

THE RIGHT TO DIE IN THE UNITED STATES, CANADA, AND CHINA: LEGAL FICTIONS AND THEIR UTILITY IN A COMPARATIVE PERSPECTIVE

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The right to die continues to spark controversies around the world; a lot of debate about it in the United States and worldwide results from disparate treatment of different forms of the right to die. For example, all U.S. states permit withdrawal of life-sustaining medical treatment, while only a handful of them have legalized physician-assisted suicide, and all of them prohibit lethal injection. This article argues that the disparities in how the right to die is regulated in the United States are attributable to legal fictions about intention and causation and that those fictions have outlived their utility and should be abandoned, especially in light of the Obergefell v. Hodges decision of the Supreme Court. The paper also looks into the experience of Canada and China to see how a legal regime of the right to die without legal fictions might look. Finally, the paper proposes a framework for future development of the right to die regulations in the United States.

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INTRODUCTION

The right to die—the right to choose the time, place, and manner of one’s own premature death—continues to spark controversies in the United States and around the world. In the summer of 2016, the Supreme Court of New Mexico refused to recognize a constitutional right to a physician’s aid in dying for competent, terminal patients.¹ At approximately the same time, the Canadian legislature passed a bill legalizing medical assistance in dying through a lethal injection or a prescription of a lethal dose of medication.² A case involving *santhara*—a religious practice of fasting to death—is still pending before the Supreme Court of India.³ (In the meantime, the highest court suspended the ban on *santhara* issued by a lower court.)⁴ Other examples include the legalization of physician-assisted dying in California,⁵ the failure to legalize the same measure in the United Kingdom,⁶ the legalization of pediatric euthanasia in Belgium,⁷ and the ruling of the European Court of Human Rights on the permissibility of withdrawal of life-saving treatment from a permanently incompetent patient.⁸

As these examples demonstrate, there are medical (e.g., physician-assisted suicide) and non-medical (e.g., voluntarily refusing to eat and drink) ways to execute the right to die. In this article, I shall focus on the medical forms of the right to die. While there is no universal consensus in the literature on what the right to die implies, many authors agree that it can be executed in the following medical ways:⁹ (1) voluntary active euthanasia, in which a medical professional, following a request from her patient,¹⁰ administers a lethal drug to that patient, resulting in the patient’s death (which I shall call “Injection”); (2) voluntary passive euthanasia, in which a medical

¹ *Morris v. Brandenburg*, 376 P.3d 836, 838-39 (N.M. 2016).

² An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), S.C. 2016, c 3 (Can.).

³ *India Top Court Lifts Ban on Jains’ Santhara Death Fast*, BBC NEWS (Aug. 31, 2015), <http://www.bbc.com/news/world-asia-india-34105602> [<https://perma.cc/KKD6-B8EX>].

⁴ *Id.*

⁵ End of Life Option Act, CAL. HEALTH AND SAFETY CODE § 443.2 (2016).

⁶ James Gallagher & Philippa Roxby, *Assisted Dying Bill: MPs Reject ‘Right to Die’ Law*, BBC NEWS (Sept. 11, 2015), <http://www.bbc.com/news/health-34208624> [<https://perma.cc/2LAF-UPTD>].

⁷ Andrew M. Siegel et al., *Pediatric Euthanasia in Belgium: Disturbing Developments*, 311 JAMA 1963 (2014). *See also* Nicola Slawson et al., *Terminally Ill Child First to Be Helped to Die in Belgium*, THE GUARDIAN (Sept. 17, 2016), <https://www.theguardian.com/society/2016/sep/17/terminally-ill-child-first-helped-to-die-belgium> [<https://perma.cc/8AF3-BKWF>] (discussing the first case of pediatric euthanasia in Belgium pursuant to the legislation enacted in 2014).

⁸ *Lambert v. France*, EUR. CT. H.R.1, 4, 51 (2015).

⁹ *See, e.g.*, NEW YORK STATE TASK FORCE ON LIFE & THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994); ROBERT H. BLANK, END-OF-LIFE DECISION MAKING: A CROSS-NATIONAL STUDY 4 (Robert H. Blank & Janna C. Merrick eds., 2005); Timothy E. Quill, Bernard Lo & Dan W. Brock, *Palliative Options of Last Resort: A Comparison of Voluntarily Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia*, 278 JAMA 2099 (1997).

¹⁰ If the patient is incompetent, the patient’s representative (a guardian, a health care proxy, or a relative) can make that request on the patient’s behalf. The same is true for voluntary passive euthanasia.

professional, following a request from her patient, withdraws and then withholds life-saving treatment from that patient, also resulting in the patient's death ("Withdrawal");¹¹ (3) physician-assisted suicide, in which a doctor at her patient's request prescribes her a lethal dose of medication, which the patient then self-administers in order to end her own life ("Prescription"); and, (4) palliative care hastening death (arguably distinguishable from voluntary active euthanasia), in which a doctor administers large doses of pain control medications to her patient to reduce the patient's suffering, which may also result in the patient's death as a side-effect ("Sedation").

The earlier examples also demonstrate that different types of the right to die are treated differently, even within the same country or state. For example, all U.S. states permit Withdrawal,¹² whereas only a handful of them legalized Prescription,¹³ and all of them prohibit Injection.¹⁴ Furthermore, as some of the justices of the United States Supreme Court indicated, while there was no right to Prescription under the federal Constitution, there was a constitutionally protected right to Withdrawal and the option of Sedation was also available for patients.¹⁵ Internationally, different treatment of the right to die in different countries or states results in so-called "suicide tourism" — the situation in which a patient travels from her home country or state to a different one where certain types of the right to die are legal and where she can execute her end-of-life decision.¹⁶

This different treatment of different methods of the right to die is one of the major reasons why the current debate about the right to die keeps going. For many people it is not intuitively clear why, for example, the U.S. government prohibits Prescription while making Withdrawal legal. In this paper, I analyze the decisions of the U.S. state and federal courts on Withdrawal to trace the doctrinal origins of allowing it in the United States. I then look into how the doctrine of the right to Withdrawal was applied to Prescription, Sedation, and Injection in the United States. I also compare the regimes governing different forms of the right to die in the United States with those in Canada and China. Finally, I make several suggestions about how the regime of the right to die could

¹¹ Voluntary passive euthanasia can also be executed in the form of terminal sedation, where a doctor first sedates her patient into unconsciousness at the patient's request and then withdraws and withholds life-saving treatment from the patient.

¹² ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* 2-4, 2-5 (3rd ed. Supp. 2011).

¹³ California End of Life Option Act, Cal. Health & Safety Code D. 1, Pt. 1.85 (2016); Oregon Death with Dignity Act, Or. Rev. Stat. tit.13, c. 127.805, § 2.01 (1997); Vermont Patient Choice at End of Life Act, Vt. Stat. tit. 18, § 5283 (2013); Washington Death with Dignity Act, Wash. Rev. Code Ann. c. 70.245 (2009); *Baxter v. State*, 224 P.3d 1211 (Mont. 2009).

¹⁴ See, e.g., *Washington v. Glucksberg*, 521 U.S. 702, 732 (1997) (noting a state concern that "permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia," implying that voluntary euthanasia is prohibited); see also *People v. Kevorkian*, 639 N.W.2d 291, 305 (Mich. App. 2001) ("[W]e can find no meaningful precedent for expanding the right to privacy to include a right to commit euthanasia so that an individual can be free from intolerable and irremediable suffering. To our knowledge, no court of last resort in this country has ever recognized such a right. Even in the assisted suicide cases dealing with an asserted 'right to die,' courts have steadfastly refused to expand the right to privacy to include the right to commit or receive euthanasia.").

¹⁵ *Glucksberg*, 521 U.S. at 737-38 (O'Connor, J., concurring) ("There is no dispute that dying patients . . . can obtain palliative care, even when doing so would hasten their deaths.").

¹⁶ See, e.g., Nicole Weisensee Egan, *Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, PEOPLE.COM, (Nov. 2, 2014), <http://www.people.com/article/brittany-maynard-died-terminal-brain-cancer> [perma.cc/PUF2-SSR3] (discussing the case of Brittany Maynard who was diagnosed with a terminal brain tumor and had to travel from California to Oregon to obtain medical assistance in dying).

develop in the United States in light of its doctrinal origins and comparative perspectives on it.

The paper makes three claims. First, I show that when the state courts and the Supreme Court recognized the patient's right to Withdrawal, they did so based on the notions of quality of life, respect for individual autonomy, and compelling governmental interests — as well as the considerations of formal administrability and institutional competence. Furthermore, the courts consistently addressed the first three notions in a certain lexical order: they checked the patient's quality of life first. If it was deemed "acceptable," then the courts generally found compelling state interests that outweighed the patient's right to refuse treatment; if the quality of the patient's life was considered too low by the courts, then they were willing to recognize the patient's right to end her life-saving treatment and her life.

Second, I argue that legal fictions about causation and intention are an important doctrinal element of the patient's right to Withdrawal. Those fictions became particularly important when the courts confronted the issues of Prescription, Injection, and Sedation and applied the doctrine of Withdrawal to those issues. I claim that the costs of employing those fictions far outweigh their benefits and that the utility of those fictions is even lower after the recent Supreme Court decision in *Obergefell v. Hodges*.¹⁷ Accordingly, I suggest that courts and state legislatures reject them.

Third, I suggest several ways that right to die regulations in the United States could develop after the courts and the legislatures reject explicit or implicit legal fictions about causation and intention. I offer examples of how courts in Canada and China ignored legal fictions about causation and intention in end-of-life contexts, leading to more consistent regulations on the right to die. I argue that U.S. courts and state legislatures could follow Canada's approach.

While there is no shortage of the literature on the right to die,¹⁸ my analysis and the arguments it advances will make a novel contribution to the discussion. First, authors discussing the right to die seem preoccupied with the ideas of individual autonomy or the inviolability (sanctity) of human life,¹⁹ as if those ideas occupy the central place in the U.S. doctrine on the right to die. I demonstrate that while individual autonomy and inviolability of human life are certainly important for the debate on the right to die, the legal doctrine developed somewhat differently. As far as Withdrawal (and in some states, Prescription) is concerned, it is the idea of quality of life that precedes the ideas of individual autonomy and sanctity of life. This understanding is important in both formulating legal arguments about the right to die and in making a prognosis about how it could develop.

Second, while a number of authors focused on the problem of legal fictions in the right to die context, some of them discussed fictions related to the doctrine of substituted judgment.²⁰ While

¹⁷ 135 S. Ct. 2584 (2015).

¹⁸ For book-length treatments of the problem of the right to die and related legal and philosophical issues, see, e.g., ALAN MEISEL ET AL., *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* (3rd ed. 2004); EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES (John Keown ed., 1995); GLENYS WILLIAMS, *INTENTION AND CAUSATION IN MEDICAL NON-KILLING: THE IMPACT OF CRIMINAL LAW CONCEPTS ON EUTHANASIA AND ASSISTED SUICIDE* (2007); RONALD DWORKIN, *LIFE'S DOMINION* (1993).

¹⁹ See, e.g., John Finnis, *Euthanasia, Morality, and Law Article*, 31 *LOY. L.A. L. REV.* 1123 (1998); Ronald Dworkin et al., *Assisted Suicide: The Philosophers' Brief*, *N.Y. REV. BOOKS*, (Mar. 27, 1997), <http://www.nybooks.com/articles/1997/03/27/assisted-suicide-the-philosophers-brief/> [perma.cc/3GTV-PGG7].

²⁰ See, e.g., Louise Harmon, *Falling off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 *YALE L.J.* 1 (1990); Edward D. Robertson, Jr., *Is "Substituted Judgment" a Valid Legal Concept?*, 5 *ISSUES L. & MED.* 197 (1989).

the legal fictions of causation and intention also received some attention (and criticisms) from scholars,²¹ the utility of those fictions was not systematically examined in light of the doctrine of the right to die and the implication of rejecting those fictions. Finally, the essay also opens a new comparative dimension between the right to die in the United States, Canada, and China, and explores how the lessons from the latter two countries could be instructive for the United States.

The structure of the paper follows its main arguments. The first part gives an overview of the decisions of the state courts and the Supreme Court of the United States on Withdrawal and analyzes their doctrinal foundation. The second part compares the regime of Withdrawal with the regimes of Prescription, Injection, and Sedation, reveals the legal fictions about intention and causation used by the courts when discussing different forms of the right to die, and discusses the utility of those legal fictions. The third part provides an overview of the regimes of the right to die in Canada and China, demonstrates how those regimes are relevant to that in the United States, and suggests possible ways of developing the right to die doctrine in the United States without legal fictions about intention and causation. The conclusion provides a brief summary of my argument.

I. THE DOCTRINE OF THE RIGHT TO WITHDRAWAL IN THE UNITED STATES

This part of the essay examines the decisions reached by the state courts and the United States Supreme Court on the patient's right to die. It also examines the doctrinal elements of the right to Withdrawal formulated by the judiciary and the interaction between the doctrines.

A. Doctrinal Elements of the Right to Withdrawal

Medical technologies that could prolong patients' lives, such as the use of ventilators for artificial respiration, brought immediate and obvious benefits for patients. These technologies also posed a challenge for those who did not want their lives to be artificially extended and refused life-saving treatment, for the family members of these suffering patients, and for the judiciary, which had to deal with medical realities using existing and familiar tools of legal doctrine. In the United States, when faced with these technological and medical advances, the state judiciary proceeded with caution, buttressing their decisions in Withdrawal cases upon the right of a competent patient to control the course of her medical treatment.²² That right, in turn, found further support in the common law doctrines of self-determination, bodily integrity, and informed consent, and the constitutional law doctrine of the right to privacy.²³ The courts reasoned that the patient's right of

²¹ See, e.g., FRANKLIN G. MILLER & ROBERT D. TRUOG, *DEATH, DYING, AND ORGAN TRANSPLANTATION: RECONSTRUCTING MEDICAL ETHICS AT THE END OF LIFE* 1-25 (2012); GLENYS WILLIAMS, *INTENTION AND CAUSATION IN MEDICAL NON-KILLING: THE IMPACT OF CRIMINAL LAW CONCEPTS ON EUTHANASIA AND ASSISTED SUICIDE* (2007); Janna Satz Nugent, "Walking into the Sea" of Legal Fiction: An Examination of the European Court of Human Rights, *Pretty v. United Kingdom and the Universal Right to Die*, 13 J. TRANSNAT'L L. & POL'Y 183 (2003).

²² *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .").

