro. n. 2, at 287 (even without pre-1990 data, the Dutch experience supports the slippery slope argument). In fact, according to a more recent article, the number of...

137. “Nearly two years after the Netherlands became the first country to legalize euthanasia and doctor-assisted suicide, an estimated 2,000–3,000 lives end that way there each year. . . . There is some dispute about the number of mercy killings performed in the Netherlands, but both sides agree there has been no surge in reported cases since the law took effect in April 2002.” Keith B. Richburg, supra n. 88.

138. John Keown, supra ch. 1 n. 4, at 79 (author discusses the expansion of the concept of “unbearable suffering”).

139. See Raphael Cohen-Almager, supra n. 69, at xii, 103 et seq.


141. Robert I. Mishbin, supra intro. n. 5, at 102.


143. Liezl van Zyl, supra intro. n. 18, at 107.

144. Wesley J. Smith, supra intro. n. 10, at 93; Peter Singer, supra ch. 1 n. 7, at 158; Robert I. Mishbin, supra intro. n. 5, at 99; David C. Thomasama et al., “Asking to Die,” supra n. 88, at 319, 503.


147. Carlos F. Gomez, M.D., supra n. 73, at 21.

148. Herbert Hendin, M.D., “Why the Netherlands? Why the United States,” in “Seduced by Death,” supra ch. 4 n. 83, at 163, 171 (“The common [Dutch] attitude was that the doctor may have been mistaken, but that he was entitled to his judgment on the matter. . . . [This is] consistent with . . . the Dutch lack of moral passion and unwillingness to assign individual responsibility.”).

149. John Keown, supra ch. 1 n. 4, at 167.
150. Id.; Wesley J. Smith, supra intro. n. 10, at 117.
151. Lee v. Oregon, 107 F.3d. 1382 (9 Cir., 1997); Annette E. Clark, supra intro. n. 15, at 61; Wesley J. Smith, supra intro. n. 10, at 126.
152. Derek Humphrey and Mary Clement, supra intro. n. 4, at 274.
153. Id., at 294. With this perspective, the attempt of U.S. Attorney General Ashcroft to undermine the act by taking away the ability of Oregon doctors to use any federally controlled drug to conduct euthanasia is ironic. See Nelson Lund, “Why Ashcroft Is Wrong on Assisted Suicide,” 113 Commentary 50 (2002).
154. John Keown, supra ch. 1 n. 4, at 176, 172, 179.
155. Id., at 176 (for 1998), 177 (for 1999), 179 (for 2000).
157. The number of suicides was 46 in 2006 (Steve Geissinger, “To the North, Euthanasia Up,” Oakland Tribune, local section [March 9, 2007]), 42 in 2003, 30 in 2002, 21 in 2001, 27 in 2000, 27 in 1999, and 16 in 1998. “Assisted-Suicide Numbers Increase,” Statesman Journal (Mar. 10, 2004). Interestingly, while it is estimated that nationally 1 in 250 deaths is really disguised PAS, in Oregon all evidence indicates that the death by PAS rate is far lower—1 in 1,000. Linda Ganzini and Steven K. Dobscha, supra ch. 3 n. 29, at 121. In fact, “a very small percentage of terminally ill Oregonians seem determined to request lethal medication.” Howard Wineberg and James L. Weith Jr., “Physician-Assisted Suicide in Oregon: What Are the Key Factors?” 27 Death Studies 501, 501 (2003). This is consistent with national data indicating that “Only a small minority of terminally ill people seek to hasten their own deaths.” “Few Ponder Euthanasia, Study Says,” Globe and Mail (Toronto) (Nov. 15, 2000), A-19. See also Robyn Leigh and Brian Kelly, “Family Factors in the Wish to Hasten Death and Euthanasia,” in “Older Adults,” supra n. ch. 3 n 13, at 185; (“[T]he overwhelming majority of terminally ill patients fight for life to the end and only 2–4 percent of suicides occur in the setting of terminal illness”).
158. John Keown, supra ch. 1 n. 4, at 177.
159. There were 69 in 1998 and 71 in 2000. Id., at 176–77.
165. Barry Rosenfeld, supra intro. n. 12, at 159 ("... a referral for more adequate palliative care was the most common physician response to requests for lethal medications ... "). Cf. Howard Weinberg and James L. Werth Jr., supra ch. 4 n. 36, at 511 ("Oregonians do not appear to be taking medications to end their lives because of lack of end-of-life care, given that 80% of those using PAS were enrolled in hospice with the other 20% declining hospice"); Pamela J. Miller, "Life after Death with Dignity: The Oregon Experience," 45 Social Work 263, 268 (2000) ("Oregon has the lowest in-hospital mortality rate in the country, admission rates into hospice have increased 20 percent, and the use of medical morphine has increased 70 percent. Oregon has developed comfort care teams that specifically address pain management.").


