

The Dangers of Assisted Suicide

No Longer Theoretical

By Mary E. Harned
Staff Counsel, Americans United for Life

Euthanasia advocates in the United States argue that they support “aid in dying” rather than suicide. However, “aid in dying”—which Kathryn L. Tucker, the Director of Legal Affairs for Compassion & Choices defines as “the practice of a physician prescribing medication that a mentally competent, terminally-ill patient can ingest to bring about a peaceful death if the dying process becomes unbearable”¹ —is simply physician-assisted suicide by a misleading name. The terms “aid in dying,” “death with dignity,” and “patient-directed dying” are merely euphemisms for the practice. In fact, these terms are not recognized by the medical community and are simply used by suicide advocates to mask what they advocate.

Nonetheless, proponents continue to cloak physician-assisted suicide in these compassionate-sounding terms as they promote it in state legislatures across the country. Today, two states—Oregon and Washington—statutorily authorize physician-assisted suicide by the name of “death with dignity.” Further, at least six other states have considered legalizing physician-assisted suicide in recent years.

Euthanasia advocates turn to the courts to achieve what they cannot accomplish democratically through legislatures. While the United States Supreme Court held in 1997 that there is no federal constitutional right to assisted suicide under the Due Process or Equal Protec-

tion Clauses of the Fourteenth Amendment,² courts have considered whether a “right” to assisted suicide exists under state constitutions. In December 2008, a Montana trial court created such a right in the Montana Constitution.³ Upon review, the Montana Supreme Court did not reach the issue of whether there is a “right” to physician-assisted suicide; however, the court ruled that existing state laws and policies did not preclude it. Physicians who assist in suicides can raise a “consent” defense if later prosecuted.⁴

Recently, however, states have rejected the efforts of euthanasia advocates. In 2011, the people of Idaho responded to pressure from advocates to “find” legal recognition of physician-assisted suicide within their law by enacting a *new* law prohibiting it. In 2010, a Connecticut court held in *Blick v. Connecticut* that the state’s manslaughter statute “does not include any exception from prosecution for physicians who assist another individual to commit suicide.” Further, the court held that “the legislature intended the statute to apply to physicians who assist a suicide, and intended the term ‘suicide’ to include self-killing by those who are suffering from unbearable terminal illness.” Therefore, prosecutors were within their authority to prosecute physicians for providing “aid in dying.” In a discussion of *Blick*, a publication of the American Medical Association (AMA) characterized the plaintiff’s argument that “aid in dying”⁵ was not prohibited



as “assisted suicide” as a “novel approach.”⁶ Further, in Montana efforts to codify the state supreme court’s aforementioned opinion have thus far failed.

Unquestionably, euthanasia advocates have had some success in embedding their distorted view of end of life issues in the minds of the American people. The so-called “right to die” is now a phrase of common household knowledge, as are the euphemisms for physician-assisted suicide. While most states explicitly or implicitly prohibit assisted suicide, educational and legislative efforts must continue in order to prevent the acceptance and legalization of suicide—by any name—as appropriate “medical treatment” and a legitimate “choice.”

ISSUES

While euthanasia advocates market physician-assisted suicide as an

option for “mentally competent, terminally ill patients” facing unbearable suffering, implementation of the practice looks quite different. Rather than “empowering” individuals facing terminal illness to make their own decisions, the mere availability of physician-assisted suicide can pressure sick, depressed, elderly, or disabled patients to end their lives.

In fact, in court filings, euthanasia advocates define the phrase “terminally ill” so broadly that virtually all persons could claim some sort of need for or “right” to physician-assisted suicide. In the Montana case *Baxter v. State*, suicide advocates, led by Compassion & Choices, defined “terminally ill adult patient” as a per-

son 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time.⁷

This definition is not at all limited to “terminal illnesses” or any specific set of illnesses, conditions, or diseases. Therefore, it could be used in any number of “incurable” or “irreversible” medical situations, including diabetes or asthma. For example, an 18-year-old college student with controlled diabetes, but who relies on medical treatments in order to maintain such

control over the disease, falls under this definition of a “terminally ill adult.” Furthermore, there is no specific timeline for suspected death under this definition.

As discussed below, the dangers inherent in the

legalization of physician-assisted suicide range from untreated depression to elder abuse to the slippery slope of outright euthanasia. In order to avert these dangers and affirm that the lives of all Americans are valuable, states must reject efforts to extend the legalization of physician-assisted suicide to more states.