²³ Not all courts were willing to proceed on the notion of privacy, however. See, e.g., *In re Storar*, 52 N.Y.2d 363, 376 (N.Y. 1981) ("[The petitioner] urges that [the right of a patient to control the course of his medical treatment] is also guaranteed by the Constitution, as an aspect of the right to privacy. Although several courts have so held, this is a disputed question. . . . [We do not] reach that question in this case because the relief granted to the petitioner . . . is adequately supported by common-law principles.") (citations omitted).

consent to certain medical treatment necessarily included the right to refuse medical treatment—even a life-saving one, the termination of which would necessarily result in the patient’s death.²⁴

The courts also acknowledged that the patient’s right to refuse medical treatment was not absolute. To the contrary, it had to be balanced against the state’s interests in protecting human life, preventing suicide, protecting the innocent third parties, and preserving the integrity of the medical profession.²⁵ When caught between two compelling claims—those of individual patients and of state governments—the courts needed to find some conceptual basis to reconcile the two. They found that basis in the theory of quality of life.²⁶

The courts’ reasoning about quality of life appears to build upon the assumption that the life of the same human being can be qualitatively different in its various stages. How do we distinguish between those stages, and accordingly, between different levels of quality of life? Two criteria emerge: an objective one and a subjective one. According to the objective criteria, the quality of life of a given patient can drop when the patient suffers from a medical condition with no prognosis of improvement (for example, quadriplegia, a terminal disease, a persistent vegetative state, or a severe mental impairment paired with an incurable disease).²⁷ I call this criterion an “objective” one since its absence or presence can be established at a given moment with an adequate degree of certainty using medical tests and other falsifiable, objective data. This objective aspect of the quality of the patient’s life should not be confused with a purportedly “objective” assessment of the value of the patient’s life to the society. In fact, several courts underscored that the concept of quality of life shall not be confused with the concept of value of life.²⁸

²⁴ See, e.g., *Bouvia v. Super. Ct. of L. A. Cty.*, 179 Cal. App. 3d 1127, 1137 (Cal. 1986) (“A patient [of adult years and in sound mind] has the right to refuse any medical treatment, even that which may save or prolong her life.”). See also *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (“The [United States Supreme Court] found the unwritten constitutional right of privacy to exist Presumably this right is broad enough to encompass a patient’s decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman’s decision to terminate pregnancy under certain conditions.”) (internal citations omitted); *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass., 370 N.E.2d 417, 424 (Mass. 1977) (“[A]rising from the same regard for human dignity and self-determination, is the unwritten constitutional right of privacy found in the penumbra of specific guaranties of the Bill of Rights. . . . As this constitutional guaranty reaches out to protect the freedom of a woman to terminate pregnancy under certain conditions . . . , so it encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances.”) (internal citations omitted).

²⁵ See, e.g., *In re Conroy*, 98 N.J. 321, 348-49 (N.J. 1985) (“Courts and commentators have commonly identified four state interests that may limit a person’s right to refuse medical treatment: preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties.”). Later on, when the courts faced the problem of Prescription, another compelling state interest surfaced in the government’s reasoning: prevention of a “slippery slope” toward euthanasia. I shall discuss that interest later when addressing the problem of Prescription.

²⁶ The idea of quality of life is by no means limited to the right to die circumstances. One prominent instance where the idea finds its application is the system of assessment of health interventions called “quality-adjusted life years” (“QALY”) used in allocation of scarce resources, such as organ transplants. See generally Franco Sassi, *Calculating QALYs, Comparing QALY and DALY Calculations*, 21 HEALTH POL’Y PLAN. 402 (2006). (“DALY” stands for “disability-adjusted life years.”).

²⁷ See, e.g., *Quinlan*, 355 A.2d at 662 (characterizing persistent vegetative state as a “biologically vegetative remnant of life”).

²⁸ *Conroy*, 98 N.J. at 367 (“We do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else’s life is not worth living simply because, to that person, the patient’s

The subjective criterion, by contrast, is about the patient's individual perception of what makes human life better or worse. There, the courts have been attentive to the patient's complaints about an unfavorable balance of pleasures and pains in their unfortunate condition, incapability of independent existence and pursuit of life plans, and the lack of dignity coming from reliance on artificial sustainment of life.²⁹

The idea of quality of life had profound consequences for the doctrine of the right to Withdrawal developed by the state courts. Specifically, the idea allowed the state judiciary to draw three important distinctions; the second one, however, was later abandoned by some of them. First, using the objective criterion of quality of life, the judiciary was able to distinguish "traditional" suicide from "natural death."³⁰ In particular, the courts noted that "natural death" resulting from Withdrawal was not suicide for the patients whose quality of life was below a certain threshold, as such patients who wanted life-sustaining treatment to be discontinued died not from the doctor's "affirmative, assertive, proximate conduct" but merely from allowing the disease, or another underlying condition, to take its "natural course."³¹

Second, the objective criterion of quality of life made it possible for the courts to distinguish between "ordinary" and "extraordinary" means of treatment, the latter referring to medical interventions that are futile and therefore unreasonably costly to a patient.³² It could be inferred from the courts' reasoning that, while a competent patient could reject extraordinary treatment without disturbing state interests in the preservation of human life and prevention of suicide, the same state interests could override the patient's refusal of ordinary treatment (that is,

'quality of life' or value to society seems negligible.")).

²⁹ See, e.g., *Quinlan*, 70 N.J. at 39 ("We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life support apparatus, even if it meant the prospect of natural death."); *Bouvia*, 179 Cal. App. 3d at 1142-43 ("In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless.").

³⁰ The state courts have probably borrowed the idea of "natural death" from the Catholic Church, which has constantly emphasized that the cause of the patient's death in the situation of Withdrawal is the natural progression of the disease and not the fact that the treatment was withdrawn. See, e.g., Robert J. McClory, *Faithful Departures: How Catholics Face the End of Life*, U.S. CATHOLIC, <http://www.uscatholic.org/church/2008/07/faithful-departures-how-catholics-face-end-life> (discussing the claim of a Catholic bishop that "[t]he cause of death [of a male patient removed from life support] was not the absence of a ventilator but the emphysema-related inability of his lungs to furnish his body with oxygen.").

³¹ *Bouvia*, 179 Cal. App. 3d at 1145. In that case, the court allowed the quadriplegic patient to refuse a nasogastric tube through which the patient was fed. *Id.* at 1134-5. This means that "allowing the nature to take its course" in that case meant allowing the patient to starve herself to death and to die not from the underlying disease but from a collapse of bodily functions from lack of nutrition.

³² *Quinlan*, 70 N.J. at 48 ("[I]n light of the situation in the present case . . . one would have to think that the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient."). Again, this distinction between ordinary and extraordinary means can also be traced to the teachings of the Catholic Church. See, e.g., Pope Pius XII, *The Prolongation of Life: An Address of Pope Pius XII to an International Congress of Anesthesiologists* (1958) (arguing that "one is held to use only ordinary means [to preserve life and health]—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult.").

medical intervention(s) bringing reasonable hopes of recovery).³³ As I mentioned earlier, this distinction was eventually abandoned by some of the state courts.³⁴

Finally, both objective and subjective criteria of quality of life gave the courts a conceptual basis to distinguish between suicide and “natural death” on the basis of the patient’s intention. Indeed, in the situation where the medical condition and prognosis of the patient are such that certain medical interventions keeping the patient alive are “extraordinary” (objective criterion), it becomes more (albeit not entirely) plausible to argue that, if the patient wishes to discontinue those interventions, she intends not so much to end her life, but rather to terminate the “undignified” treatment of her. Why? Because an extraordinary extension of life in which a human being is heavily dependent upon medical personnel and mechanical devices (ventilators, nasogastric tubes, catheters, etc.) is perceived to deprive life of its intrinsic dignity (subjective criterion). Therefore, the reasoning goes, it is plausible to think of a patient intending to restore her dignity, rather than to terminate her life, when ordering the life-sustaining treatment to be withdrawn and withheld from her.

Based on these distinctions, state courts reconciled compelling state interests in protecting of life, preventing suicide, and preserving of the integrity of the medical profession with legal recognition of the patient’s autonomy in Withdrawal by making state interests irrelevant to the Withdrawal decisions. Indeed, if we conceptualize the right to Withdrawal as the “right to natural death,” the state’s concerns about preventing suicide become irrelevant: the patient does not commit suicide but rather, as one judge put it, “conclud[es] [her] life”³⁵ in a dignified manner. Furthermore, the state’s interest in preserving life no longer applies, for it is not the “life” that is being “preserved” in cases of Withdrawal, but rather an artificially extended “remnant of life.”³⁶ Also, allowing medical professionals to withdraw and withhold life-sustaining treatment from certain patients leaves medical ethics intact, as medical ethics “do[es] not require medical intervention in disease at all costs”³⁷ anyway.

By contrast, the state interest in protecting innocent third parties could still override the right of a patient whose quality of life was “low.” For example, if patients suffering from a terminal, contagious disease were quarantined and treated against their will, the courts would likely find the violations of bodily integrity, self-determination, informed consent, and privacy to be permissible.³⁸

This analysis demonstrates that the idea of quality of life was pivotal for the doctrine of the right to Withdrawal developed by the state courts, as it enabled them to reconcile the patient’s rights with the interests of the government. The Supreme Court of the United States adopted the same doctrinal approach to Withdrawal, as several cases demonstrate. For example, in the case of *Cruzan v. Missouri Department of Public Health*,³⁹ the Court said in *dictum*: “[W]e assume that the

³³ *Quinlan*, 355 A.2d at 663-64.

³⁴ See, e.g., *Conroy*, 486 A.2d at 1234 (“We also find unpersuasive the distinction relied upon by some courts, commentators, and theologians between ‘ordinary’ treatment, which they would always require, and ‘extraordinary’ treatment, which they deem optional.”).

³⁵ *Conroy*, 486 A.2d at 1224. See also *Quinlan*, 35 A.2d at 665 (“We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death.”).

³⁶ *Id.* at 662.

³⁷ *Conroy*, 486 A.2d at 1224.

³⁸ Cf. *Jacobson v. Mass.*, 25 S.Ct. 358 (1905) (discussing mandatory vaccination).

³⁹ 497 U.S. 261 (1990).

United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”⁴⁰ At first sight, it seems that the Court was primarily focusing on the issue of whether a competent patient has the right of Withdrawal. The inclusion of the word “lifesaving” in that statement, however, indicates that the quality-of-life calculus was also important for the *Cruzan* Court (artificial hydration and nutrition presumably become “lifesaving” when the quality of the patient’s life drops). Later cases decided by the Court provide further support for this view.

In the next right to die case concerning Prescription—*Washington v. Glucksberg*⁴¹—the Court characterized its pronouncement in *Cruzan* in the following way: “Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption [in *Cruzan*] was entirely consistent with this Nation’s history and constitutional traditions.”⁴² On the one hand, this could be read as signaling that the Court was sympathetic to the idea that quality of life was irrelevant when a patient exercised her right to “refuse unwanted medical treatment.” Under that theory, even if the patient’s prognosis is favorable, her refusal of life-sustaining treatment must prevail over compelling state interests in protecting life, preventing suicide, and preserving the integrity of the medical profession.⁴³

On the other hand, in the other Prescription case decided together with *Glucksberg*, *Vacco v. Quill*,⁴⁴ the Court framed the right to refuse medical treatment using the familiar vocabulary that state courts used to discuss quality of life. In particular, the *Vacco* Court noted that “when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology”⁴⁵ and that “a physician who withdraws, or honors a patient’s refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient’s wishes.”⁴⁶ This conceptualization of the right to Withdrawal makes sense only for terminally ill patients and therefore stems from the idea of quality of life. Therefore, the Court’s characterization of the right to refuse medical treatment in *Vacco* signals an unwillingness to abandon the idea of quality of life and move to a purely rights-based regime for the right to die.⁴⁷

At the same time, the Supreme Court’s decision in *Vacco* was based on the Court’s interpretation of the federal Constitution. The right to refuse medical treatment, however, is also founded in state constitutions, statutes, and case law, which may grant a broader right to die than

⁴⁰ *Id.* at 279.

⁴¹ 521 U.S. 702 (1997).

⁴² *Id.* at 725. The Court also noted, “[In *Cruzan*,] [w]e have also assumed, and strongly suggested, that the Due Process Clause protects the traditional right to refuse unwanted lifesaving medical treatment.” *Id.* at 720.

⁴³ Several authors support this position. *See, e.g.*, Alan Meisel, Lois Snyder & Timothy Quill, *Seven Legal Barriers to End-of-Life Care: Myths, Realities, and Grains of Truth*, 284 JAMA 2495, 2407 (2000) (arguing that “[t]he law allows any patient to refuse any treatment that he/she does not want, in the interest of protecting bodily integrity, even if that treatment would be life sustaining and the patient is not terminally ill.”). *See also* ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISION MAKING* 5-6, 5-7, 5-8 (3d ed. 2004) (discussing the decisions of the state courts affirming a competent patient’s right to refuse life-saving medical treatment regardless of the patient’s prognosis).

⁴⁴ 521 U.S. 793 (1997).

⁴⁵ *Id.* at 801.

⁴⁶ *Id.*

⁴⁷ *See, e.g.*, *In re Browning*, 568 So. 2d 4, 10 (1990) (“A competent individual has the constitutional right to refuse medical treatment regardless of his or her medical condition.”).

that delineated by the Supreme Court. For example, a state court may grant a fully competent patient the right to refuse medical treatment regardless of her medical condition.⁴⁸ The law in other states, however, may grant the right to refuse life-saving treatment only to patients in terminal conditions, like many of the advance directives state statutes do.⁴⁹ In the latter case, quality of life (patient's terminal condition) precedes considerations about individual autonomy of incompetent patients.

As this analysis demonstrates, when the state courts and the Supreme Court confronted the right to die in the context of Withdrawal, they found that right to be supported not only in the common law principles of informed consent, bodily integrity, and self-determination and in the constitutional right to privacy,⁵⁰ but also in the idea of quality of life. (The latter idea resulted in the courts effectively interpreting the right to withdraw life-saving medical treatment as the right to die a "natural death.") The courts also considered several important governmental interests that weighed against the recognition of Withdrawal and balanced them against the patient's quality of life and constitutional and common-law rights. Finally, when doing the balancing between those three substantive arguments, the courts were also mindful of the "systemic" arguments about formal administrability and institutional competence.⁵¹ In particular, the judiciary was concerned not only about the substance of legal rules, but also about how administrable they were (for example, the distinction between ordinary and extraordinary treatment)⁵² and who was in the best position to enact them (the legislatures or the courts).⁵³

In the next section, I show how exactly the balancing among the substantive elements of the doctrine of the right to Withdrawal was done.

B. Interaction among the Substantive Elements of the Doctrine

The reasoning of some of the state supreme courts and of the United States Supreme Court strongly indicates that not all substantive elements of the doctrine of the right to Withdrawal were created equal. Instead, the courts placed them in a certain lexical ordering: quality of life came first, and then, depending on its assessment, the court would recognize that either the patient's rights prevailed over state interests, or *vice versa*.

In the influential case of *Quinlan*, the Supreme Court of New Jersey stated that "the State's interest [in preservation of human life] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which

⁴⁸ See MEISEL ET AL., *supra* note 43.

⁴⁹ See, e.g., WASH. REV. CODE ANN. § 70.122.030 ("Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition.") (emphasis added); ALA. CODE § 22-8A-4 (d) ("An advance directive for health care shall become effective when: . . . (2) two physicians . . . have personally examined the declarant and have diagnosed and documented in the medical record that the declarant has either a terminal illness or injury or is in a state of permanent unconsciousness.") (emphasis added).

⁵⁰ See *supra* notes 22-24 and accompanying text.

⁵¹ On the classification of legal arguments into substantive and systemic arguments, see generally, Duncan Kennedy, *A Semiotics of Legal Argument*, 42 SYRACUSE L. REV. 75 (1991).

⁵² *In re Conroy*, 486 A.2d 1209, 1234-35 (1985).

⁵³ *Id.* at 1220 ("Perhaps it would be best if the Legislature formulated clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients. As an elected body, the Legislature is better able than any other single institution to reflect the social values at stake.").

the individual's rights overcome the State interest."⁵⁴ Later on, the same state court in the *Conroy* case spelled out two tests to determine the "best interests" of an incompetent patient that would allow the patient's guardian to withdraw life-saving treatment from the patient.⁵⁵ Both tests heavily relied upon the patient's quality of life, which had to be determined prior to withdrawal of treatment. The "limited-objective test" requires that "some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that *it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him.*"⁵⁶ Under the "pure-objective test" (applied in the absence of trustworthy evidence of the patient's will), "the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life [and] unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane."⁵⁷ A guardian could request Withdrawal only if one of the tests was met.