168. John Keown, supra ch. 1 n. 4, at 176, 178, 179. Cf. Bert Gordijn, “New Developments,” supra ch. 4 n. 74, at 40 (for those seeking euthanasia in the Netherlands, pain is not the most important reason).


171. John Keown, supra ch. 1 n. 4, at 171.

172. Id., at 172; Kathleen Foley and Herbert Hendin, “The Oregon Experiment,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 145; id., at 166 (anonymous study found that 43 percent of those requesting PAS were in pain).


174. Id., at 172, 175.

175. Kathleen Foley and Herbert Hendin, “The Oregon Experiment,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 150.

176. John Keown, supra ch. 1 n. 4, at 172, 175.


178. Tony D. Pasquale and John P. Gluck, supra intro. n. 16, at 504.

179. John Keown, supra ch. 1 n. 4, at 175. See also Kathleen Foley and Herbert Hendin, “The Oregon Experiment,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 151 (60 percent were depressed).

180. “The Case against Assisted Suicide,” supra intro. n. 18, at 145, 172. In 2005, only two of 38 patients who ended their lives through PAS had a “psychiatric referral.” “Physicians for Compassionate Care Analyzes Oregon’s Assisted

181. Kathleen Foley and Herbert Hendin, “The Oregon Experiment,” in The Case against Assisted Suicide,” supra intro. n. 8, at 166.

182. John Keown, supra ch. 1 n. 4, at 177.

183. Id., at 179.

184. Steven White, “Euthanasia Jurisprudence and Physician-Assisted Suicide: What Did Glucksberg Teach Us?” 75 J. Ala. Acad. Sci. 214, 222, (2004) (“No law can be ‘abuse proofed.’ But no abuses of the Oregon law have been reported since its activation in 1997.”); Linda Ganzini and Steven K. Dobscha, supra ch. 3 n. 29, at 121 (“Whatever the reason, these data do not support a slippery slope of increasing death-hastening acts—within or outside the law”); Barry Rosenfeld, supra intro. n. 12, at 154 (“Hence, most commentators have continued to suggest that [the Oregon act] has been utilized in an appropriate and thoughtful manner, without evidence of either abuse or misuse, and that fears of a growing reliance on assisted suicide over time have simply not been realized this far [n. omitted]”); B. Steinbeck, “The Case for Physician Assisted Suicide: Not (Yet) Proven,” 31 J. Med. Ethics 235 (2005) (“. . . fears that legalizing PAS [by means of the Oregon law] might lead to overuse do not seem to have been realized”). Nonetheless, anti-PAS constituencies point to two cases in which they claim the standards of the act were clearly violated. B. Steinbeck, supra, at 42–43; N. Gregory Hamilton, M.D., and Catherine A. Hamilton, M.A., supra ch. 3 n. 18, at 1061–62. However, in each of these cases, “there are two ways to see the story” (B. Steinbeck, supra, at 39), one of which supports the pro-PAS position that the safeguards of the act are working as envisioned. Id., at 39–40.

In fact, in criticizing the Dutch guidelines as inadequate, the author of an extensive study of the Dutch practice repeatedly cited to various sections of the Oregon guidelines as examples of appropriate guidelines, contrasting the Oregon regime with that of the Dutch. Raphael Cohen-Almager, supra ch. 4 n. 69, at 181, 182, 184, 185.

185. Michael Manning, M.D., supra intro. n. 6, at 47.


the House of Lords on Medical Ethics by the Linacre Centre for Health Care Ethics,” in “Clinical Practice,” supra ch. 1 n. 3, at 142 (food and hydration are not considered medical treatment).