The Dangers of Assisted Suicide

Depression

Most if not all terminally ill patients who express a wish to die meet diagnostic criteria for major depression or other mental conditions.⁸ Depression is frequently underdiagnosed and

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undertreated, especially in elderly individuals and patients with chronic or terminal medical conditions.⁹ In one study, treatment for depression resulted in the cessation of suicidal ideation for 90 percent of the patients.¹⁰

Despite these statistics, “safeguards” in Washington and Oregon, where physician-assisted suicide is legal, are failing to protect patients, as there are no requirements that patients receive psychological evaluation or treatment prior to receiving lethal drugs. In 2010, only 1 out of 65 patients in Oregon who died as a result of physician-assisted suicide was referred for psychiatric or psychological counseling.¹¹ In Washington, the Department of Health received a psychiatric/psychological consulting form for only 3 of 87 patients. No information is available regarding whether they were treated for any mental complications.¹²

Further, most patients who request physician-assisted suicide do not have longstanding relationships with the physicians who provide the lethal drugs. In Oregon, some physicians prescribe lethal drugs for patients whom they have known as little as one week or less.¹³ In Washington in 2010, half of the patients had a “relationship” with their physician of only 3 to 24 weeks.¹⁴ This lack of a long-term relationship between doctor and patient precludes a doctor from truly understanding a patient’s psychological condition, and encourages physician shopping.

Pain

Euthanasia advocates wrongfully claim that assisted suicide is “needed” for those terminally ill patients who face, or fear, great pain. But most experts in pain management believe that 95 to 98 percent of such pain can be relieved.¹⁵ In most cases, patients who request assisted suicide on the basis of pain will withdraw the request after pain management, depression, and other concerns are addressed.¹⁶

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Very few of these individuals ultimately choose suicide.¹⁷ Given that our healthcare system often fails to diagnose and treat depression or provide adequate palliative care, the legalization of physician-assisted suicide is profoundly dangerous for individuals who are ill and vulnerable or “whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group.”¹⁸

Critically, the availability of assisted suicide may lead to a decrease in or failure to increase the availability of pain management and palliative care. In fact, proper palliative care is languishing in Oregon. In 2004, Oregon nurses reported that the inadequacy of meeting patients’ needs had increased “up to 50 percent” and that “[m]ost of the small hospitals



in the state do not have pain consultation teams at all.”¹⁹

Further, the American Medical Association (AMA) does not support physician-assisted suicide, even for individuals facing the end of life. The AMA states that

“allowing physicians to participate in assisted suicide would cause more harm than good. Physician-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.” The AMA advocates that multidisciplinary interventions be sought, including specialty consultation, hospice care, pastoral support, family counseling, emotional support, comfort care, and pain control.²⁰

Coercion

Many patients who request physician-assisted suicide are coerced or pressured by family members. Some patients believe they will be a “burden” on their families. There have been documented accounts of individuals committing suicide under pressure and/or duress from family members, friends, and/or suicide advocates present at the ingestion of lethal drugs.²¹ In 2010, over one-fourth (1/4) of patients who died after ingesting a lethal dose of medicine in Oregon and Washington did so because, at least in part, they did not want to be a “burden” on family members, raising the concern that patients were pushed into suicide.²²



The Death with Dignity Act in Oregon provides an example of how this coercion is embedded in the state law. While the Act requires two witnesses at the time of request for physician-assisted suicide, one of those witnesses can be a relative who stands to inherit

from the patient, and the second witness can simply be a friend of the relative. The witness requirement, therefore, does not adequately protect against coercion.²³

Terminally ill patients also face a form of coercion from health insurance companies and other healthcare payers who provide coverage for suicide assistance, but not for treatment of disease or palliative care. This poses a significant threat to vulnerable persons who may not have adequate access to medical care. A lack of options may effectively pressure patients into assisted suicide.