Similarly, the decisions of other state courts and the United States Supreme Court are replete with references to the quality of life of the patients seeking Withdrawal.⁵⁸ If the court agreed that both objective and subjective criteria of quality of life were satisfied (we may call this the "insufficiency threshold," meaning that the quality of life drops below a certain level), then the court was willing to endorse the patient's choice (or the choice of the patient's representative on her behalf) to end her life. In other words, if the quality of life was below the "insufficiency threshold," then the courts were willing to analyze the authenticity of the patient's choice to end her life, including: whether there was clear and convincing evidence of that choice, whether the patient made a living will or appointed a healthcare proxy, whether a patient's guardian asking for the life-sustaining treatment to be discontinued acted in the best interests of the patient, whether the patient was under undue influence, and so on.

By contrast, if the court determined the quality of the patient's life to be above the insufficiency threshold, it would recognize compelling state interests in protecting innocent lives, preventing suicide, and preserving the integrity of the medical profession. Thus, in the case of a Jehovah's Witness who was hospitalized after losing about two-thirds of her blood from a ruptured ulcer⁵⁹ and, in medical judgment, could be saved with a "better than 50 per cent chance,"⁶⁰ a federal

⁵⁴ *In re Quinlan*, 355 A.2d 647, 664. *See also Conroy*, 486 A.2d at 1223 (1985) ("Whether based on common-law doctrines or on constitutional theory, the right to decline life-sustaining medical treatment is not absolute. In some cases, it may yield to countervailing societal interests in sustaining the person's life.").

⁵⁵ *Conroy*, 486 A.2d at 1231-32.

⁵⁶ *Id.* at 1232.

⁵⁷ *Id.*

⁵⁸ *See, e.g., Cruzan*, 110 S.Ct. 2841, 2945 (1990) ("[The patient] now lies in a Missouri state hospital in what is commonly referred to as a persistent vegetative state: generally, a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function."); *Conroy*, 486 A.2d at 1217 ("[The patient] was not brain dead, comatose, or in a chronic vegetative state. . . . [H]owever . . . her intellectual capacity was very limited, and . . . her mental condition probably would never improve."); *Bouvia v. Super. Ct. of L.A. Cnty.*, 179 Cal. App. 3d 1127, 1136 (Cal. 1986) ("[The patient's] physical handicaps of palsy and quadriplegia have progressed to the point where she is completely bedridden. Except for a few fingers of one hand and some slight head and facial movements, she is immobile. . . . She lies flat in bed and must do so the rest of her life. She suffers also from degenerative and severely crippling arthritis. She is in continual pain.").

⁵⁹ *In re President & Dir. of Georgetown Coll., Inc.*, 331 F.2d 1000, 1006 (D.C. Cir. 1964).

⁶⁰ *Id.* at 1007.

judge ordered a blood transfusion despite the objection of both the patient and her husband.⁶¹ In particular, Judge Skelly Wright from the D.C. Circuit argued that,

[u]nder the circumstances [of the case], it may well be the duty of a court of general jurisdiction . . . to assume the responsibility of guardianship for [the patient], as for a child, at least to the extent of authorizing treatment to save her life. And if, as shown above, a parent has no power to forbid the saving of his child's life, *a fortiori* the husband of the patient here had no right to order the doctors to treat his wife in a way so that she would die.⁶²

Judge Skelly Wright further argued that,

The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of *voluntary* abandonments [to refuse life-saving medical treatment]. The patient had a responsibility to the community to care for her infant. *Thus the people had an interest in preserving the life of this mother.*⁶³

This reasoning strongly suggests that, as long as the quality of the patient's life has not dropped below the insufficiency threshold (in this case, determined in terms of the chances of the patient's survival), the state interest in preservation of innocent human life trumps the "voluntary abandonment" of that life by the patient. The reasoning also implies that if the quality of the patient's life is below that threshold, then she would have the right to refuse life-sustaining treatment. While it is true that this and other cases concerning involuntary blood transfusions were decided before the Withdrawal cases, it bears noting that they were not overruled in later case law (to the contrary, the Supreme Court of New Jersey relied on them when deciding *Conroy*).⁶⁴

This brings us to the general idea of balancing in the state and federal courts' decisions concerning the right to Withdrawal. The courts first looked at the quality of the patient's life: if it was "low," then they were willing to recognize the patient's right of Withdrawal; if it was "high," then the courts instead triggered the state police power of preservation of human life. The idea of quality of life as conceptualized by the state and federal courts in the United States has three distinctive features, each of which is important for the regulation of the right to die.

First, the quality of the patient's life was determined by the courts using first objective (the patient's medical diagnosis and prognosis) and then subjective (the level of the patient's suffering) criteria. The same approach was adopted by the legislatures that passed the statutes allowing Withdrawal for patients in *terminal* conditions.⁶⁵ This insistence on the objective criterion of quality of life puts the United States in contrast to other countries that have made medical assistance in

⁶¹ *Id.* at 1002.

⁶² *Id.* at 1008.

⁶³ *Id.* (emphasis added).

⁶⁴ *In re Conroy*, 486 2A.2d 1209, 1226. Notably, some state courts seem to have held that that a competent patient may refuse life-saving medical treatment regardless of her prognosis; those courts skipped the quality of life part of the reasoning and based their decisions on the notion of individual autonomy. See MEISEL ET AL., *supra* note 43. At the same time, the established case law in other states requires inquiry into the quality of the patient's life first.

⁶⁵ See *supra* note 49.

dying available to patients whose perception of quality of life trumps the objective criteria of quality of life. For example, the Supreme Court of Canada in its blockbuster case on the right to die⁶⁶ framed the condition that made a patient eligible for physician's assistance in dying as follows: "a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."⁶⁷ The absence of the patient's prognosis from the definition and the emphasis on the patient's perception of her condition ("enduring suffering that is intolerable to the individual") suggests that if the patient suffers, for example, from incurable depression or progressing dementia, she would be eligible for a physician's assistance in dying despite the fact that her condition doesn't bring her anywhere near imminent death.

Second, putting the quality of life with its objective criterion before ideas about the patients' rights and the state interests purported to give an objective, impartial tone to the courts' reasoning. Instead of directly enforcing an idea of the patient's rights or an idea of preservation of life, the courts first assessed objective medical data about the patient's condition and then, based on that assessment, proceeded to deciding on the patient's claim to refuse life-saving treatment.⁶⁸

Third, the idea of quality of life as articulated by the state supreme courts and the United States Supreme Court is closely bound with the statements about causation and intention. As I mentioned earlier, it was the idea of quality of life that allowed the courts to distinguish between suicide and "natural" death from the perspectives of causation and intention. That distinction, in turn, was instrumental to the recognition of the right to Withdrawal for patients whose quality of life was below the insufficiency threshold and, as I shall demonstrate shortly, to the disparate treatment of different types of the right to die. In the second part of this essay, I shall compare the legal regimes of different types of the right to die in the United States, examine the statements about causation and intention as applied to those types, demonstrate that they were false, and analyze the utility of making those false statements.

II. WITHDRAWAL, PRESCRIPTION, INJECTION, AND SEDATION: DISPARATE TREATMENT AND LEGAL FICTIONS

A. The Legal Regimes of Prescription, Injection, and Sedation in Comparison to Withdrawal

Injection (i.e., voluntary active euthanasia) is illegal in the United States.⁶⁹ The act of a physician administering a lethal drug to a competent patient after the patient's voluntary request is considered murder and treated accordingly.⁷⁰ Even in those states that permit Prescription, the legislatures and the courts have specifically emphasized that the legalization of Prescription does

⁶⁶ Carter v. Canada (Attorney General), 2015 SCC 5.

⁶⁷ *Id.* at para 4.

⁶⁸ *In re Quinlan*, 355 A.2d 647, 664.

⁶⁹ *See, e.g.*, *People v. Kevorkian*, 639 N.W.2d 291, 305 (Mich. App. 2001) ("[W]e can find no meaningful precedent for expanding the right to privacy to include a right to commit euthanasia so that an individual can be free from intolerable and irremediable suffering. To our knowledge, no court of last resort in this country has ever recognized such a right. Even in the assisted suicide cases dealing with an asserted 'right to die,' courts have steadfastly refused to expand the right to privacy to include the right to commit or receive euthanasia.").

⁷⁰ *Id.*

not mean or condone the legalization of euthanasia.⁷¹ Many statutes affirming the patients' right to refuse medical treatment have similar provisions.⁷²

Prescription (i.e., physician-assisted suicide), by contrast, has been legalized by a handful of states. Four of them—California, Oregon, Vermont, and Washington—legalized Prescription by statutes.⁷³ In a fifth state, Montana, the state supreme court created a defense of consent against criminal charges for homicide (and, presumably, assisting suicide) brought against doctors who participated in Prescription.⁷⁴ In all five states the legislatures and the judiciary followed the familiar doctrinal path of Withdrawal: the right to Prescription is available only to qualifying patients whose quality of life has dropped below a certain level (i.e., those who are terminally ill); otherwise, the state interests trump the will of a competent patient.⁷⁵ (For example, a patient with progressing Alzheimer's disease is not eligible for Prescription in the United States, as the condition is not terminal.)⁷⁶ Furthermore, in all five states where Prescription is legal the physicians follow a strict protocol to ensure that their patients are making truly autonomous decisions to end their lives.⁷⁷

In some states, the legal status of Prescription is uncertain, either because there is no prosecution by the state authorities for the practice, or because the state law knows of no separate crime of aiding and abetting suicide. For example, in the recent case of *Commonwealth v. Carter*⁷⁸ the Supreme Judicial Court of Massachusetts affirmed the indictment for involuntary manslaughter for verbal encouragements to commit suicide (in that case, the defendant was in a romantic relationship with the victim and psychologically pressured the victim into committing suicide). At the same time, the highest state court specifically noted that the case was “not about a person seeking to ameliorate the anguish of someone coping with a terminal illness and questioning the value of life. Nor [was] it about a person offering support, comfort, and even assistance to a mature adult

⁷¹ CAL. HEALTH & SAFETY CODE § 443.18 (West 2015); VT. STAT. ANN. tit. 18, § 5292 (West 2013); WASH. REV. CODE ANN. § 70.245.180 (West 2009); OR. REV. STAT. ANN. § 127.880 (West 1995).

⁷² See, e.g., ALA. CODE § 22-8A-10 (West, 1981) (“Nothing in this chapter [regulating termination of life-support procedures] shall be construed to condone, authorize or approve mercy killing or physician assisted suicide or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.”).

⁷³ California End of Life Option Act, Cal. HEALTH & SAFETY CODE D. 1, Pt. 1.85 (2016); Vermont Patient Choice at End of Life Act, VT. STAT. tit. 18, § 5283 (2013); Washington Death with Dignity Act, WASH. REV. CODE ANN. c. 70.245 (2009); Oregon Death with Dignity Act, OR. REV. STAT. c. 127.800 (1997). When the draft of this article was prepared for submission, Prescription was legalized in Colorado, see COLO. REV. STAT. ANN. § 25-48-103 (West 2016), and the District of Columbia, see D.C. Code Ann. § 7-661 (West).

⁷⁴ *Baxter v. State*, 224 P.3d 1211 (Mont. 2009). Therefore, strictly speaking, it would be not correct to state that Prescription is now fully “legal” in Montana—the state supreme court did not decriminalize it, but rather stated that if criminal charges of homicide are filed against a doctor who prescribed the lethal medication, the doctor can plead the statutory defense of the patient’s consent to Prescription.

⁷⁵ *Baxter*, 224 P.3d at 1214, 1222; Cal. Health & Safety Code § 443.2 (West 2016); Vt. Stat. Ann. tit. 18, § 5283 (West 2015); Wash. Rev. Code Ann. § 70.245.020 (West 2009); Or. Rev. Stat. Ann. § 127.805 (West 2017).

⁷⁶ See, e.g., Stephen G. Post, *Physician-Assisted Suicide in Alzheimer’s Disease*, 45 J. AM. GERIATRICS SOC. 647, 648 (1997) (“Alzheimer’s disease, Parkinson’s disease, multiple sclerosis (MS), AIDS, and many other diseases are profoundly devastating without being immediately ‘terminal.’”).

⁷⁷ *Baxter*, 224 P.3d at 1215; Cal. Health & Safety Code §§ 443.3 (a), 443.5, 443.6, 443.7 (West 2016); Vt. Stat. Ann. tit. 18, § 5283 (a) (West 2015); Wash. Rev. Code Ann. §§ 70.245.040, 70.245.050, 70.245.090 (West 2009); Or. Rev. Stat. Ann. § 127.840 (West 2017).

⁷⁸ *Commonwealth v. Carter*, 52 N.E.3d 1054 (Mass. 2016).

who, confronted with such circumstances, has decided to end his or her life.”⁷⁹ This indicates that the highest state court did not want its holding to address Prescription (for example, a situation where the doctor advises her terminal patient to travel to Vermont to seek assisted dying there). Absent clearer legislative or judicial guidance, the legal status of Prescription in Massachusetts remains uncertain.

In the majority of states, however, Prescription, like Injection, is illegal, and the statutes authorizing Withdrawal in some of those states specify that they do not condone physician-assisted suicide.⁸⁰ At the same time, the Supreme Court indicated that Sedation (i.e., palliative care hastening death) was available for patients.⁸¹ This means that Withdrawal and Sedation on the one hand, and Prescription and Injection on the other hand, are treated differently in most of the United States. What are the doctrinal justifications for such disparate treatment?

The courts attempted to answer that question when they distinguished between Withdrawal and Sedation on the one hand, and Prescription and Injection on the other hand by relying on legal and moral accounts of causation and intention. In the next sections I shall show how the courts interpreted the notions of causation and intention and how they substituted them with legal fictions.

B. Causation and Intention in Withdrawal, Prescription, Injection, and Sedation

1. Causation

With respect to Withdrawal, the state courts (and then the Supreme Court) framed causation in a peculiar way. Specifically, as I noted earlier, the courts said that what they authorized was not the right to die as defined in the beginning of this article (that is, the right to choose the time, place, and manner of one’s own premature death), but rather the right to die a “natural death.”⁸² From the perspective of causation, in the case of Withdrawal, the courts deemed the patient’s death to be caused by the natural progression of her illness, not by the doctor’s conduct (i.e., action and/or inaction).

This claim is painfully problematic from a real-life perspective. Whether we understand causation from a probabilistic perspective⁸³ or from the standpoint of common sense⁸⁴, it is clear

⁷⁹ *Id.* at 636.

⁸⁰ *See, e.g.*, Ala. Code § 22-8A-10 (2010) (“Nothing in this chapter [regulating termination of life-support procedures] shall be construed to condone, authorize or approve mercy killing or physician assisted suicide or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this chapter.”). In some states, however, the advance directives statutes do not explicitly mention Prescription. *See, e.g.*, Mass. Gen. Laws, ch. 201D, § 12 (1990) (“Nothing in this chapter shall be construed to constitute, condone, authorize, or approve suicide or mercy killing, or to permit any affirmative or deliberate act to end one’s own life other than to permit the natural process of dying.”); Mont. Code Ann. §§ 50-9-205(1) (2003) (“This chapter does not condone, authorize, or approve mercy killing or euthanasia.”).

⁸¹ *Washington*, 521 U.S. at 737-8.

⁸² McClory, *supra* note 30; *Bouvia*, 179 Cal. App. 3d at 1145.

⁸³ *See generally* Christopher Hitchcock, *Probabilistic Causation*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed.), <http://plato.stanford.edu/archives/win2012/entries/causation-probabilistic/> [<https://perma.cc/6475-5EHF>].