188. Margaret Somerville, supra ch. 1 n. 10, at 47 (the nature of marker events is that those on one side of the line are different from those on the other side, particularly with regard to avoiding precedent).

189. Marvin Harris, Cows, Pigs, Witches, and Wars 107, 196, 206–7 (Vintage 1975); Pennethorne Hughes, Witches (Penguin 1965) (author attributes the general elimination of witchcraft practice in Europe to purges by the church and state and also as the result of economics, culminating in the Industrial Revolution, during which peasants, who practiced the “old ways,” were brought in contact with the new ideas of the urban population).

190. Pennethorne Hughes, supra n. 189, at 172–73.

191. Marvin Harris, supra n. 189, at 207 (500,000 killed); Pennethorne Hughes, supra n. 189, at 195 (nine million killed).

192. Pennethorne Hughes, supra n. 189, at 213–15. Cf. also Marvin Harris, supra n. 189, at 243 (author details the resurgence of the occult in modern American life).

193. Pennethorne Hughes, supra n. 189, at 164. Cf. also Exodus 7:8, in Tanakh: A New Translation of the Holy Scriptures according to the Traditional Hebrew Text (Jewish Publ. Society 1985) (Moses has a competition with the pharaoh’s court magicians).

194. Pennethorne Hughes, supra n. 189, at 164.


196. Pennethorne Hughes, supra n. 189, at 197.

197. Id., at 184.

198. Id., at 190.

199. Id., at 184.

200. Marvin Harris, supra n. 189, at 238.

201. Id.

202. Pennethorne Hughes, supra n. 189, at 202–5; Marvin Harris, supra n. 189, at 213.

203. Pennethorne Hughes, supra n. 189, at 202.

204. Id., at 198.

205. Id., at 206–7.


207. Daniel Callahan and Margot White, supra ch. 4 n. 169, at 61.

208. Id., at 58–59.

209. See, generally, Daniel Callahan, “Self-Extinction: The Morality of the Helping Hand,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 82 (“There is no way, even in principle, to write or enforce a meaningful law that can guar-
antee effective procedural safeguards [for PAS]). See also Gerald Dworkin, R.G.
Frey, and Sissela Bok, supra ch. 3 n. 25, at 46–47.

210. See, for example, Michael M. Burgess, “The Medicalization of Dying,”
in “Legal Euthanasia: Ethical Issues in an Era of Legalized Dying,” 18 J. Med. &
Phil. 269, 274 (Margaret P. Battin and Thomas J. Bole III, issue eds.) (1993).

211. See Steve P. Calandrillo, supra ch. 4 n. 34, at 91 (describes “a Model Act
to Authorize and Regulate Physician-Assisted Suicide”). See also Charles H.
Baron et al., “A Model State Act to Authorize and Regulate Physician-Assisted

212. “If the law is too bureaucratic, too intrusive, or gives insufficient legal shel-
ter to doctors acting in good faith, it will be ignored in practice and will fail in its
objective of re-regulating PAS/AE. The challenge for those interested in minimizing
harm is to design a regime that is robust, but which is also more attractive than the
stresses and risks of illicit action. Locating this middle ground is all the more con-
troversial because of the feared consequences of ‘unsafe’ law.” R.S. Magnusson,

213. See, generally, Daniel Callahan and Margot White, supra ch. 4 n. 169.

Issue 5

1. Derek Humphrey and Mary Clement, supra intro. n. 4; Sue Woodman,
Last Rights: The Struggle over the Right to Die (Perseus 1998). See also Wesley J.
Smith, supra intro. n. 10, at 6; Margaret Somerville, supra ch. 1 n. 10, at 312;
Bernadette-Tobin, “Did You Think about Buying Her a Cat? Reflections on the
Concept of Autonomy,” 11 J. Contemp. Health Law & Pol’y 417 (1991); and Steve
P. Calandrillo, supra ch. 4 n. 34, at 65 (“. . . autonomy has thus become something
of a trump card in the debates of recent years . . .”). Cf. Brian Clark, Whose Life Is
It Anyway? (Bard 1978).