For example, in 2008, patient Barbara Wagner was denied coverage under her Oregon state health plan for medication that would treat her cancer and extend her life; instead, the state health plan offered to pay for the cost-effective option of ending her life by physician-assisted suicide.²⁴

Elderly Americans

Physician-assisted suicide can be the ultimate manifestation of elder abuse. The National Center on Elder Abuse estimates that one to two million Americans aged 65 or older “have been injured, exploited, or otherwise mistreat-



ed by someone on whom they depended for care or protection.²⁵ Too often, the physicians and family members to whom a terminally-ill patient looks to for support and protection are the same ones counseling that suicide may be the best option for the patient. Facing deteriorating health and increasing age, the elderly are at a greater risk of suicide than any other age group.²⁶

Physician-assisted suicide greatly increases the risk of elder abuse and suicide among the elderly by creating yet another path of abuse against older individuals—abuse which is often subtle and extremely difficult to detect. In fact, legalized physician-assisted suicide may hide abuse of elderly and disabled Americans by providing complete liability protection for doctors and promoting secrecy.

For example, in Oregon physicians providing physician-assisted suicide are self-reporting, death certificates are required to report a “natural” death (as opposed to a suicide), and there are no requirements that witnesses be present at the time of death. Further, Oregon collects information about the time and circumstances of patients’ deaths only when the physician or another healthcare provider is present at the time of death. Yet in 2010, physicians were present in only 25 of the deaths²⁷ —meaning that information on over 60 percent of the patients’ deaths is unknown. This creates unacceptable gaps in Oregon’s data. Further, a publication of the AMA has reported that the Oregon Department of Human Services “has no regulatory authority or resources to ensure compliance with the law.”²⁸

The Disabled and Other Vulnerable Americans

Additionally, none of the reasons frequently cited by patients requesting physician-assisted suicide—a fear of a perceived (not necessarily actual) loss of autonomy, loss of dignity, and decreasing ability to participate in activities that make life enjoyable²⁹ —are unique to terminally ill patients. For example, a person left paralyzed after an accident or illness could also use these reasons to claim a “need,” or a “right,” to physician-assisted suicide.

Therefore, it will be difficult, if not impossible, to limit physician-assisted suicide to “competent, terminally ill patients.” Individuals who are not competent, who are not terminally ill (but potentially in more pain than a terminally ill patient), or who cannot self-administer lethal drugs will also seek the option of physician-assisted suicide, and no principled basis will exist to deny them this “right.” For instance, an Oregon Deputy Attorney General has opined that the Americans with Disabilities Act (ADA) would likely require the state to offer “reasonable accommodation” to “enable the disabled to avail themselves” of the Death with Dignity Act.³⁰

Assisted Suicide in Other Countries – The Slippery Slope Becomes a Reality

Physician-assisted suicide and euthanasia have been legal in the Netherlands and Belgium for years. Yet instead of strengthening autonomy at the end of life, the legalization of physician-assisted suicide and euthanasia has proven to degrade and dehumanize the lives of patients, resulting in physicians routinely performing euthanasia without the consent of their patients. As the New York State Task Force on



Life and the Law concluded, “[A]ssisted suicide and euthanasia are closely linked; as experience in the Netherlands has shown, once assisted suicide is embraced, euthanasia will seem only a neater and simpler option to doctors and their patients.”³¹

A report commissioned by the Dutch government demonstrated that more than half of euthanasia and assisted-suicide-related deaths were involuntary in the year studied.³² At least half of Dutch physicians actively suggest euthanasia to their patients.³³ Studies in 1997 and 2005 revealed that eight (8) percent of infants who died in the Netherlands were euthanized by doctors.³⁴



The slippery slope is also manifest in Belgium. A recent study published in the *Canadian Medical Association Journal*³⁵ showed that out of 1,265 nurses questioned, 120 of them (almost 10 percent) reported that their last patient was involuntarily euthanized. Only four (4) percent of nurses involved in *involuntary* euthanasia reported that the patient had ever expressed his or her wishes about euthanasia. Most of the patients euthanized without consent were over 80 years old, reaffirming the fact that assisted suicide and euthanasia quickly lead to elder abuse. The researchers acknowledged that nurses are likely reluctant to report illegal acts (here, euthanizing a patient without physician involvement)—thus, it is possible that the number of nurses killing their patients without physician involvement is much higher than revealed by

the study. The researchers concluded that “[i]t seems the current law . . . and a control system do not prevent nurses from administering life-ending drugs.” In other words, the “safeguards” purported by suicide advocates simply do not work.

Refusal or Withdrawal of Life-Sustaining Treatment is not Physician-Assisted Suicide

Despite the claims of euthanasia advocates otherwise, there is a medically- and court-recognized difference between the withdrawal of life-sustaining treatment, which allows death, and the use of lethal drugs or other means to directly cause death.