⁸⁴ FRANKLIN G. MILLER & ROBERT D. TRUOG, *DEATH, DYING, AND ORGAN TRANSPLANTATION: RECONSTRUCTING MEDICAL ETHICS AT THE END OF LIFE* 11-13 (2012) (discussing the common sense-based account of

that in the situation of Withdrawal the patient dies *both* from her underlying condition *and* from the doctor's conduct; doctor's conduct may include withdrawal of life-saving treatment (e.g., unplugging the patient from a ventilator) or withholding that treatment from the patient.⁸⁵ Absent any of these conditions, the patient's death would not ensue.

Nevertheless, the concept of "natural death" has firmly established itself in the state courts' jurisprudence on Withdrawal, and it has crept into the decisions of the United States Supreme Court concerning Prescription. The case of *Vacco v. Quill*⁸⁶ is illustrative here. In this case, the plaintiffs were challenging the constitutionality of the New York ban on Prescription under the equal protection clause. Plaintiffs argued that since New York allowed its citizens to refuse life-sustaining medical treatment (i.e., Withdrawal), and since the Withdrawal was "essentially the same thing"⁸⁷ as Prescription, the latter should have been permitted as well. The Supreme Court disagreed and distinguished between Withdrawal and Prescription along the lines of causation and intent.

In its discussion of causation, the Court concluded, "[W]hen a patient refuses life-sustaining medical treatment, [s]he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, [s]he is killed by that medication."⁸⁸ This conclusion, however, is unavailing. As common sense and my earlier analysis of causation make clear, when the patient refuses life-sustaining treatment, the reason why she dies is twofold: the withdrawal and withholding of treatment *and* the underlying medical condition. Regardless of the patient's condition, she would not die until the doctor withdraws life-saving treatment from her; had the opposite been true, Withdrawal cases would not have been brought to courts. The conclusion of the Court, however, seems to ignore that.

Likewise, unconvincing is the Court's formulation of the distinction between Prescription and Withdrawal as that between "killing" and "letting die."⁸⁹ The Court seems to have overlooked that in Prescription the physician is not necessarily "killing" the patient. It could be plausibly argued that the doctor participating in Prescription is "killing" her patient if she knows with certainty that the patient is going to take the lethal medication. At the same time, the latter is plainly not the case according to the reports from the states where Prescription is allowed: many patients do not self-administer the prescribed lethal drugs.⁹⁰ In those scenarios of Prescription where the patient gets the lethal drug from her doctor and never ingests it, it makes no sense to speak of Prescription as "killing." This assertion can only be made when we think that the patient would die from merely

causation in courts' decisions).

⁸⁵ *Id.* at 4.

⁸⁶ 521 U.S. 793 (1997).

⁸⁷ *Id.* at 798.

⁸⁸ *Id.* at 801.

⁸⁹ *Id.* at 806.

⁹⁰ See, e.g., OREGON PUBLIC HEALTH DIVISION, *Oregon Death with Dignity Act: 2015 Data Summary*, Feb. 4, 2016, <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf> [<https://perma.cc/QG3J-9D26>] (reporting that during 2015, 218 patients received prescriptions for lethal medications and 132 died from taking the medications prescribed under the state Death with Dignity Act [about 40% of the patients got the prescription but did not ingest the medication]). See also WASHINGTON STATE DEPARTMENT OF HEALTH, *2015 Death with Dignity Act Report: Executive Summary*, <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf> [<https://perma.cc/45DS-QHGX>] (stating that in 2015 medication under the state Death with Dignity Act was dispensed to 213 patients, of whom 166 were reported to have died from ingesting the medication, which means that about 22% of the patients who got the prescription did not ingest the lethal medication).

being prescribed a lethal dose of medication. The Court's unqualified conclusion that *every* situation of Prescription is "killing" is, to say the least, questionable.

There is, however, a plausible causation-based distinction to be drawn between Withdrawal and Injection. To be sure, the two do not differ in terms of action and inaction of the doctor causing the patient's death.⁹¹ In the case of Withdrawal, the doctor performs an action (discontinues the treatment) and then fails to act (withholds life-saving treatment), causing (along with the patient's underlying condition) the patient's death. In the case of Injection, the doctor performs an action (administers the lethal dose of medication) and then fails to act (e.g., does not provide the patient with an antidote), causing the patient's death. In this respect, the dichotomy between "killing" and "letting die," which often appears in the literature,⁹² is of no use when distinguishing between Withdrawal and Injection: both situations require action ("killing" either by withdrawal of treatment or injection of a lethal drug) and inaction ("letting die" by withholding treatment).

The causation-based distinction between Withdrawal and Injection lies instead with necessary and sufficient conditions for the patient's death. Whereas in Withdrawal, where those conditions are twofold (the patient's condition and the doctor's conduct), in Injection the doctor's conduct is the necessary and sufficient condition for the patient's death: the patient dies after being administered the lethal dose of medication irrespective of her underlying condition.⁹³ This distinction arguably makes a difference from the perspective of preserving the integrity of the medical profession: it could be argued that while in Withdrawal the doctor is only one of the contributors to the patient's death, whereas in Injection her conduct is the sole reason that the patient dies, and that could corrode the doctor's morality. I shall return to this argument later when discussing possible alternatives to the current regime of the right to die in the United States.

These are legal fictions about causation. I shall now focus on another concept the courts used to distinguish different methods of the right to die—intention—and shall demonstrate that legal fictions related to it were also abundant.

2. Intention

The courts have approached the concept of intention in Withdrawal and Prescription using the doctrine of double effect ("Doctrine"). The Doctrine was famously formulated by Aquinas⁹⁴ and

⁹¹ Janna Satz Nugent, "Walking into the Sea" of Legal Fiction: An Examination of the European Court of Human Rights, *Pretty v. United Kingdom and the Universal Right to Die*, 13 J. TRANSNAT'L L. & POL'Y 183, 205-207 (2003).

⁹² For criticism of this distinction in end-of-life context, see James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED 78 (1975).

⁹³ One of the paraphrases of this distinction between sufficient and insufficient conditions of the patient's death sometimes is the one between the doctor's direct and indirect involvement in the patient's death. See, e.g., ALAN MEISEL, KATHY L. CERMINARA & THADDEUS M. POPE, *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* 12-5 *et seq.* (3rd ed. 2004).

⁹⁴ "Nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention. Now moral acts take their species according to what is intended, and not according to what is beside the intention, since this is accidental." THOMAS AQUINAS, *SUMMA THEOLOGICA* 2-2.64.7 (The Fathers of the English Dominican Province trans., 1948).

since then has received wide scholarly praise and criticism.⁹⁵ The Doctrine has been reformulated many times by many different authors; for the purposes of this article, I shall adopt the following formulation: in pursuit of good, it is permissible to cause harm as an unintended but foreseeable side-effect, but it is impermissible to cause the same harm as an intended means to that end.⁹⁶

Probably the most famous example of the application of the Doctrine is the so-called trolley problem devised by Philippa Foot.⁹⁷ The Doctrine teaches that when a run-away trolley is barreling down a track where it will kill five people, it is morally permissible for a bystander to redirect it to another track with only one person who will be killed. The explanation, according to the Doctrine, is this: while the harm (the death of a lone person on the second track) is foreseeable, it is not intended by the bystander as a means to achieve good (to save the lives of five people on the first track). By contrast, it would be impermissible to push a man before the running trolley in order to prevent it from hitting five people, because in that case the harm (the death of an innocent person) is the intended means to achieve the desired good.

The Doctrine is often contrasted with its rival teaching, according to which both foreseen and desired effects of one's conduct should be considered as intended.⁹⁸ Both the Doctrine and its rival have had profound impact on legal rules, and both ways of conceptualizing intention can be found in U.S. law.⁹⁹ As far as the right to die is concerned, the state courts and the United States Supreme Court relied on the Doctrine to formulate legal rules about Withdrawal, Prescription, Injection, and Sedation. Unfortunately, the courts' application of the Doctrine was often misguided and left much to be desired in terms of consistency.

Let us begin with Withdrawal. In those cases, the courts stated that in making a decision to refuse life-saving medical treatment the patient's intention was not to die or commit suicide, but rather "to allow nature to take its course."¹⁰⁰ Along the same lines, the state courts observed that

⁹⁵ For an overview of the debate about the Doctrine, see Charles Fried, *The Doctrine of Double Effect—Sacred and Profane*, in INTENTION & DOUBLE-EFFECT: THEORETICAL AND PRACTICAL CHALLENGES (forthcoming 2016). See also G. E. M. Anscombe, *Action, Intention and 'Double Effect'*, in HUMAN LIFE, ACTION & ETHICS 207-226 (Mary Geach & Luke Gormally eds., 2005); John Finnis et al., *'Direct' and 'Indirect': A Reply to Critics of Our Action Theory*, 65 THOMIST 1-44 (2001); Philippa Foot, *The Problem of Abortion and the Doctrine of Double Effect*, in VIRTUES AND VICES AND OTHER ESSAYS IN MORAL PHILOSOPHY 19-32 (2002); THOMAS SCANLON, *The Illusory Appeal of Double Effect*, in MORAL DIMENSIONS: PERMISSIBILITY, MEANING, BLAME 8-36 (2008); H. L. A. HART, *Intention and Punishment*, in PUNISHMENT AND RESPONSIBILITY: ESSAYS IN THE PHILOSOPHY OF LAW 122-126 (2008).

⁹⁶ See, e.g., Alison McIntyre, *Doctrine of Double Effect*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2014), <http://plato.stanford.edu/archives/win2014/entries/double-effect/> [<https://perma.cc/4MT4-7AXU>].

⁹⁷ Philippa Foot, *The Problem of Abortion and the Doctrine of Double Effect*, in VIRTUES AND VICES AND OTHER ESSAYS IN MORAL PHILOSOPHY, at 23 (2002). An unintended (and perhaps unforeseeable) side-effect of that example is the growing field of "trolleyology"—the area of moral philosophy that studies hundreds of variations of the initial trolley problem that year by year are getting more and more exotic.

⁹⁸ Jeremy Bentham, who distinguished between "direct" and "oblique" intention, is among the most famous proponents of this view. See JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION ch. IX.IX (Oxford: Clarendon Press, 1907).

⁹⁹ See Charles Fried, *The Doctrine of Double Effect—Sacred and Profane*, in INTENTION & DOUBLE-EFFECT: THEORETICAL AND PRACTICAL CHALLENGES (forthcoming 2016) (discussing the role of the Doctrine in criminal, constitutional, and international law). See also RESTATEMENT (SECOND) OF TORTS: INTENT § 8A (AM. LAW INST. 1965) (discussing intent of consequences that are desired and that the actor knows are certain).

¹⁰⁰ *Bowia*, 179 Cal. App. 3d at 1144.

“people who refuse life-sustaining medical treatment may not harbor a specific intent to die; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering.”¹⁰¹ Similarly, Chief Justice Rehnquist writing for the unanimous Supreme Court in *Vacco* opined that “a patient who refuses or discontinues treatment might not [have the specific intent to end his or her own life]”.¹⁰² With respect to the intention of a doctor, Rehnquist argued that “a physician who withdraws, or honors a patient’s refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient’s wishes” and to cease futile treatment that does not benefit the patient.¹⁰³ The state supreme courts shared that approach to the physician’s intention.¹⁰⁴

This analysis is unavailing for a number of reasons. First, with respect to the intention of the patient, the modality used by the former Chief Justice (“might not [have the specific intent to end his or her own life]”) is misleading. In fact, following the logic of the judicial treatment of Withdrawal, it would be fair to argue that the recognition of Withdrawal by the state and federal judges was based on the presumption that the patient *does not* intend to die. Had the judges recognized that the patient asking for the withdrawal of life-saving treatment intended to die, there could be no meaningful distinction between Withdrawal and Prescription from the standpoint of the patient’s intention as interpreted by the courts.¹⁰⁵

Second, with respect to the doctor’s intention, to say that a physician who discontinues medical treatment from a patient does not intend the death of that patient is a very broad generalization that is not always true. It is not implausible to think of a doctor who is *motivated* by respect for the patient’s wishes and therefore *intends* her patient to die, because this is the desire the patient articulated to her.¹⁰⁶

Notice how the state and federal judiciaries are, to use the phrase of one state judge, “danc[ing] around the issue” of intention.¹⁰⁷ The court effectively stated that while the patient’s death was an imminent side-effect of discontinuing life-saving treatment, the patient and the doctor were not intending but merely foreseeing it; their intention was, by contrast, to be free (or to make their patients free) of unwanted medical treatment. This doctrinal way of framing the issue of intention sounds strikingly similar to the Doctrine with its distinction between intended and foreseeable effects. Therefore, the doctrinal position of the courts on the patient’s intention is subject to the same criticism that the Doctrine has (rightfully) received: if two effects of the same conduct are so proximate to each other that they are virtually inseparable, how plausible is it to argue that one effect is intended while the other is not?¹⁰⁸

As applied to Withdrawal, the question can be put sharply as follows: if the patient refuses

¹⁰¹ *Conroy*, 98 N.J. at 351.

¹⁰² *Vacco*, 521 U.S. at 802.

¹⁰³ *Id.* at 801.

¹⁰⁴ *See, e.g., Bouvia*, 179 Cal. App. 3d at 1144.

¹⁰⁵ *Id.* at 1146-1147 (Compton, J., concurring).

¹⁰⁶ MILLER & TRUOG, *supra* note 84, at 16-17.

¹⁰⁷ *Bouvia*, 179 Cal. App. 3d at 1147 (Compton, J., concurring) (original quotations omitted).

¹⁰⁸ Foot, *supra* note 97, at 21 (“A certain event may be desired under one of its descriptions, unwanted under another, but we cannot treat these as two different events, one of which is aimed at and the other not. And even if it be argued that there are . . . two different events . . . the two are obviously much too close for an application of the doctrine of the double effect.”).

life-saving treatment, she and her doctor *know* with certainty that in her condition she will die as a result of the treatment's withdrawal since the treatment's withdrawal and the patient's death are bound by causal connection. In that situation, is it plausible to say that the patient and the doctor were intending a cause (withdrawal of treatment) but not the effect (death)? To give an example by analogy: suppose I am aware that I have a severe allergic reaction (anaphylactic shock) to iodine, then ask someone to inject some iodine into my body, and then die as a result of the injection and anaphylactic shock that ensued. Under those circumstances, how much sense would it make to argue that I intended iodine to be injected but not my death? I think not much, as the iodine injection and my death are causally connected, and it is nonsensical to intend the former without intending the latter.

But let us suppose that the critics of the Doctrine are wrong and that it is generally possible to intend a cause without intending its effect. Even that charitable interpretation of the Doctrine does not justify Withdrawal. It is not implausible to imagine that for the unfortunate patients who found themselves in grave medical condition, death is the only realistic means of terminating their anguish¹⁰⁹—after all, Withdrawal is classified as one of the types of the right to *die* for a reason. If that is true, then death becomes the intended means to reach the final goal (alleviation of suffering).¹¹⁰ And if that is true, then Withdrawal is outlawed by the Doctrine, because the Doctrine forbids intending harm (the patient's death) as a means to the desired good (alleviation of suffering).

Let us now turn to Prescription. There, the Supreme Court's treatment of intention was no better than in Withdrawal. In *Vacco*, the Court opined that the doctor prescribing a lethal dose of medication to the patient “must, necessarily and indubitably, intend primarily that the patient be made dead.”¹¹¹

That statement is inaccurate under the Doctrine. As I mentioned earlier, there is data from Oregon and Washington that demonstrates that many patients there get the prescriptions for lethal drugs from their doctors but ultimately do not take those drugs.¹¹² The doctors are aware of that data, meaning that when they prescribe the lethal drug for their patients, they foresee (or maybe even know with virtual certainty) that at least some of those patients want the drug for peace of mind (i.e., the knowledge that they are in control over their lives) and will not actually take it. Under those circumstances, it is incorrect to state that any doctor participating in Prescription “must, necessarily and indubitably, intend primarily that the patient be made dead;” the doctor may well be indifferent to the ultimate choice that the patient makes with respect to her life.¹¹³ By contrast, if doctors had the intention “that the patient be made dead,” they would refuse to prescribe the drug to the patients who, in their judgment, might get the drug but not end up taking it.