2. The first argument ties autonomy to sanctity of life. “Submission to the
Select Committee of the House of Lords on Medical Ethics by the Linacre Cen-
tre for Health Care Ethics,” in “Clinical Practice,” Book Two, “Euthanasia and
the Law: The Case against Legalization,” supra ch. 1 n. 3, at 132. This argument
posits that the principle of sanctity of life is what makes the notion of autonomy
coherent. Why should we respect your individual choices? Why do we give you
equal value regardless of whether you’re rich or poor, brilliant or stupid? The
answer, as already discussed, is the commitment of our society to the right and
principle of equal justice. The right and principle, in turn, ultimately are based on
the notion that all lives have equal value because they are equally sacred. As such,
autonomy cannot be relied on to justify a denial of life’s absolute sanctity through
taking that life through suicide since our very respect for autonomy is dependent
on accepting the sacredness of life.

I do not find this argument persuasive. The commitment to equal justice does
not necessarily require reliance on notions such as sacredness. While admittedly having a moral flavor, equal justice can equally be based on a political philosophy, which reflects the conception of the individual in a modern, liberal society (exemplified by the Western democracies). It is a concept that gives high value to the individual creation of ideas and identity and serves as a form of insurance against the risk that any of us could have had an unlucky draw at birth in the social lottery (e.g., in the distribution of brains, wealth, status, health, and support). But it is just one vision of a society. Some societies do not focus on the individual but on the broader unit, and in that effort they have even discouraged individuality (e.g., in Maoist China or ancient Sparta). Even in America, the land of the rugged individual, movements appear from time to time that ask us to think not as individuals but as a community.

Moreover, the argument does not follow on its own terms. In the context of considering autonomy, it is true that the concept is underlain by the notion that my life has as much value as anyone else’s and that my right to choose for myself merits the same respect as another’s right to choose. All that said, it still is not clear to me why I can’t make the choice to end my life. Someone making that choice for me against my desires based on their assessment of my comparative value would assuredly violate the principle of equal justice. But that is not what we are talking about here, at least not on a theoretical level (admittedly, on a pragmatic plane, there are concerns about coercion by family members and doctors, which I considered when addressing the slippery slope).

The second argument posits that autonomy cannot logically coexist with self-destruction. See Luke Gormally, “Walton, Davies, Boyd, and the Legalization of Euthanasia,” in “Euthanasia Examined,” supra intro. n. 2, at 118–19; “Submission to the Select Committee of the House of Lords on Medical Ethics by the Linacre Centre for Health Care Ethics,” in “Clinical Practice,” Book Two, “Euthanasia and the Law: The Case against Legalization,” supra ch. 1 n. 3, at 131 (autonomy is meant to be used so that we might “flourish”); and Michael J. Hyde, supra ch. 4 n. 33, at 165. The purpose of autonomy is to fulfill oneself as a person, to give an individual the full ability to exercise his or her capacity for growth and self-definition. Self-destruction, thus, is antithetical to the very enterprise underlain by autonomy.

I agree with this argument as a descriptive matter. Generally, we do use our autonomy to make choices based on what we believe (sometimes mistakenly) will be a greater fulfillment of our potential as a human being. But it does not follow that self-death is never an appropriate choice under any circumstances. Someone in the circumstances of my father is beyond the niceties of elevating his being as a full person. He was dying, every function in his body was breaking down, and he was miserable. Under the circumstances, suicide may have been an appropriate choice as a means of protecting the self from further torture while that self existed in any coherent sense and in fulfilling the final destiny of that self in its earthly journey. Thus, I do not find this position convincing.

4. Ronald Dworkin, supra ch. 1 n. 3, at 16.

5. Peter G. Filene, supra intro. n. 1, at 173–74; Anthony Fisher, “Theological Aspects of Euthanasia,” in “Euthanasia Examined,” supra intro. n. 2, at 319 (extreme autonomy is antisocial); Wesley J. Smith, supra intro. n. 10, at 6; Robert I. Mishbin, supra intro. n. 5, at 174–75; Liezl van Zyl, supra intro. n. 18, at 125; Margaret Somerville, supra ch. 1 n. 10, at 343; Ira R. Block, “Physician-Assisted Suicide Is Not an Acceptable Practice for Physicians,” in “Physician-Assisted Suicide,” supra ch. 1 n. 2, at 112–13. See also Patricia S. Mann, “Meanings of Death,” in “Expanding the Debate,” supra intro. n. 8, at 19. Cf. Liezl van Zyl, supra intro. n. 8, at iv (death can provide the opportunity for social connection).