For instance, while the AMA opposes physician-assisted suicide, it finds it ethically acceptable to withdraw or withhold life-sustaining treatment at the request of a patient who possesses decision-making capacity.³⁶ The New York State Task Force on Life and the Law also distinguished between assisted suicide and the withdrawal or refusal of life-sustaining treatment, concluding that the State’s interest in protecting patients and criminalizing physician-assisted suicide outweighed any claims of individual autonomy.³⁷ In contrast, the Task Force found that the “constitutional balancing of individual and state interests yields an entirely different result for decisions to forgo life-sustaining treatment . . . [state] interests are best served by permitting the refusal of treatment in accord with appropriate guide

lines, and [] individual decision making about treatment will ultimately promote the public good.”³⁸

Further, in *Vacco v. Quill*, the United States Supreme Court affirmed the distinction between assisting suicide and the withdrawal of life-sustaining treatment, stating it is a “distinction widely recognized and endorsed in the medical profession and in our legal traditions” and that it is important, logical, and rational.³⁹

KEY TERMS

- **Assisted suicide** is the act of suicide with the help of another party. **Physician-assisted suicide** specifically involves the help of a physician in performing the act of suicide. Such assistance usually entails the prescribing or dispensing of controlled substances in lethal quantities that hasten death.
- **Euthanasia** involves the killing of one person by or with the physical assistance of another. **Voluntary euthanasia** is the ending of one life by another at the patient’s request. **Non-voluntary euthanasia** describes “a physician’s ending the life of a patient incapable of giving or refusing consent.”⁴⁰ **Involuntary euthanasia** describes the termination of a competent patient’s life without his or her consent.⁴¹

MYTHS & FACTS

Myth: Allowing assisted suicide will not encourage the slide toward euthanasia. Safeguards can be put into place to ensure that physician-assisted suicide is only available for competent, terminally ill patients.

Fact: The tragic example of the Netherlands refutes this claim. Further, if physician-assist-

ed suicide⁴² is accepted for the terminally ill without intractable pain, then those Americans with severe chronic pain who, unlike the terminally ill, must live with such severe pain for many years to come, would also seem to have a legitimate claim to physician-assisted suicide. Thus, it is reasonable to expect physician-assisted suicide to be made available to severe chronic pain sufferers, then to non-severe chronic pain sufferers, and then to those suffering from psychological pain or distress, as in the Netherlands. Both the British House of Lords and the New York State Task Force on Life and the Law have concluded that it would not be possible to secure limits on physician-assisted suicide.⁴³ Arguably, allowing one group of patients to use physician-assisted suicide but denying it to another could be considered unconstitutional.⁴⁴

Myth: Physician-assisted suicide allows terminally ill patients a choice and preserves autonomy and dignity.

Fact: Physician-assisted suicide “will ultimately weaken the autonomy of patients at the end of life.”⁴⁵ Not only is human dignity found in more than a healthy body and autonomous lifestyle, but “the dignity of human life itself precludes policies that would allow it to be disposed of so easily.”⁴⁶ Additionally, many physician-assisted suicide patients are coerced into suicide because of familial pressures and a desire not to be a burden.⁴⁷ They often feel a need to justify their decisions to stay alive.⁴⁸ This is not the essence of choice, autonomy, or human dignity.

Myth: To say that “the so-called right to die all too easily becomes a duty to die”⁴⁹ is mere rhetoric.

Fact: It was after examining end of life issues



for almost 10 years that the non-partisan New York State Task Force on Life and the Law reached the conclusion that “the so-called right to die all too easily becomes a duty to die.” The 25-member task force, comprised of prominent physicians, nurses, lawyers, academics, and representatives of numerous religious communities, held differing views on physician-assisted suicide and euthanasia. However, the group unanimously concluded that the dangers of physician-assisted suicide vastly exceed any possible benefits.⁵⁰

Moreover, the “duty to die” is demonstrated in Oregon, where the state actively promotes assisted suicide over medical care. In just one month in 2008, at least two different terminally-ill patients were denied medical treatment under the state health insurance plan, and instead were told that the state would pay for the patients’ suicides. The message was clear: “We won’t treat you, but we will help you die.” The duty to die cannot be much clearer.

Myth: The availability of physician-assisted suicide will not inhibit the availability of palliative care.