The position of the Court on the doctor's intention in Prescription makes sense only if we abandon the Doctrine and instead adopt the rival approach—the one according to which both desire (purpose) and foresight are intentional. Under the latter approach, in order to establish the doctor's intention to make her patient dead, it would suffice to show that the doctor foresaw the patient's death with some degree of certainty. As I mentioned, that rival approach is firmly established in

¹⁰⁹ *Bowia*, 179 Cal. App. 3d at 1147 (Compton, J., concurring).

¹¹⁰ MILLER & TRUOG, *supra* note 84, at 16-17.

¹¹¹ *Vacco*, 521 U.S. at 802.

¹¹² See *Oregon Death with Dignity Act: 2015 Data Summary*, *supra* note 90; *Death with Dignity Act Report: Executive Summary*, *supra* note 90.

¹¹³ See Satz Nugent, *supra* note 91, at 207.

U.S. law, so the Court's reliance on it was *per se* unproblematic. What was problematic was that the *Vacco* Court rejected this approach and instead adopted the Doctrine of double-effect when it distinguished between Prescription, Injection, and Sedation.¹¹⁴ The fact that the Court meant to apply the Doctrine to Prescription is admirable from the perspective of consistency: The Court wanted the same Doctrine to apply to Withdrawal, Prescription, Injection, and Sedation. At the same time, the Court's own conclusions about the intentions of the doctor participating in Prescription were patently inconsistent with the Doctrine it declared to be applicable.

But even had the Court consistently applied the Doctrine to the situation of Prescription, the result still would have been unsatisfactory. If the cases of Withdrawal can be of any guidance, the Court would have applied the Doctrine to find out the doctor's intention or foresight with respect to the patient's death. That focus of the application of the Doctrine would have been misguided because the doctor's state of mind in Prescription is not about the death of the patient—it is rather about enabling the patient to make a choice between taking her own life or trying other treatment options. This choice is what the doctor prescribing a lethal drug to her patient intends. This intention of the doctor explains why doctors participate in Prescription while suspecting that the patients will actually not take the drugs. It also explains that the patient who goes to her doctor for Prescription does not necessarily intend to die; rather, she may well want the peace of mind brought about by the knowledge that she is equipped to make her final choice. This conceptualization of intention in terms of the patient's choice, rather than the patient's death, is a much better way of understanding Prescription than the focus on the patient's death inherited from criminal and tort law.¹¹⁵

The *Vacco* Court's treatment of the doctor's intention in the situation of Prescription was problematic. With respect to the patient's intention in the same context, the Court opined that “a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life.”¹¹⁶ While that statement is certainly true, the Court here seemed to follow one of the main precepts of diplomacy: always tell the truth, but never tell the whole truth. In the situation of Prescription, the whole truth is that doctor and patient participate in the procedure of prescription of a lethal dose of medication the patient can self-administer later. In that situation, the intention of the patient who is getting the prescription might well be not to die but to attain peace of mind by virtue of the knowledge that she is now in control of her life. And while *if* the patient decides to take the lethal drug to end her life, she certainly intends her death, she does not necessarily have “the specific intent to end [her] own life” when asking for the prescription. Here again we see that the application of the Doctrine of double-effect brings into focus only the patient's death. The reality of the right to die is more complex than this application of the Doctrine suggests.

The Doctrine, however, does seem to do a good job in distinguishing between two other forms of the right to die: Injection and Sedation.¹¹⁷ Indeed, in the situation of Injection (i.e., voluntary active euthanasia) the doctor both intends and foresees the patient's death; in the case of Sedation (i.e., palliative care hastening death), the doctor might foresee the death of her patient that can occur as a result of aggressive pain control therapy, but not necessarily intend it. Unlike in the situation of Withdrawal, where withdrawal of treatment and the patient's death are related as cause and effect, palliative care does not always result in the death of the patient. Therefore, in the context of Sedation it is plausible to intend alleviation of the patient's suffering without necessarily

¹¹⁴ *Vacco*, 521 U.S. at 807 n.11.

¹¹⁵ See generally WILLIAMS, *supra* note 18.

¹¹⁶ *Vacco*, 521 U.S. at 802.

¹¹⁷ *Id.* at 807, n. 11.

intending the patient's death.

In sum, it is fair to say that the courts' approach to intention was mostly epistemically unsatisfactory. The courts applied the Doctrine of double-effect to Withdrawal, but that application was misguided. Then the Supreme Court explicitly applied the same Doctrine to Prescription—but effectively failed to do so and instead implicitly adopted the rival approach (the one that treats both purpose or desire and foresight as intention). Finally, the Supreme Court did apply the Doctrine of double-effect to Injection and Sedation in an epistemologically justifiable fashion. This inconsistency resulted in an imaginary right to die universe, which is full of legal fictions about what action or inaction causes death and about what the doctors and their patients intend in different end-of-life contexts.

The table below presents those fictions in a succinct form. In the next and final section of this part of the essay, I shall address (1) why the courts were so adamant to maintain these fictions instead of embracing reality and (2) how those fictions relate to the doctrine of the right to die that I discussed in Part I.

Table 1. Legal Fictions of Causation and Intention in the Right to Die

Issue	Fiction	Reality
Causation	In Withdrawal, the patient dies from the underlying pathology.	In Withdrawal, the patient dies from the underlying pathology as well as the withdrawal and withholding of life-saving treatment.
	Withdrawal is “letting die,” whereas Prescription and Injection are “killing.”	All three methods involve the doctor's action (withdrawing treatment, prescribing the lethal drug, administering the lethal drug). Both Withdrawal and Injection involve the doctor's inaction too (withholding treatment, not administering the antidote).
Intention	In Withdrawal, the patient does not intend to die.	In Withdrawal, the patient may well intend death as the means to end her suffering.
	In Withdrawal, the doctor intends to discontinue the unwanted treatment and does not intend the patient's death.	In Withdrawal, the doctor may well be motivated by patient's suffering and expressed wish to die and, therefore, intend the patient's death as a result of withdrawal of life-saving treatment.
	In Prescription, the patient intends to die.	In Prescription, the patient intends to die if she decides to take the lethal medication. At the moment of prescription, the patient may well intend to attain peace of mind from the feeling of control over her life.

	In Prescription, the doctor intends the patient's death.	In Prescription, the doctor intends to enable the patient to make a final choice between life and death and may intend the patient's death only under some circumstances.
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C. The Utility of Legal Fictions about Causation and Intention

In his seminal book *Legal Fictions*,¹¹⁸ Lon Fuller defined a legal fiction as a “false statement recognized as having utility.”¹¹⁹ By utility, Fuller meant the reconciliation of “a specific legal result with some premise or postulate.”¹²⁰ Fuller also argued that a fiction in law has the purpose of avoiding either “the consequences of an existing, specific rule of law,” or “the implications . . . of some unexpressed and rather general and vague principle of jurisprudence and morals.”¹²¹ In what follows, I shall use this analytical framework to answer the question of what utility the legal fictions about intention and causation served in the state courts’ and the Supreme Court’s decisions on the right to die.

One obvious answer to this question is that by invoking the legal fictions about causation and intention, the courts sought to distinguish the doctors’ conduct in Withdrawal from that in assisting suicide, which was criminalized in many states when Withdrawal cases were decided.¹²² In this respect, the legal fictions served the purpose of avoiding criminal liability for doctors who effectively helped their patients terminate their own lives. The state judiciary was apparently moved by the dire situation of the plaintiffs who sought Withdrawal and therefore was reluctant to apply the aiding and abetting suicide statutes in Withdrawal cases.¹²³ Relying on the idea of quality of life and legal fictions about intention and causation, the state judges (and then the Supreme Court Justices) distinguished between suicide and refusal of treatment, thereby granting the right to Withdrawal common-law and constitutional protections.

That approach (distinguishing between suicide and Withdrawal without disturbing the existing criminal statutes, rather than inventing a new rule of criminal liability) was also desirable from the institutional competence perspective. By adopting that approach, the judiciary could plausibly argue that they did not interfere with legislative prerogatives, but rather merely interpreted the facts of the cases and decided which statute applied to those facts. The fiction about intention also looked good from the formal administrability perspective: instead of detailed fact-finding about

¹¹⁸ LON L. FULLER, *LEGAL FICTIONS* (1967).

¹¹⁹ *Id.* at 9.

¹²⁰ *Id.* at 51.

¹²¹ *Id.* at 53.

¹²² For example, had the Supreme Court of New Jersey not distinguished between Withdrawal and assisting suicide in the *Quinlan* case and subsequent case law, the doctors withdrawing and withholding life-saving treatment from their patients would have been subject to criminal liability under the state statute. N.J. REV. STAT. § 2C:11-6 (2013) (“A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.”).

¹²³ *See, e.g., Bouvia*, 179 Cal. App. 3d at 1143 (“It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure for ‘15 to 20 years.’ We cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone.”).

what the actual intention of the patient was, the courts could declare that she intended to terminate the treatment, not her life.

Finally, the legal fictions could arguably contribute to a more desirable regime of the right to die from a broad social perspective. It could be argued that the regime permitting Withdrawal but prohibiting Injection and (in most states) Prescription is good for the vulnerable groups (the elderly, the poor, racial and ethnic minorities, people with disabilities) and for the medical profession. The vulnerable groups are not victims of doctors who prefer killing their patients instead of suggesting other available treatment options to them, while the doctors' medical integrity is left intact, as they remain "healers, not killers." Furthermore, the prohibition of Prescription and Injection arguably lowers the chances of end-of-life decisions being made under undue influence from the patients' relatives and other parties who could profit from their death (because fewer such decisions are made). Relatedly, the legal fictions also serve the purpose of avoiding a "slippery slope" from Withdrawal to Prescription and Injection to contra-voluntary euthanasia.¹²⁴

The utility of legal fictions about causation and intention, however, should be measured by their benefits and costs. And the latter, I submit, significantly outweigh the former. First, the state courts' idea of "natural death" and the relevant account of causation are hard to administer, as they make sense only in the situations where the patient's medical condition and prognosis are certain about the imminence of the end of the patient's life. However, the medical prognosis for any given patient can be very indeterminate, especially in the end-of-life cases where the right to die is implicated. Therefore, the identical conduct of doctors treating different patients with different prognoses, or even with respect to the same patient whose prognosis can differ at various stages of her medical condition, can be labeled as either "allowing natural death" or as "euthanasia." This requires the judges to engage in very specific and detailed fact-finding in each case where Withdrawal is involved. Given that the results of that inquiry can change over the course of litigation (as the patient's condition can change), the rule is hard (if at all possible) to administer.

Second, the approach taken by the courts to describe causation and intention was vividly reflective of a particular moral perspective—one that prohibits the intentional taking of innocent human lives, approves the Doctrine of double-effect, distinguishes between ordinary and extraordinary treatment, and insists that the patient dies from the underlying condition, not from the fact that life-saving treatment was withdrawn from her. That moral perspective is strikingly similar to the ethical teachings of some of the Judeo-Christian religious traditions and certain types of virtue ethics (e.g., the new natural law theory) with their account of basic human goods (for example, the good of human life).¹²⁵ Earlier I mentioned that the courts' (and then the legislatures') insistence on the objective criterion of quality of life when doing the balancing of the patients' rights against the state's interests gave their pronouncements an impartial tone. The legal fictions about intention and causation with their very distinct moral flavor run afoul of that impartiality, making the courts the proponents of a particular moral (and perhaps religious) view. That, in turn, undermines the authority of the courts as impartial decision-makers.

Third, and related to the previous point, the legal fictions that were once used in connection with the idea of quality of life in Withdrawal cases are now applied independently to Prescription

¹²⁴ See, e.g., *Washington v. Glucksberg*, 521 U.S. at 732 ("[T]he State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia."). I use the term "contra-voluntary" for a situation where euthanasia is performed against the patient's wishes.

¹²⁵ See *supra* notes 30 and 32 and accompanying text. See also JOHN FINNIS, *NATURAL LAW & NATURAL RIGHTS* 86 (2d ed. 2011).

and Injection scenarios, putting the initial balancing of different interests on its head. As noted above, in Withdrawal cases the courts first assessed the quality of life (invoking fictions about causation and intention in the process) and then enforced either the patient's rights or state interests. In Prescription (where it is forbidden) and Injection, there is no assessment of quality of life at all; no matter how bad the medical condition of the patient is, state interests in preservation of life, etc., always trump patients' rights. This result also seems motivated, to use Fuller's expression, by the "unexpressed and general principle" of the moral theory mentioned earlier. At the same time, it seems that a more delicate balancing is desirable in such a sensitive area as end-of-life decision-making, as the experience of China, to which I shall turn in the next part of this essay, suggests.

Also, the same "unexpressed and general principle of morals" and the legal fictions it invokes effectively draw the line between terminal patients who are dependent on life-saving treatment (who can execute the right to die) and terminal patients who are not dependent on life support (who have to wait until their bodies collapse naturally). That distinction strikes many as arbitrary and unwarranted, further undermining the authority of the courts and legislatures that endorse it and provoking further debates about the reasonableness of the regulations on the right to die.

Fourth, the argument about the negative effects of legalizing Prescription and Injection is probably overstated. To begin with, there is no data suggesting that people's trust in medicine in those states where Prescription was legalized has diminished since legalization. The negative impact of legalization of Prescription on socially disadvantaged groups is also largely speculative. As the data from Oregon and Washington demonstrates, the patients who have received prescriptions for lethal drugs in those states are predominantly white, well-educated, and insured.¹²⁶ At the same time, most of them are aged sixty-five years or older,¹²⁷ which might suggest that Prescription mostly targets older patients, but could also indicate that it is terminal diseases that target those patients, not the doctors. With respect to the patients being manipulated into making a decision to end their lives, there may well be situations where the request for Prescription (or Injection) is not fully voluntary, or where the competence of the patient has not been estimated properly. The same concerns, however, also arise in the context of Withdrawal that has been legalized, and it is unreasonable to erect procedural safeguards protecting the autonomy of the patients refusing life-saving medical treatment while claiming that those safeguards cannot be put in place (or will be ineffective) in the case of Prescription and Injection.

Finally, the causation and intention-based distinctions between Withdrawal and Prescription that the Supreme Court relied on in *Vacco* now seem obsolete in light of the Court's recent decision in *Obergefell v. Hodges*.¹²⁸ As the *Obergefell* Court's bare majority explained, there is a close "relation between liberty and equality."¹²⁹ One of the instances where this relation was clear was the pair of the right to die cases, *Glucksberg* and *Vacco*, where the Court was deciding on

¹²⁶ See, e.g., *Oregon Death with Dignity Act: 2015 Data Summary*, *supra* note 90 (reporting that "of the 132 deaths [from Prescription] during 2015, most patients (78.0%) were aged 65 years or older. The median age at death was 73 years. As in previous years, decedents were commonly white (93.1%) and well-educated (43.1% had a least a baccalaureate degree). . . . Excluding unknown cases, most (99.2%) had some form of health care insurance, although the percent of patients who had private insurance (36.7%) was lower in 2015 than in previous years (60.2%). The number of patients who had only Medicare or Medicaid insurance was higher than in previous years (62.5% compared to 38.3%).").

¹²⁷ *Id.*

¹²⁸ 135 S. Ct. 2584 (2015).