9. Steve P. Calandrillo, supra ch. 4 n. 34, at 65 (“Contrary to Dworkin, Professor Rebecca Dresser believes that most of us do not have the strong sense of critical interest, autonomy, and continuity of the person necessary to adopt
Dworkin’s thesis. . . . She asserts that there is no evidence to support the claim that people want narrative coherence, . . .”).

**Issue 6**


3. Id.


5. Daniel Callahan and Margot White, supra ch. 4 n. 169, at 43; Joel Feinberg, supra ch. 4 n. 8, at 29. Cf. David C. Thomasama, supra ch. 4 n. 13, at 289 (author questions the possibility of a “rational” suicide).

6. Mark Sullivan, Linda Ganzini, and Stuart J. Young, “Should Psychiatrists Serve as Gatekeepers for Physician Assisted Suicide?” 28 *Hastings Center Report* 24, 25 (1998) (the modern medical model is that suicide is never the choice of a rational agent but a symptom of mental illness); Malcolm Parker, supra intro. n. 14, at 526 (“Australian researchers claiming a new psychiatric diagnosis, Demoralization Syndrome (DS), rule out the possibility of a rational suicide, finding the desire to die being symptomatic of the detectable pathology, n. omitted”). See also D. Clarke and D. Kissare, “Demoralization: Its Phenomenology and Importance,” 36 *Aust N.Z. Psychiatry* 733 (2002); and Timothy H. Lillie and James L. Werth Jr., “Introduction to Special Issues: End-of-life Issues and Persons with Disabilities,” 16 *J. Disability Pol’y Studies* 2, 2 (2005) (“Let me be clear here: I do not agree with the concept of rational suicide, especially as applied to people with disabilities, primarily because of social and cultural concerns”). But see Kyriaki Mystakidou, Efi Parpa, Elini Tsikila, Emmanuela Katsouda, and Lambors Vlahos, “The Evolution of Euthanasia and Its Perceptions in Greek Culture and Civilization,” 48 *Perspectives Bio. & Med.* 95 (2005) (“Though suicide is generally viewed to be a pathological state of mind, most often linked to depression, some professionals hypothesize that suicide in some circumstances can be quite rational”); Malcolm Parker, supra intro. n. 14, at 527 (author sees the fact that those refusing to accept that someone can rationally choose PAS but do not make the same claim about the rationality of those who refuse life-sustaining treatment “suggest that a particular moral view about assisted dying is helping to demonstrate the clinical disorder [undermining the capacity for rational suicide]”); James G. Adams, “Life or Death: Physician-Assisted Suicide and Emergency Medicine,” 3 *Academic Emergency Med.* 909, 909 (1996) (61 percent of primary care physicians believe that suicide can be rational); and Derek Humphrey and Mary Clement, supra intro. n. 4, at 80 (suicide can be a totally rational response to a particular situation).


9. Barry Rosenfeld, supra intro. n. 12, at 122–23. But see N. Gregory Hamilton, M.D., and Catherine A. Hamilton, M.A., supra ch. 3 n. 18, at 1061 (“. . . the majority of forensic Psychiatrists . . . believe that the presence of a major depressive disorder should result in an automatic finding of incompetence to make decisions about assisted suicide”).

10. Elaine Scarry, supra ch. 1 n. 9, at 29, 35; Liezl van Zyl, supra intro. n. 18, at 72.


13. Joel Feinberg, supra ch. 4 n. 8, at 29.


Issue 7

1. Paul J. Zwier, supra intro. n. 15, at 228.

2. Basic Questions on Suicide and Euthanasia: Are They Ever Right? Bio Basics Series 26 (Kregel 1998); Gerald Dworkin, R.G. Frey, and Sissela Bok, supra ch. 3 n. 25; Margaret P. Battin, “Is a Physician Ever Obligated to Help a Patient Die?” in “Regulating How We Die,” supra ch. 1 n. 7, at 23; Daniel Callahan, “Self-Extinction: The Morality of the Helping Hand,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 83 (“The two standard motives for euthanasia and assisted-suicide are said to be our right of self-determination and our claim upon mercy of others, especially doctors to relieve our suffering. These two motives are typically spliced together as a single justification.”).