Fact: Palliative care actually “languishes as a consequence” of the easy availability of physician-assisted suicide and euthanasia.⁵¹ Physicians are likely to grant requests for physician-assisted suicide before all avenues of palliative care have been explored.⁵² In addition, physicians are not pushed to better educate themselves on palliative care, and researchers spend less time looking for better palliative medications and techniques.⁵³

Endnotes

¹ K.L. Tucker & C. Salmi, *Aid in Dying: Law, Geography and Standard of Care in Idaho*, THE ADVOCATE, August 2010, at 42.

² *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*,

521 U.S. 793 (1997).

³ *Baxter v. State*, 2008 Mont. Dist. LEXIS 482 (First Jud. Dist. Ct. Mont. Dec. 5, 2008).

⁴ *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

⁵ *Blick v. Connecticut*, 2010 Conn. Super. LEXIS 1412, at *39-40 (Conn. Super. Ct. June 1, 2010).

⁶ K.B. O’Reilly, *Assisted-Suicide Statute Challenged by 2 Connecticut Doctors*, AMER. MED. NEWS (Oct. 19, 2009), available at <http://www.ama-assn.org/amednews/2009/10/19/prsd1019.htm> (last visited Aug. 31, 2011).

⁷ Plaintiffs’ Answers to State’s Interrogatories, *Baxter v. State* (Mont. 1st Jud. Dist. Ct. 2008) (on file with Americans United for Life).

⁸ See, e.g., New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 13 (1994) [hereinafter “Task Force”].

⁹ *Id.* at 32.

¹⁰ *Id.* at 26.

¹¹ See *Oregon Death with Dignity Act Annual Report for Year 13*, available at <http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx> (last visited Aug. 31, 2011).

¹² *Washington State Department of Health 2010 Death with Dignity Act Report*, available at <http://www.doh.wa.gov/dwda/forms/DWDA2010.pdf> (last visited Aug. 31, 2011).

¹³ *Oregon Death with Dignity Act Annual Report for Year 13*, *supra*.

¹⁴ *Washington State Department of Health 2010 Death with Dignity Act Report*, *supra*.

¹⁵ See, e.g., T.E. Quill & C.K. Cassel, *Professional Organizations’ Position Statements on Physician-Assisted Suicide: A Case for Studied Neutrality*, ANNALS OF INTERNAL MED. 138(3):208 (2003), available at <http://www.annals.org/cgi/reprint/138/3/208.pdf> (last visited Aug. 31, 2011). See also Project on Death in America/Open Society Institute, Brief of *Amicus Curiae* for Reversal of the Judgments Below at Part II.A.1, *Vacco v. Quill*, 521 U.S. 793 (1997) (stating that pain can be alleviated in 98 percent of cases); Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 166 (1996) (stating that knowledgeable physicians and researchers claim that pain can be alleviated in 98 percent of cases).

¹⁶ Task Force, *supra*, at 108 N.113.

¹⁷ *Id.* at 178

¹⁸ *Glucksberg*, 521 U.S. at 732 (quoting New York State Task Force on Life and the Law, *supra*, at 120).

¹⁹ See Brief *Amicus Curiae* of International Task Force et al., filed in *Baxter v. Montana*, available at <http://www.internationaltaskforce.org/montana.htm> (last visited Aug. 31, 2011) (citing House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Testimony of Sue Davidson of the Oregon Nurses Ass’n*, response to question 1098).

²⁰ American Medical Association, *Code of Medical Ethics, Opinion 2.211 – Physician-Assisted Suicide*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml> (last visited Aug. 31, 2011).