¹²⁹ *Id.* at 2604.

the due process and equal protection aspects of Prescription, respectively. The arguments of the two cases were intertwined: in order to exclude Prescription from the “history and tradition” of end-of-life decision-making in Withdrawal in *Glucksberg*,¹³⁰ the Court distinguished Prescription from Withdrawal in *Vacco* using legal fictions about intention and causation.¹³¹ In other words, the Court’s holding in *Vacco* that Prescription is different from Withdrawal was instrumental to the Court’s holding in *Glucksberg* that Prescription should not enjoy the same legal status as Withdrawal. After the criticisms of *Glucksberg* voiced by the Court in *Obergefell*,¹³² however, the distinction between Withdrawal and Prescription drawn in *Vacco* becomes unnecessary: if the Court does not have to rely on history and traditions to find a substantive due process right to Prescription, then it is immaterial that the *Vacco*’s reasoning excludes Prescription from the history and tradition of the United States.

All this demonstrates, I think, that the legal fictions about causation and intention in the right to die context have outlived their usefulness: the benefits they confer are no longer greater than the costs they produce, and it would be rational to get rid of them. What could the implications of that approach be? In the next and final part of this essay I shall examine two countries where the courts decided not to rely on legal fictions to distinguish between different forms of the right to die. I further discuss how their experiences could be of use in the United States and offer some practical suggestions on how the courts and legislatures could move forward after abolishing legal fictions about intention and causation in the context of the right to die.

III. THE PRESENT AND THE FUTURE OF THE RIGHT TO DIE: CANADA, CHINA, AND THE UNITED STATES

The first two sections of part III bring a comparative perspective into my analysis and use the examples of Canada and China to demonstrate how the courts in those countries developed the doctrine of the right to die without legal fictions about causation and intention. The third section discusses how those strategies could be applied in U.S. courts and legislatures and suggests several ways that the norms on right to die could develop in the future.

A. Medical Assistance in Dying in Canada

As I mentioned in the Introduction, in the summer of 2016 the Canadian Parliament passed a bill legalizing medical assistance in dying.¹³³ That law allows physicians and nurse practitioners to prescribe or administer lethal doses of medication to their patients so that the latter can exercise their right to die.¹³⁴ The law was passed pursuant to the landmark decision of the Supreme Court of

¹³⁰ *Glucksberg*, 521 U.S. at 721.

¹³¹ *Vacco*, 521 U.S. at 801.

¹³² *Obergefell*, 135 S. Ct. at 2602 (“*Glucksberg* did insist that liberty under the Due Process Clause must be defined in a most circumscribed manner, with central reference to specific historical practices. Yet while that approach *may have been appropriate for the asserted right there involved (physician-assisted suicide)*, it is inconsistent with the approach this Court has used in discussing other fundamental rights, including marriage and intimacy.”) (emphasis added).

¹³³ An Act to Amend the Criminal Code and to Make Related Amendments to Other Acts (Medical Assistance in Dying), S.C. 2016, c 3 (Can.).

¹³⁴ *Id.*

Canada—*Carter v. Canada (Attorney General)*¹³⁵—which found the criminal prohibition of physician-assisted death for qualifying patients void and gave the Parliament “the opportunity to craft the appropriate remedy.” The Parliament failed to do so within a one-year period specified by the court, so the latter had to extend the grace period for six months. The law differs from the *Carter* decision in several important ways¹³⁶ and in those respects arguably replaces the rules set forth by the Supreme Court. But for the purposes of this essay I will focus on the Supreme Court’s reasoning in *Carter*, as it provides ample evidence to trace the way the court dealt with the problem of the right to die, including the issues of intention and causation.

Doctrinally, the issue before the Supreme Court was whether a criminal prohibition of physician-assisted dying (implied from a broader criminal prohibition against counseling, aiding, and abetting suicide) violated sections one and seven of the constitutional document called the Canadian Charter of Rights and Freedoms.¹³⁷ Section one provides that the Charter “guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”¹³⁸ Under section seven, “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.”¹³⁹

The Supreme Court first examined the prohibition of physician-assisted dying under the provisions of section seven and came to the conclusion that the rule in question did deprive the plaintiffs¹⁴⁰ of their right to life, liberty, and security of the person.¹⁴¹ The court opined that the governmental regulation violated their right to life because it effectively coerced the plaintiffs to make a “cruel” choice between ending their lives while they still could by committing suicide or waiting until their bodies deteriorate and collapse from the progression of their pathologies.¹⁴² The court also found that the prohibition violated the rights to liberty and security of the person because it interfered with “[a]n individual’s response to a grievous and irremediable medical condition [which] is a matter critical to their dignity and autonomy.”¹⁴³

Under its section seven analysis, the court also held that those deprivations of the right to life, liberty, and security of the person were not in accordance with the principles of fundamental justice because of their overbreadth.¹⁴⁴ The court reached that conclusion when comparing the

¹³⁵ 2015 SCC 5.

¹³⁶ For a discussion of discrepancies between the *Carter* decision and the enacted Bill C-14 and the constitutional challenges they might bring about, see Konstantin Tretyakov & I. Glenn Cohen, *Medical Assistance in Dying and “Suicide Tourism” to Canada: Bill C-14 from Comparative Perspective*, [Open Volume] J. ETHICS IN MENTAL HEALTH (2016), http://www.jemh.ca/issues/open/documents/JEMH_Open-Volume_Benchmark_Medical_Assistance_in_Dying_And_Suicide_Tourism_July2016.pdf. [<https://perma.cc/WFJ6-D6RE>].

¹³⁷ Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act, 1982, c 11 (U.K.).

¹³⁸ *Id.* § 1.

¹³⁹ *Id.* § 7.

¹⁴⁰ The plaintiffs in *Carter* included patients with terminal (amyotrophic lateral sclerosis) and non-terminal (spinal stenosis) conditions. *Carter*, 2015 SCC 5, at paras. 11, 17.

¹⁴¹ *Id.* at para. 70.

¹⁴² *Id.* at para. 1.

¹⁴³ *Id.* at para. 66.

¹⁴⁴ *Id.* at para. 86.

objective of the rule in question (protection of the vulnerable)¹⁴⁵ with the scope of the rule itself (blanket prohibition against any physician-assisted death). The court opined that since the prohibition applied not only to “vulnerable persons . . . being induced to commit suicide at a moment of weakness,” but also to “people with disabilities who have a considered, rational and persistent wish to end their own lives,” it was overbroad.¹⁴⁶

Having determined that the prohibition of physician-assisted death violated section seven, the court proceeded to section one, which would allow abridgments of certain rights “to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”¹⁴⁷ Under section one, the court applied what can be called the Canadian counterpart to the U.S. strict scrutiny test¹⁴⁸ (both in terms of its doctrinal components and fatality to the scrutinized legislation). In order to survive section one analysis, the law must have a pressing and substantive objective (the prohibition satisfied this prong of the test) and its means to reach that objective must be proportionate to it. The court defined proportionate as rationally connected to the objective, minimally impairing on the right in question, and proportionate in terms of “deleterious and salutary effects of the law”.¹⁴⁹ The prohibition in question failed the second leg of the second prong of the test: the court held that a blanket prohibition was not minimally impairing in light of the evidence from other jurisdictions where more “complex regulatory responses” were put in place and the system of safeguards protected the vulnerable from being abused.¹⁵⁰ Having reached that conclusion, the court declared the prohibition void.¹⁵¹

The *Carter* opinion did not come out of the blue. To the contrary, it was a result of decades of doctrinal development, including several prominent cases about Withdrawal¹⁵² and a case on physician-assisted dying where a divided court reached an opinion¹⁵³ that was opposite to, and would be overruled by, a unanimous court in *Carter*. Those earlier opinions where the Justices dealt with the issues of Withdrawal, Prescription, Injection, and Sedation discussed the issues of intention and causation at varying length. For example, in *Nancy B.* the court cast the issue of causation in the context of Withdrawal in the familiar terms of “natural death.” Specifically, the court noted that “[w]hat [the patient] is seeking, relying on the principle of personal autonomy and her right of self-determination, is that *the respiratory support treatment being given [to] her cease so that nature may take its course* In order to do this, as she is unable to do it herself she needs the help of a third person. Then, *it is the disease which will take its natural course.*”¹⁵⁴ In *Rodriguez*, the majority

¹⁴⁵ *Id.* at paras. 73-74.

¹⁴⁶ *Id.* at para. 86.

¹⁴⁷ Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, *being* Schedule B to the Canada Act, 1982, c 11 (U.K.).

¹⁴⁸ As some authors have noted, “[t]he [United States Supreme] Court’s most common articulations of strict scrutiny are that the state must show its action is necessary to further a compelling state interest or that its action is narrowly tailored to further a compelling state interest.” Roy G. Spece, Jr. & David Yokum, *Scrutinizing Strict Scrutiny*, 40 VT. L. REV. 285, 295 (2015).

¹⁴⁹ *Carter*, [2015] SCC 5 (Can.), para. 94.

¹⁵⁰ *Id.* at paras. 98, 104, 106, 107, 121.

¹⁵¹ *Id.* at paras. 121-122.

¹⁵² *See, e.g.*, *Nancy B. v. Hôtel Dieu de Québec* [1992], 86 D.L.R. 4th 385 (Can. Que. Sup. Ct.); *Malette v. Shulman* (1990), 67 D.L.R. 4th 321 (Can. Ont. C.A.).

¹⁵³ *Rodriguez v. British Columbia (Att’y General)*, [1993] 3 S.C.R. 519 (Can.).

¹⁵⁴ *Nancy B.*, 86 D.L.R. at 392 (emphasis added).

framed the problem of intention as follows: “[T]he distinction drawn here is one based upon intention—in the case of palliative care the intention is to ease pain, which has the effect of hastening death, while in the case of assisted suicide, the intention is undeniably to cause death.”¹⁵⁵

These examples make clear that in the pre-*Carter* era the Canadian judiciary relied on the legal fictions about intention and causation, just as their colleagues in the United States keep doing to this day. The *Carter* court, however, declined to follow this familiar doctrinal track. Instead, the court was silent on the issue of causation and reticent on the intention component of physician-assisted dying. The court touched upon the latter only when accepting the definition of physician-assisted death suggested by the plaintiffs: “[T]he situation where a physician provides or administers medication that *intentionally* brings about the patient’s death, at the request of the patient.”¹⁵⁶ This indicates, I believe, the court’s view that both desire (purpose) and foresight qualify as intention, which in turn implies the court’s rejection of the Doctrine of double effect (since under the Doctrine, in Prescription a physician may foresee the patient’s death but not necessarily intend it).

This conclusion about the court’s approach to intention in the right to die context is further supported by another feature of the *Carter* opinion: its consequentialist orientation when it comes to different legal approaches to the right to die. In particular, the court did not voice any disagreement with the finding of a lower court judge who “found that the ‘preponderance of the evidence from ethicists is that *there is no ethical distinction between physician-assisted death and other end-of-life practices whose outcome is highly likely to be death.*’”¹⁵⁷ Furthermore, the court affirmatively spoke along the same lines:

An individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. *The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician’s assistance in dying.* This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus trenches on liberty. . . . Logically speaking, *there is no reason to think that the injured, ill and disabled who have the option to refuse or to request withdrawal of lifesaving or life-sustaining treatment, or who seek palliative sedation, are less vulnerable or less susceptible to biased decision-making than those who might seek more active assistance in dying.* The risks [associated with the legalization of Prescription and Injection] that Canada describes are already part and parcel of our medical system.¹⁵⁸

In other words, the court was reluctant to draw a line between Withdrawal and Sedation on the one hand, and Prescription and Injection on the other hand. That reluctance, I think, was at least in some part motivated by the court’s rejection of legal fictions about intention and causation, which the court’s previous decisions had embraced. The court’s abandonment of those fictions was also crucial to resolving the issue of whether the blanket prohibition on Prescription and Injection

¹⁵⁵ Rodriguez, [1993] 3 S.C.R. at 607.

¹⁵⁶ Carter, [2015] SCC, para. 40 (emphasis added).

¹⁵⁷ *Id.* at para. 23 (emphasis added).

¹⁵⁸ *Id.* at paras. 66, 115 (emphasis added).

was minimally impairing plaintiffs' rights. This issue, as the court put it, lay "at the heart of [the *Carter*] case" and was resolved with reference to evidence of different regimes of the right to die in Canada and other countries.¹⁵⁹ The rejection of legal fictions allowed the court to draw parallels between the different forms of the right to die and conclude that as long as Withdrawal and Sedation were legal and as long as the safeguards protecting the vulnerable worked in those situations, it made no logical or practical sense to prohibit Prescription and Injection. That conclusion would have been impossible had the court clung to legal fictions purportedly distinguishing between different forms of the right to die.

While Canadian constitutional law can be of limited guidance in the United States, I believe *Carter* is still instructive. As I mentioned earlier, the section one analysis applied by the Canadian Supreme Court looks strikingly similar to the strict scrutiny test used in the United States. And if the United States Supreme Court decides to hear another case about Prescription after having shaken off the limitations imposed by the *Glucksberg* history and tradition test and apply strict scrutiny, *Carter* could be indicative of the thrust of the Court's analysis.¹⁶⁰

The Canadian example demonstrates what happens to the regime of the right to die when legal fictions about intention and causation are abandoned: it becomes consistent. Now, let us turn to a different part of the world to see how the rejection of legal fictions played out there.

B. Withdrawal and Sedation with Intention to Cause Death in China

Exploring Chinese approaches to the right to die can be a difficult task, for both the doctrinal underpinnings of the right in question and the practices of its implementation are very different from those in the United States and Canada. Furthermore, the regulations of the right to die are much less certain than in many Western countries. Therefore, the Chinese approach does not so readily present available parallels to the situation in the United States as the Canadian approach does. At the same time, Chinese views on the right to die can still be instructive for the U.S. audience, as they help both to flesh out the problem of legal fictions and to illuminate the importance of the doctrinal elements of the right to die and their careful balancing.

In what follows I shall analyze the Chinese doctrine of informed consent and a corresponding doctrine of the right to refuse life-saving medical treatment in terms of their statutory and regulatory content, central premises (including causation and intention), and application by the people's courts in China. Then I shall demonstrate how the moral and legal premises of the doctrines of informed consent and Withdrawal found their application in the first (and thus far the only) "euthanasia" court case in China.

1. Withdrawal

In China the concept of Withdrawal originates from the patient's right of informed consent and the corresponding right to refuse medical treatment. The legal pedigree of these rights in China,

¹⁵⁹ *Id.* at para. 104.

¹⁶⁰ It is relevant to note here that one of the reasons why the Canadian Supreme Court upheld the decision of a trial court judge that cut against the case law of that time was that "[t]he argument before the trial judge invoked a different legal conception of [section seven] than that prevailing when [the previous case] was decided." *Carter*, 2015 SCC 5, para. 46. It would not be too farfetched to imagine that the Supreme Court might decide to hear the right to die case because the "legal conception" of substantive due process spelled out in *Glucksberg* has changed since *Obergefell*.

however, seems much less robust than in the United States, as they are mostly statutory and regulatory constructs that have been developing in the Chinese law since the early 1990s.

In China, the provisions on the right of informed consent (from which the right to refuse treatment can be deduced)¹⁶¹ can be found in statutes and regulations about the medical profession, including Law on Tort Liability, Law on Practicing Doctors, Rules on Handling Medical Accidents,¹⁶² Rules on Management of Medical Institutions,¹⁶³ and Enforcement Rules for the Rules of Management of Medical Institutions.¹⁶⁴

In addition to these acts, there are also several laws and regulations that provide for the involuntary medical treatment of certain groups of patients, including the Law on Prevention and Treatment of Infectious Diseases¹⁶⁵ and Mental Health Law.¹⁶⁶ I do not address these two laws, not because their provisions are less important, but rather because they concern special categories of patients and do not give a general picture of the law of informed consent in China.