5. Robert Finn, Cancer Clinical Trials: Experimental Treatments and How They Can Help You 41–42 (O’Reilly 1999); Derek Humphrey and Mary Clement, supra intro. n. 4, at 40–41; Robert I. Mishbin, supra intro. n. 5, at 108; Liezl van Zyl, supra intro. n. 18, at 35; William F. May, “Ethical Considerations in Life and Death Decisions,” in Life and Death Issues 56 (James E. Hammer III, D.D.S., Ph.D., and Barbara Sax Jacobs, eds., Univ. of Tenn. 1986); Annette E. Clark, supra intro. n. 15, at 117.


8. Carl E. Schneider, supra n. 6, at 51, 94.

9. Id., at 49, 51.


11. Carl E. Schneider, supra n. 6, at 41.

12. Id., at xiv.

13. Id., at 49.


15. Liezl van Zyl, supra intro. n. 18, at 165; David C. Thomasama, supra ch. 4 n. 13, at 193; Annette E. Clark, supra intro. n. 15, at 115–16.


17. See J.P. Bishop, “Framing Euthanasia,” J. Med. Ethics 225, 227 (2006) (author uses experience with DNR codes to demonstrate how doctors can totally influence their patients’ choices by the specific word choices they use in presenting options). See also Daniel Callahan and Margot White, supra ch. 4 n. 169, at 28 (can’t really assess the adequacy of a particular patient’s consent for PAS.
because the patient will be dead); and Raphael Cohen-Almadar, supra, ch. 4 n. 69, at 97–98 (in fact, by raising the topic of euthanasia as a just “medical” option, doctors can influence their patients’ decisions).


19. Gerald Dworkin, R.G. Frey, and Sissela Bok, supra ch. 3 n. 25.

20. Beth Spring and Ed Laron, supra ch. 2 n. 16, at 131. As a deontological counterargument to the idea that patient autonomy mixed with mercy can justify PAS, some have pointed out that relieving suffering necessarily implies the existence of a formerly suffering person who is now relieved. If you kill someone, you may end them and their suffering with it, but no one will exist who will be relieved. It is an interesting argument (in the genre of if a tree falls in the forest and there is no one to hear it), but ultimately I believe it begs the real question. Is there a time when stopping suffering is more important than life itself so that assisted suicide is morally justified?


For example, one author interprets the situation in the Netherlands as one in which physicians can abrogate one of the two foundational principles of the Dutch law—patient consent (i.e. autonomy) and unbearable suffering (i.e., mercy)—and still be found sympathetic in carrying out euthanasia if the remaining principle (i.e., autonomy or mercy) is sufficiently compelling in the individual case. See Raphael Cohen-Almager, supra ch. 4 n. 69, at 169.