- ²¹ See, e.g., Herman Hendin, SEDUCED BY DEATH: DOCTORS, PATIENTS, AND ASSISTED SUICIDE 50-56, 61, 128-32, 142 (1998).
- ²² *Oregon Death with Dignity Act Annual Report for Year 13, supra*; *Washington State Department of Health 2010 Death with Dignity Act Report, supra*.
- ²³ See Oregon Health Authority: Death with Dignity Act, *Frequently Asked Questions about the Death with Dignity Act*, available at <http://public.health.oregon.gov/PROVIDERPARTNER-RESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Pages/faqs.aspx> (last visited Aug. 31, 2011).
- ²⁴ See, e.g., S. Ertelt, *Woman Victimized by Oregon Assisted Suicide Law Urges Washington to Vote No* (October 28, 2008), available at <http://www.lifenews.com/2008/10/28/bio-2608/> (last visited Aug. 31, 2011).
- ²⁵ National Center on Elder Abuse Fact Sheet, *Elder Abuse Prevalence and Incidence*, available at http://www.ncea.aoa.gov/ncearoot/Main_Site/pdf/publication/FinalStatistics050331.pdf (last visited Aug. 31, 2011).
- ²⁶ Task Force, *supra*, at 30.
- ²⁷ *Oregon Death with Dignity Act Annual Report for Year 13, supra*.
- ²⁸ L. Prager, *Details emerge on Oregon's first assisted suicides*, AMER. MED. NEWS (Sept. 7, 1998).
- ²⁹ See *Oregon Death with Dignity Act Annual Report for Year 13, supra*.
- ³⁰ See Correspondence of Deputy Attorney General David Schuman to state Senator Neil Bryant (Mar. 15, 1999).
- ³¹ Task Force, *supra*, at 145.
- ³² See W.J. Smith, FORCED EXIT: THE SLIPPERY SLOPE FROM ASSISTED SUICIDE TO LEGALIZED MURDER 118-19 (2003) (citing the Dutch government's *Rommelink Report*).
- ³³ See *id.* at 119 (citing R. Fenigsen, *Report of the Dutch Government Committee on Euthanasia*, 7 ISSUES LAW & MED. 239 (Nov. 1991); Special Report from the Netherlands, N.E.J.M. 1699-711 (1996)).
- ³⁴ See *id.* at 129-30 (citing A. van der Heide et al., *Medical End of life Decisions Made for Neonates and Infants in the Netherlands*, LANCET 350:251 (July 26, 1997)); A.M. Vrakking et al., *Medical End of life Decisions Made for Neonates and Infants in the Netherlands*, 1995-2001, LANCET 365:1329 (Apr. 9, 2005).
- ³⁵ E. Inghelbrecht et al., *The role of nurses in physician-assisted deaths in Belgium*, CAN. MED. ASS'N J. (June 15, 2010).
- ³⁶ See American Medical Association, *Opinion 2.211 – Physician-Assisted Suicide*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.shtml> (last visited Aug. 31, 2011); American Medical Association, *Opinion 2.20 – Withholding or Withdrawing Life-Sustaining Medical Treatment*, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion220.shtml> (last visited Aug. 31, 2011).
- ³⁷ Task Force, *supra*, at 73.
- ³⁸ *Id.* at 74-75.
- ³⁹ *Vacco*, 521 U.S. at 800-01, 808.
- ⁴⁰ Task Force, *supra*, at 13 (emphasis added).
- ⁴¹ *Id.* at 92.
- ⁴² See, e.g., the story of “Netty Boomsma” in Hendin, *supra*, at 76-83. Few advocates of PAS argue that the right to physician-assisted suicide should be limited to the terminally-ill. Task Force, *supra*, at 74 n.113.
- ⁴³ *Report from the Select Committee on Medical Ethics*, House of Lords Session 1993-94, § 238; Task Force, *supra*, at 145. On May 12, 2006, the House of Lords again rejected proposed laws to allow physician-assisted suicide.
- ⁴⁴ E. Chevlen, *The Limits of Prognostication*, 35 DUQ. L. REV. 337, 348 (1996) (“If autonomy is the guiding principle and the determination of pain and suffering is so subjective, then any competent person... has the right to choose euthanasia.”) Hendin, *supra*, at 122. The New York State Task Force concluded that “it will be difficult, if not impossible, to contain the option to such a limited group.... [N]o principled basis will exist to deny [other patients] this right.” New York State Task Force on Life and the Law, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 5 (Supp. 1997) [hereinafter “Task Force Supp.”]. The Task Force explains that if the right to refuse medical treatment is not limited to the terminally-ill, then physician-assisted suicide will not be limitable, either. *Id.* at 12-13.
- ⁴⁵ *Id.* at 18; see also Task Force, *supra*, at 134 (stating that while the “autonomy” of some patients may be extended, the autonomy of many others would be compromised with the legalization of physician-assisted suicide).
- ⁴⁶ Task Force, *supra*, at 138.
- ⁴⁷ See, e.g., Hendin, *supra*, at 50-56, 61, 128-32, 142.
- ⁴⁸ Task Force, *supra*, at 95.
- ⁴⁹ *Id.* at 99.
- ⁵⁰ *Id.* at ix, 120.
- ⁵¹ Hendin, *supra*, at 244.
- ⁵² Task Force Supp., *supra*, at 4.
- ⁵³ See, e.g., Hendin, *supra*, at 15.