The rules in the general documents on informed consent are somewhat vague and in part contradictory. For example, while some of the documents refer to “the patient’s consent” (患者同意, *huànzhě tóngyì*),¹⁶⁷ other documents suggest more strongly that the patient’s consent must be informed (知情同意, *zhīqíng tóngyì*).¹⁶⁸ The documents also specify the doctor’s duty to obtain

¹⁶¹ While the norms regulating the patient’s privacy (隐私, *yǐnsī*) can also be found in Chinese law, the idea of privacy in China seems much less robust than in the United States and primarily encompasses the confidentiality of the patient’s records. See *Zhiye Yishi Fa* (执业医师法), [Law on Practicing Doctors of the People’s Republic of China] (promulgated by the Standing Comm. of the Nat’l People’s Cong., Jun. 26, 1998, effective May 1, 1999) [hereinafter “Law on Practicing Doctors”], arts. 22.3, 37.9; *Qinquan Zeren Fa* (侵权责任法) [Law on Tort Liability] (promulgated by the Standing Comm. of the Nat’l People’s Cong., Dec. 26, 2009, effective Jul. 1, 2010) [hereinafter “Law on Tort Liability”], art. 2. See also *Guanyu Shenli Yuliao Sunhai Zeren Jiufen Anjian Shiyong Falü de Jieshi* (关于审理医疗损害责任纠纷案件适用法律若干问题的解释) [Interpretation on the Applicable Law in Cases of Handling Medical Damages Liability Disputes] (Sup. People’s Ct. Dec. 23, 2012), para. 35, <http://china.findlaw.cn/yiliao/ylsgql/yiliaochulifagui/1110214.html> (discussing the patient’s privacy in the context of the doctors’ duty to preserve their patients’ personal data).

¹⁶² *Yiliao Shigu Chuli Tiaoli* (医疗事故处理条例) [Rules on Handling Medical Accidents] (promulgated by the St. Council, Feb. 20, 2002, effective Sept. 1, 2002), PEKING UNIV. CTR. FOR LEGAL INFORMATION, <http://en.pkulaw.cn.pennlaw.idm.oclc.org/display.aspx?id=2276&lib=law&SearchKeyword=medical%20accidents&SearchCKeyword=> (hereinafter “Rules on Handling Medical Accidents”) (China).

¹⁶³ *Yiliao Jigou Guanli Tiaoli* (医疗机构管理条例) [Rules on Management of Medical Institutions] (promulgated by the St. Council, Feb. 26, 1994, effective Sept. 1, 1994), PEKING UNIV. CTR. FOR LEGAL INFORMATION [hereinafter “Rules on Management”] (China).

¹⁶⁴ *Yiliao Jigou Guanli Tiaoli Shishi Xize* (医疗机构管理条例实施细则) [Enforcement Rules for the Rules of Management of Medical Institutions] (promulgated by the Ministry of Health, Aug. 29, 1994, effective Sept. 1, 1994; rev’d by the Ministry of Health, Nov. 1, 2006), PEKING UNIV. CTR. FOR LEGAL INFORMATION [hereinafter “Enforcement Rules”] (China).

¹⁶⁵ *Chuanranbing Fangzhi Fa* (传染病防治法) [Law on Prevention and Treatment of Infectious Diseases] (promulgated by the Standing Comm. Nat’l People’s Cong., Aug. 28, 2004, effective Dec. 1, 2004), art. 39(3) (specifying that the organs of public security can assist medical institutions in enforcing the quarantine medical treatment on patients not complying with the terms of quarantine), PEKING UNIV. CTR. FOR LEGAL INFORMATION (China).

¹⁶⁶ *Jingshen Weisheng Fa* (精神卫生法) [Mental Health Law] (promulgated by the Standing Comm. Nat’l People’s Cong., Oct. 26, 2012, effective May 1, 2013), art. 28, 35 (providing for contra-voluntary diagnosis and treatment of mentally ill patients), PEKING UNIV. CTR. FOR LEGAL INFORMATION (China).

¹⁶⁷ Rules on Management, art. 33.

¹⁶⁸ Law on Practicing Doctors, art. 26; Law on Tort Liability, art. 55.

consent from their patients and/or their family members for certain (but not all) kinds of treatment, but the list of types of treatment for which consent is required differs between statutes and regulations.¹⁶⁹ Finally, while some documents state that doctors must rescue patients in critical condition without their consent or consent from family members,¹⁷⁰ a more recent statute provides that there is no such duty.¹⁷¹

Despite these discrepancies, several common characteristics of the Chinese regime of informed consent can be discerned from these statutes and regulations. First, the patient's "right" of informed consent (and the corresponding right to refuse medical treatment) apparently exists in China, although it finds no direct stipulation in the black letter of the Chinese law. Instead, the Chinese statutes and regulations speak of the doctors' duty to obtain consent (informed or not) from their patients and/or their family members. A violation of that duty results in tort, disciplinary, or administrative liability of doctors and medical institutions. Some examples demonstrate that the hospitals and the people's courts in China construe this duty formally with little regard to the patients' best interests. A pertinent example here is the case of Xiao Zhijun (肖志军), who refused to give written consent for caesarian section surgery on behalf of his wife. The hospital did not perform the surgery, and both the woman and her fetus died.¹⁷² This case, which occurred in 2007, provoked social debates of wide magnitude, and many blamed the hospital for its formalistic approach to patient's consent. Nevertheless, the authorities stated that the hospital's inaction was lawful.¹⁷³

Second, the patient's right to choose the course of her treatment or to refuse it is subject to the wider discretion of physicians and the patient's family members, who can conceal information from the patient in order not to hurt her and make decisions about the treatment behind her back. The laws and regulations also frequently mention the duty to obtain the patient's consent together with the duty not to harm the patient by disclosing relevant information. All this leads to significant abridgments of the patient's autonomy in medical decision-making. A pertinent example here comes from the province of Guangzhou, where a woman was in active labor but refused to grant consent for a caesarian section. The doctors consulted her family members who gave their consent on the surgery. The fetus died, but the woman survived, and the doctors were not held liable for the

¹⁶⁹ Rules of Management, art. 33 (stating that the patient's consent is required for surgeries, special tests, and special treatments); Law on Practicing Doctors, art. 26 (requiring the patient's consent for experimental clinical treatment). The term "special tests and special treatments" is defined in Enforcement Rules, *supra* note 164, art. 88 (defining special tests or treatments as diagnostic or treatment activities that have one of the following characteristics: (1) present a certain risk for the patient and are capable of producing negative effects in general; (2) present a certain risk for the patient and are capable of producing negative effects because of the patient's bodily characteristics or life-threatening condition; (3) experimental clinical treatment and examination; (4) examinations and treatments that can produce a considerable economic impact upon the patient).

¹⁷⁰ Law on Practicing Doctors, art. 24; Rules on Management, art. 31.

¹⁷¹ Law on Tort Liability, art. 56.

¹⁷² Gao Yandong (高艳东), Xiao Zhijun An Zhong de Xingfa Nanti he Jiazhi Quxiang—Byzuowei, Yinguo Guanxi yu Jianjie Guyi zhi Xinjie (肖志军案中的刑法难题和价值取向——不作为、因果关系与间接故意之新界) [Difficult Criminal Issues and Value Judgments of the Xiao Zhijun Case—The New Definitions of Inaction, Causal Relation, and Indirect Malus], 10 J. SW. U. POL. SCI. & L. 88 (2008) [<https://perma.cc/BH7C-3VTM>].

¹⁷³ Xiao Zhijun An Sifa Jianding Jieguo Gongbu. Huanzhe Siwang yu Yiyuan Wuguan (肖志军案司法鉴定结果公布 患者死亡与医院无关) [The Results of Judicial Expertise of the Xiao Zhijun Case Published: No Link between the Patient's Death and the Hospital], CCTV.COM, Jun. 5, 2009, <http://news.cctv.com/china/20090605/100482.shtml>.

treatment they performed against the patient's wishes.¹⁷⁴ Studies undertaken by several authors¹⁷⁵ also demonstrate that doctors and nurses working in intensive care units do not disclose the truth about diagnosis and prognosis to their patients out of concerns about their well-being (consequentialism) and instead defer to the patient's families to make decisions about treatment.¹⁷⁶

Third, a patient's consent is required only for certain types of medical procedures. The list of medical interventions requiring the patient's (and her family's) consent drawn up by the Ministry of Health may be broad, but it is still a list—and not, for example, a blanket disposition to the effect that informed consent is required in all situations unless specified otherwise. With respect to Withdrawal, it is unclear whether life-sustaining medical treatments (such as putting the patient on a ventilator or inserting a nasogastric tube into a patient's body) are within the list of medical interventions that require consent, although it seems likely that they are: life-saving treatment is costly and, if not covered by insurance, can be a significant economic burden to patients and their families.

The doctrine of Withdrawal that emerges from these rules and the practice of their implementation differs significantly from its U.S. counterpart. First, the autonomy of the patient (and her corresponding right) has a much weaker presence in the doctrine. In fact, the will of the patient regarding her treatment (or refusing it) may well be overridden by the will of her family members. Furthermore, the doctor's orientation toward the patient's family in the medical decision-making process often leaves the patient unaware of her current condition and further impedes her autonomous decision-making.

Second, the thrust of the Chinese doctrine of informed consent (and a corresponding doctrine of Withdrawal) seems to be more consequentialist than in the United States. This is apparent from (1) the types of treatment for which the patient's (or her family's) consent is required (the kinds of treatment that are likely to produce significant impact on the patient's and/or her family's physical, emotional, or financial well-being) and (2) the protective orientation of informed consent rules meant not to harm the patients by disclosing certain sensitive information to them. Furthermore, the very idea of informed consent in China emerges in the context of liability of the doctors and medical institutions; in other words, the basis of the need for consent is not so much the patient's right as the negative consequences that medical professionals would suffer if they do not obtain consent.

Finally, the doctrine of Withdrawal that can be deduced from the rules on informed consent in the context of civil, administrative, or disciplinary liability necessarily puts emphasis on the issues of intention and causation that are important in imposing that liability. At the same time, as the implementation of the doctrine suggests that if the patients' family members agree on withdrawal of life-saving treatment from their relative, a commencement of a court action to hold the doctor or the hospital liable is unlikely. In the situations when the family is divided on whether the patient should be removed from life support or not, doctors are likely not to discontinue life-saving treatment, as being alive is presumably better for the patient than being dead and doctors are

¹⁷⁴ Yunfu Ju Quanzi, Yuyuan Qiangxing Pougong Jiuming Yin Zhengyi (孕妇拒签字 医院强行剖宫救命 引争议) [A Pregnant Woman Refuses to Give Written Consent, The Hospital's Forced Caesarian Section Causes Controversy], SINA NEWS, Jan. 5, 2011, [<https://perma.cc/A8AY-8GVQ>].

¹⁷⁵ See generally Li Bin Li, *Clinical Review: Ethics and End-of-Life Care for Critically Ill Patients in China*, 17 CRITICAL CARE 244 (2013); Mei-che Samantha Pang, *Protective Truthfulness: The Chinese Way of Safeguarding Patients in Informed Treatment Decisions*, 25 J. MED. ETHICS 25 247 (1999).

¹⁷⁶ Li, *supra* note 175, at 245.

highly unlikely to be held liable for a “wrongful life” of the patient. In the very rare situation when such an issue is presented before the people’s court, the court will likely defer to medical experts on the issue of what caused the death of the patient. The doctor’s intention will likely be construed broadly enough to embrace both purpose (desire) and foresight, which is in line with the consequentialist notion of intentionality.¹⁷⁷

2. “Euthanasia”

There have been several cases in China where the local media reported a death as “euthanasia,” although the deaths arose in non-medical contexts and would be better classified as either murder or aiding and abetting suicide.¹⁷⁸ One case, however, did arise in a doctor–patient relationship (or, as some authors writing about China put it, a “doctor–family–patient relationship”)¹⁷⁹ and is therefore relevant to the discussion of medical aspects of the right to die. The characteristics of the doctrine of informed consent (weaker patient autonomy, wider involvement of the family, and consequentialism) were prominent in that case.

The case came from an intermediate people’s court of Shaanxi province that passed judgment on convictions of two men (a son and doctor) who were accused of murdering a woman (the mother).¹⁸⁰ The mother was admitted to a hospital and diagnosed with liver cirrhosis with ascites, hepatic encephalopathy, and decubital ulcers in terminal stage; the doctors informed the relatives that there was no hope of saving the mother’s life.¹⁸¹ The mother suffered from acute pain and cried that she “wanted to die,”¹⁸² although there is nothing in the case record suggesting that she made an informed choice to terminate her life. The mother’s son repeatedly asked her attending physician to give her some medicine so that she would die without pain.¹⁸³ Having been asked three times, the physician prescribed a 100 milliliter injection of chlorpromazine and promethazine;¹⁸⁴ the woman actually received two injections of this mixture—75 and 100 milliliter—and died

¹⁷⁷ Cf. Bentham, *supra* note 98.

¹⁷⁸ See, e.g., *Chongqing: Erzi Feifa Zhu Muqin “Anlesi” Bei Panxing 3 Nian* (重庆：儿子非法助母亲“安乐死”被判刑3年) [Chongqing: The Son Who Helped Mother with “Euthanasia” Sentenced to 3 Years], 360DOC, Nov. 17, 2012 [https://perma.cc/D7SC-D6TS].

(discussing the case of a son who, following repeated requests of his terminally ill mother to terminate her life, provided her with toxic pesticides which mother ingested and died; the son was sentenced to three years imprisonment); Wang Gang (王钢), *Zishe de Rending ji Qi Xiangguan Xingwei de Xingfa Pingjia* (自杀的认定及其相关行为的刑法评价) [The Criminal Law Perspective on Suicide and Its Related Conduct], 4 FAXUE YANJIU 154, 154 (2012) (discussing the case of a man whose elderly wife was not terminally ill, but was paralyzed and experienced severe pains; following her repeated requests to die [because she did not want to be a burden to her family], the husband provided his wife with pesticides; after the wife took the toxic substance and died, the man was sentenced to three years in prison with a four-year suspension of sentence.).

¹⁷⁹ Pang, *supra* note 175, at 250.

¹⁸⁰ Pu Liansheng Ying Chuiwei Bingren Qinshu Wang Mingchen de Yaoqiu wei Bingren Zhushu Yaowu Cujin Qi Siwang An (蒲连升应危病人亲属王明成的要求为病人注射药物促使其死亡案) [The Case of Pu Liansheng Who Agreed to the Request of Wan Mingcheng, a Relative of a Terminally Ill Patient, to Give an Injection to That Patient and Hasten Her Death], LEXISNEXIS (Shaanxi Province Hanzhong Dist. Interm. People’s Ct., Mar. 25, 1992) (China).

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ *Id.*

fourteen hours after the second one.¹⁸⁵ The case was brought to the local people's court by the state prosecutors, who followed a tip from family members who were unhappy about the mother's death and went after the son (who repeatedly asked for the medication to be prescribed and administered to his mother) and the doctor (who wrote the prescription and supervised the injections made by interns and one other physician).

Initially, it was not clear from the facts of the case whether what happened in Shaanxi province was Injection, Sedation, or natural death: the mother died several hours after the second injection of barbiturates, and it is medically uncertain whether the drugs hastened her death, or were the sole cause of that death, or maybe the woman would have died anyway (with or without the drugs) as her diseases progressed. The lower people's court, before passing its judgment, ordered an expert medical review of the facts of the case; the experts concluded that the main reason for the mother's death was hepatic encephalopathy.¹⁸⁶ The experts further concluded that the prescribed and administered dose of drugs—175 milliliter—was within the normal range and that the barbiturates deepened the mother's state on unconsciousness and hastened her death, but were not the direct cause of death.¹⁸⁷ Accordingly, the case was not about Injection, because the cause of the mother's death was not the two injections. I read this expert opinion to mean that what happened in that case was Sedation—although, from the perspective of intention, a rather peculiar one, because both the doctor and the son were found by the court to have intended the patient's death.