**Issue 8**

1. Yale Kamisar, supra ch. 1 n. 42, at 133–34. See also Larry I. Palmer, *Endings and Beginnings: Law, Medicine, and Society in Assisted Life and Death* (Praeger 2000) (contending that PAS is an issue for the legislature, too complex for the courts, as it is a product of institutional arrangements among law, medicine, and such).
2. Kay Redfield Jamison, supra intro. n. 6, at 15.
3. Id.
4. Id.
5. Id.
6. Id.
7. Beth Spring and Ed Laron, supra ch. 2 n. 16, at 64; Steven Miles, Demetra M. Pappas, and Robert Koepp, “Considerations of Safeguards Proposed in Laws and Guidelines to Legalize Assisted Suicide,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 270; Glanville Williams, supra ch. 1 n. 41, at 257; Lawrence Gostin, supra ch. 1 n. 4, at 95.
8. Beth Spring and Ed Laron, supra ch. 2 n. 16, at 64; Steven Miles, Demetra M. Pappas, and Robert Koepp, “Considerations of Safeguards Proposed in Laws and Guidelines to Legalize Assisted Suicide,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 210; Glanville Williams, supra ch. 1 n. 41, at 261.
9. U.S. Const. Art I, § 9(3); Stacy L. Mojica and Dan S. Murrel, supra intro. n. 5, at 482.
10. Steven Miles, Demetra M. Pappas, and Robert Koepp, “Considerations of Safeguards Proposed in Laws and Guidelines to Legalize Assisted Suicide,” in “Physician-Assisted Suicide,” supra intro. n. 11, at 210; Glanville Williams, supra ch. 1 n. 41, at 262; Stacy L. Mojica and Dan S. Murrel, supra intro. n. 5, at 95.
13. Sanford H. Kadish, supra ch. 1 n. 13, at 863.
15. See Joshua Dressler, Understanding Criminal Law 13, § 2.03 [D] (2d ed., Matthew Bender 1995) (“Why is denunciation desirable [as a purpose of criminal punishment]? First, it’s educative. We inform individuals that the community considers specific conduct improper.”).
16. Liezl van Zyl, supra intro. n. 18, at 75. See also Cruzan v. Missouri Department of Health, 497 U.S. 261, 335 (1990); Sue Rodriguez v. Attorney General Canada and Attorney General British Columbia, 3 Can. Sup. Ct. Reps. 603 (Part 4, 1993). But see Washington v. Glucksberg, 521 U.S. 702, 752 (Stevens, concurring) (implies that government cannot interfere with constitutional rights solely for educative or symbolic value: “‘... unqualified interest in the preservation of human life’... is not sufficient to outweigh the interest in liberty that may justify the only possible means of preserving a dying person’s dignity and alleviate her intolerable suffering”).

18. A theoretical argument has also been put forth that suicide and assisted suicide are matters protected by the First Amendment. Ronald Dworkin has written that the current debate over assisted suicide reflects a difference in beliefs over the meaning of what constitutes the “sacredness/sanctity of life.” As this debate, over which the country is divided fundamentally, takes the form of opposing religious values, this essentially involves First Amendment freedom of religion guarantees. Under these circumstances, the Constitution forbids the state the right to intrude. See Ronald Dworkin, supra ch. 1 n. 3, at 157, 164–65. See also David McKenzie, “Church, State, and Physician-Assisted Suicide,” 46 J. Church & State 787, 809 (2004). While it is intriguing, there appear to be two fundamental problems with this contention. First, there are those who oppose PAS on totally non-religious grounds. See Yale Kamisar, “Some Non-religious Views against Proposed ‘Mercy Killing’ Legislation,” in “Death-Dying,” supra ch. 1 n. 3, at 411; Yale Kamisar, supra ch. 1 n. 42, at 118; and Phillip Berry, “Euthanasia: A Dialogue,” 26 J. Med. Ethics 370 (2000) (author posits dialogue between a patient who desires euthanasia and an atheist physician who refuses to supply it). Second, the court has distinguished religious “belief” (which is constitutionally protected as an absolute) with religious “activity” (which can be regulated). See, for example, Employment Division v. Smith, 494 U.S. 872 (1990) (court permits application of drug laws to Native American peyote ceremony); and Reynolds v. United States, 98 U.S. (8 Otto) 145 (1878) (even though polygamy is part of the Mormon religious tradition, it may be prohibited under the general law prohibiting polygamy).


22. Alan Ides and Christopher N. May, supra n. 21, at 205–9 (“narrowly tailored to meet a compelling need”).
25. M.T. Meulders-Klein, supra ch. 1 n. 3, at 44. See also Frances M. Kamm,


27. M.T. Meulders-Klein, supra ch. 1 n. 3, at 38 (one cannot consent to a battery and thereby waive one’s right not to be harmfully touched unless battery is part of a violent sport such as boxing or football); Witmore v. Arkansas, 495 U.S. 149, 175 n. 1 (1990) (Marshall, J., dissenting) (the justice cites to 13 states prohibiting a waiver by the defendant of a direct appeal in death penalty convictions); Daniel Callahan, supra intro. n. 1, at 105 (one can’t waive the right not to be sold into slavery).


30. Margaret Somerville, supra ch. 1 n. 10, at 31; Daniel Callahan, supra intro. n. 1, at 36–37, 150 (one can’t control everything in life and some richness can be achieved by not doing so).


33. Alan Donagan, supra ch. 1 n. 39, at 237.

34. Daniel Callahan, supra intro. n. 1, at 147; Paul Ramsey, “The Indignity of Death with Dignity,” in “Death-Dying,” supra ch. 1 n. 3, at 307; Margaret
Somerville, supra ch. 1 n. 10, at 257 (this notion of dignity should be thought of as “social dignity”).

35. Daniel Callahan, supra intro. n. 1, at 12 et seq.; Margaret Somerville, supra ch. 1 n. 10, at 258–59.


What is important is this: how one “frames” the “liberty right” determines whether support for it can be found in the history and traditions of the nation. If one frames it narrowly and in negatively charged emotive language, little support will be found. If framed broadly, much support will often be found.


43. Id.


46. *Vacco v. Quill*, 521 U.S. 793 (1997). The Supreme Court found that the state law barring assisted suicide is “evenhanded” (id., at 799–800) and meets the “minimum rationality” standard (id., at 801) (distinguishing between PAS and withdrawing treatment is “clearly rational”).

47. *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 445–46 (1985) (“[I]t would be difficult to find a principled way to distinguish a variety of other groups who have perhaps immutable disabilities setting them off from others,
who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large. One need mention in this respect only the aging, the disabled, the mentally ill, and the infirm. We are reluctant to set out on that course, and we decline to do so.”). See also Alan Ides and Christopher N. May, supra n. 21, at 246; Yale Kamisar, “The Rise and Fall of the ‘Right’ to Assisted Suicide,” in “The Case against Assisted Suicide,” supra intro. n. 18, at 86 notes 67, 68.


49. Frontiero v. Richardson, 411 U.S. 677, 688 (1973); Michael M. v. Superior Court, 450 U.S. 464, 468–69 (1981) (the standard of review requires that the law reflects no gender “stereotypes,” that it serve an “important” governmental objective, and that the objectives be “genuine”).


53. Liezl van Zyl, supra intro. n. 18, at 91–133; Yale Kamisar, supra ch. 4 n. 170, at 495.

Issue 9


4. John Rawls, supra n. 1, at 146–52; Alan Donagan, supra ch. 1 n. 39, at 22.

5. The concept of maximum ignorance in probability theory is attributed by some to the French scientist Pierre-Simon Laplace (1749–1827). Under this con-
cept, if one is attempting to calculate the probability of a certain event (about which little or nothing is known a priori about the relative possibilities of the outcomes) and there have been no prior trials testing whether or not the event will occur, the probability at this point of maximum ignorance is fifty-fifty. See “Pierre-Simon Laplace” at en.wikipedia.org. In other sources, the concept of maximum ignorance is attributed to Rev. Thomas Bayes. See “Stephen D. Unwin” at en.wikipedia.org. This is not surprising since “[Bayes’s] friend, Richard Price, edited and presented the work in 1763, after Bayes’s death, . . . [and] Pierre-Simon Laplace replicated and extended these results in an essay of 1774, apparently unaware of Bayes’s work.” See “Bayes’ Theorem” at en.wikipedia.org.

6. Ronald Dworkin, supra ch. 1 n. 3, at 47.


9. B. Steinbock, supra ch. 4 n. 36, at 253 (the author takes the consequentialist position balancing the current “need” for PAS with the currently perceived “risks”). Cf. Steve P. Calandrillo, supra ch. 4 n. 34, at 100 (“The crucial point to take away from the valuable anti-PAS research is not that the practice should be banned outright, but that it must be carefully scrutinized and regulated”).

10. Annette E. Clark, supra intro. n. 15, at 109; Yale Kamisar, supra ch. 1 n. 42, at 119.

11. Gerald Dworkin, R.G. Frey, and Sissela Bok, supra ch. 3 n. 25, at 65; Lynn Tracy Nerland, supra intro. n. 5, at 129–31 (the Japanese give doctors a defense for mercy killing); N.D.A. Kemp, supra intro. n. 10, at 219 (the author discusses the “good faith assistance” defense, which was presented to Parliament in 1985 and defeated by a margin of 48 to 15).


13. See Guido Calabresi and Phillip Bobbitt, supra ch. 1 n. 2.