The lower court also refused to treat the Shaanxi case as one of Injection, following direct instructions from the Supreme People's Court.¹⁸⁸ The SPC intervened after a publication in the media drew attention to the case and caused nation-wide debates.¹⁸⁹ Specifically, the SPC advised the lower court that this was a case “of a new kind” and must be decided “carefully” in the absence of statutory regulations.¹⁹⁰ The SPC also ordered the lower court to report the draft of its judgment to the SPC before passing it.¹⁹¹ Later on, when the lower people's court reported the case to the SPC again, the SPC noted that the term “euthanasia” was not defined legally and that the case did not raise the issue of euthanasia. The SPC also ordered the lower court to decide the case based on article 10 (now article 13) of the Chinese Criminal Code, which provides that if the “consequences are obviously minor and the harm is not serious,” certain otherwise criminal conduct does not constitute a crime.¹⁹²

Based on these instructions, the lower people's court acquitted both the son and the doctor.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Wo Guo Shouli 'Anlesi' An Jiemi* (我国首例“安乐死”案解密) [Unveiling the Secrets of China's First “Euthanasia” case], NANFANG DAILY, May 20, 2001, <https://perma.cc/M4MJ-KMRF>. According to the Chinese Constitution, the Supreme People's Court “supervises the administration of justice by the people's courts at various local levels.” XIANFA [CONSTITUTION] art. 127 (1982) (China). One of the methods of this supervision is the official interpretation by the Supreme People's Court of how to specifically apply laws and decrees in judicial process, and one of the forms of this interpretation is an “official reply” (批复, *pīfù*), which the highest court used in this case to guide the lower court.

¹⁸⁹ *Wo Guo Shouli 'Anlesi' An Jiemi*, (我国首例“安乐死”案解密) *supra* note 188.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² *Zhonghua Renmin Gongheguo Xingfa* (中华人民共和国刑法), [Criminal Code of the People's Republic of China] (promulgated by the Nat'l People's Cong., Jul. 7, 1979, as amended through Aug. 29, 2015, effective Nov. 1, 2015), art. 13.

Despite the fact that the mother never made an informed request to end her life and, as the lower court noted, both the son and the doctor intended to terminate the mother's life, the court acquitted them because of the minor circumstances and the non-serious harm of their conduct. The way the intermediate people's court and the Supreme People's Court disposed of this case demonstrates that the Chinese courts were consistent in the application of the central features of the doctrines of informed consent and Withdrawal in end-of-life decision-making: the role of the family, weaker autonomy of the patient, and consequentialism. The court also emphasized intention and causation.

First, with respect to the family and its role in medical decision-making, the doctor, when prescribing injections to his terminal patient, followed the requests of the son who wanted the patient to die without pain; as mentioned earlier, the record does not indicate that the doctor even asked the opinion of the patient (after all, she may have been completely unaware of her true diagnosis and prognosis). At the same time, the people's courts did not find that violation of the patient's autonomy appalling: while the son did affirmatively seek the death of his mother (perhaps against her will), the court still opined about the minor consequences and the absence of serious harm from the son's behavior. This indicates, I believe, the court's acceptance of the decisions that were made on behalf of a competent patient by the member of the patient's family.

Second, intention and causation were also pivotal in that case. With respect to causation, the courts did not venture to deliberate on what the cause of the patient's death was—instead, they deferred to medical experts and their opinion. The same approach will likely prevail in Withdrawal cases, which would also be about civil, disciplinary, or administrative liability of doctors or medical institutions. With respect to intention, the court opined that both the son and the doctor intended to kill the patient. In light of the uncertainty around the cause of the patient's death, this part of the opinion could be read as the court's approval of the notion of intention that includes both desire (purpose) and foresight – the doctor was not sure whether the drug would end his patient's life but likely foresaw it.

Finally, the court's reasoning about minor consequences and non-serious harm is distinctively consequentialist, both in its emphasis on the effects of the suspects' conduct and its disregard of the autonomy of the patient. The court estimated that the woman would have died anyway and concluded that the conduct of the son did not pose a great harm to society. This consequentialist reasoning is epitomized in a theory about the value of life (生命价值, *shēngmìng jiàzhí*), according to which the value of an individual's life is proportionate to the rational capacity of that individual and can be external or internal.¹⁹³ The external value of human life is its value to other people and society in general; the internal value is quality of life.¹⁹⁴ As the quality of lives of terminally ill or profoundly disabled patients or patients in a persistent vegetative state is very low, that reduces the value of their lives.¹⁹⁵ This low value of life excludes those patients from certain ethical principles, for example, the duty of filial piety: the family has no moral duty to care about a relative whose quality and value of life are low.¹⁹⁶ Under this analysis, the low value of lives of certain humans also makes euthanasia appropriate for them, as it does not violate their interests (being "alive" only extends the process of dying and suffering) and is good for society (scarce medical resources are allocated to help those who can be cured).

¹⁹³ See, e.g., Qiu Renzong (邱仁宗), SHENGMING LUNLIXUE (生命伦理学) [Bioethics] 114 (2010).

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* at 136-37.

¹⁹⁶ *Id.* at 137.

These gruesome implications of the doctrine of the value of life lurking behind the people's court's reasoning in this case might seem irrelevant to the United States and other countries where the doctrine of the right to die takes the patients' rights into account. At the same time, the experience of China is still instructive to the United States in at least two aspects. First, it shows that it is possible to reason about the right to die without resorting to the crutches of legal fictions about intention and causation.

Second, and perhaps more importantly, the Chinese example also demonstrates the importance of a careful balancing of competing interests about the right to die and of a neutral doctrine that results from that balancing, neither of which seems to be happening in modern China. The rigid consequentialism that permeates many aspects of life and official ideology of today's China disregards concerns about individual autonomy. Furthermore, even within consequentialist realms the balancing that the people's courts have done leaves much to be desired. The people's courts sent a signal to vulnerable social groups that if a Chinese citizen faces imminent death, her life can be involuntarily—or maybe contra-voluntarily—terminated by a doctor without criminal consequences, and that signal was not a desirable outcome from a broader consequentialist perspective. Also, a number of Chinese scholars (much like their peers in the United States) are concerned about the disparate effects of such legal treatment of the right to die on vulnerable groups of the population (the elderly, the poor, people with disabilities, peasants from economically disadvantaged rural areas), medical mistakes, and the lack of integrity in the medical profession.¹⁹⁷

Why does that matter? Because, as I demonstrated earlier, in the United States the doctrine of the right to die, especially as far as Prescription and Injection are concerned, is also non-neutral. To the contrary, it reflects a specific moral theory (pertinent to the new natural law and some religious teachings) that rejects the balancing between competing interests in the way that the doctrine of Withdrawal purports to do. And this lack of neutrality is also undesirable from a broader social perspective: it sends a wrong signal to society about the lack of neutrality of the courts, draws arbitrary lines between different categories of patients, and results in unnecessary pain and suffering for many of them.

Since the legal fictions about intention and causation violate the ideal of neutrality, it seems desirable to get rid of them. In the next and last section of this part I shall examine possible ways to abandon legal fictions about intention and causation in the right to die context and explore possible implications of that approach.

C. Abandoning Legal Fictions: Strategies and Possible Implications

The examples from foreign jurisdictions demonstrate the importance of a morally neutral method of reasoning about the right to die and the possibility of doing such reasoning (i.e., balancing) without legal fictions about intention and causation. At the same time, in the United States the courts have found such a neutral method of balancing competing interests in the idea of quality of life, which determines whether to enforce the patients' rights or the government's interest with respect to the right to die. That neutral way of balancing is distorted by a moral theory underlying legal fictions about causation and intention. Therefore, in order to restore the neutrality of the method we should be rid of those fictions. In what follows I shall examine the implications

¹⁹⁷ See, e.g., Zhao Xuelian (赵雪莲) & Mao Qun'an (毛群安), *Zhongguo Anlesi Shishi de Bukexingxing Fenxi* (中国安乐死实施的不可行性分析) [The Analysis of Non-Feasibility of Euthanasia in China], 107 CHINESE MED. ETHICS 16 (2006).

of that approach for different forms of the right to die in the United States.

1. Withdrawal and Prescription

Once the legal fictions about intention and causation are abandoned, it becomes clear that Withdrawal falls under the scope of the common-law prohibition of assisting others in committing suicide, for in the situation of Withdrawal the doctor's action and inaction (withdrawal and withholding life-saving treatment, respectively) help the patient to end her life, which the doctor might plausibly intend. This does not mean, of course, that abandoning legal fictions will lead to the criminal prosecution of the doctors participating in Withdrawal; as I mentioned earlier, every state has legalized Withdrawal by enacting advance directive statutes. Withdrawal, which is assisting the patient to commit suicide by a medical professional, enjoys a statutory exemption from the scope of criminal law; it is therefore logical to ask whether Prescription, which is also assisting the patient to commit suicide by a medical professional, should be likewise exempt from criminal liability.

If we apply the same analysis based on causation and intention (but without legal fictions) to answer the last question, it will go like this. From the perspective of real intention, there are no relevant differences between Withdrawal and Prescription: in both cases the doctors may or may not intend the death of their patients (in Prescription, as I argued earlier, the doctor's primary intention would be to enable the patient to make a choice), and the patients may or may not intend their own death as the only possible means of ending suffering.

From the perspective of real causation, there are three differences between Withdrawal and Prescription. First, in Withdrawal, the patient is not required to perform an action to cause her death, while in Prescription she is (the patient has to ingest the drugs). Second, Withdrawal requires the doctor's inaction (withholding medical treatment), while Prescription does not. Finally, Withdrawal requires a certain condition of the patient for death to ensue, whereas Prescription does not (if the patient feels better when she ingests the lethal medication, she will still die).

Do those causation-based distinctions between Withdrawal and Prescription warrant different legal regimes for the two? I think not. The first distinction is without a difference: criminal liability for committing suicide has been abolished, and prohibiting Prescription because the patient may ultimately kill herself would be legally questionable.¹⁹⁸ The second distinction flies in the face of the logic of Withdrawal's regime: it makes no sense to allow Withdrawal that requires the doctor's inaction while prohibiting Prescription that does not (so the role of the doctor in Prescription is even more passive than in Withdrawal). Finally, the third distinction does not make any difference either: the right to Prescription in the United States is requested for terminal patients only.

As this analysis demonstrates, while there are some distinctions to be drawn between Prescription and Withdrawal, none of them warrants a disparate legal treatment of the two. What about state interests—maybe they are more compelling in Prescription cases than in Withdrawal cases? If we conceptualize both Withdrawal and Prescription as assisting the patient's suicide, the state interests in protection of life and prevention of suicide are equally strong for both Withdrawal

¹⁹⁸ Cf. *Carter v. Canada (Attorney General)*, 2015 S.C.R. 5, at para. 78 (“[The statute that imposes criminal liability for assisting suicide] is not directed at preserving life, or even at preventing suicide—attempted suicide is no longer a crime.”).

and Prescription, and it is illogical to allow the former while proscribing the latter.¹⁹⁹ Similarly, the interest of protection of the patients and innocent third parties is equally strong in Withdrawal and Prescription scenarios, as in both situations a patient could be misdiagnosed with a terminal condition and/or could be under duress, or her death may cause pain and suffering to her family members. As far as the integrity of the medical profession is concerned, it would be more logical to outlaw Withdrawal and allow Prescription out of that concern, as Withdrawal requires both action and inaction from a participating doctor, whereas Prescription requires only action which does not necessarily lead to the patient's death.

Finally, what about a slippery slope from Withdrawal to Prescription, and then perhaps to Injection and even contra-voluntary euthanasia? This fear of the slippery slope, I submit, seems to be motivated more by the public perception of and attitudes toward "euthanasia" than by moral philosophy and the logic of the law. Of course, it is possible for the state to draw a sharp line and allow only Withdrawal and nothing else. This line, however, strikes many as arbitrary. The truth is that all the necessary and sufficient doctrinal elements to legalize Prescription in the United States are already in place in the doctrine of Withdrawal; the only thing that prevents that doctrine from being applied to Prescription are legal fictions—which, as I argued, have long outlived their utility, including the utility to serve as "barriers" on the slippery slope to contra-voluntary medical killings. As I showed earlier, the practice of the states where Prescription has been legalized suggests that the fears about that kind of slippery slope are unwarranted.

As this analysis demonstrates, the implication of abandoning legal fictions about causation and intention will be a consistent regime of legalizing Withdrawal and Prescription for terminally ill patients. This consistency stemming from the rejection of legal fictions is not unprecedented in the United States. For example, the Supreme Court of Montana opined that a state statute legalizing Withdrawal

authorizes physicians to commit a direct act of withdrawing medical care, which hastens death. In contrast, the physician's involvement in aid in dying consists solely of making the instrument of the 'act' available to the terminally ill patient. The patient himself then chooses whether to commit the act that will bring about [her] own death.²⁰⁰

This reasoning played a crucial role in the state supreme court's holding that Prescription was not against public policy in Montana. As the court opined, "[t]here is no suggestion in the [statute legalizing Withdrawal] that a lesser physician involvement (making available a lethal [dose] of medicine)—which is then vetted by a terminally ill patient's intervening choice and subsequent self-administered ingestion—is against public policy."²⁰¹

How could we reach a consistent treatment of Withdrawal and Prescription—one that is free from legal fictions? At first, it might seem that the courts could play an active role in that process. After all, it was the judiciary that was instrumental in distinguishing between suicide and refusal of life-saving medical treatment – so why couldn't they develop a doctrine that would shield Prescription from the statutes against aiding and abetting suicide? Some of the judges in the United States seem to be inclined to follow that route; for instance, in Montana the state supreme court

¹⁹⁹ Cf. *Carter*, 2015 S.C.R. 5, at para. 115.

²⁰⁰ *Baxter*, 224 P.3d at 1218.

²⁰¹ *Id.* See also *supra* note 154.

applied a statutory defense of consent against criminal charges for assisting suicide in Prescription cases.²⁰² The supreme court of Massachusetts has indicated its inclination not to criminalize assisted suicide as well.²⁰³

Furthermore, the courts could have distinguished between suicide, on the one hand, and Withdrawal and Prescription, on the other hand, based not on fictions about intention and causation, but rather on the patient's state of mind. In recent years, more and more medical professionals opine that labeling Prescription as "physician-assisted *suicide*" is quite misleading. For example, in the recent *Brandenburg v. Morris* case about Prescription from New Mexico, one of the witnesses (a licensed psychiatrist who teaches at the Center for Ethics and Healthcare at Oregon Health and Science University) testified that "a death from aid in dying is not the same as a suicide. Suicide is typically brought on by a 'psychiatric condition' such as depression and is characteristically an 'impulsive' and 'solitary act.' . . . By contrast, aid in dying is characterized by a 'deliberative process,' which 'almost always involves the person discussing [aid in dying] with [his or her] family and friends.'"²⁰⁴ This reasoning (which seems to correspond to reality) suggests that the courts might abridge the application of the criminal statutes against assisted suicide to non-medical contexts where a proper protocol for determining the patient's opinion has not been followed.

However, these two possible strategies (developing a statutory defense of consent or limiting the application of anti-assisting suicide statutes) are problematic, both doctrinally and practically. First, they will be doctrinally hard for the courts to follow. A statutory defense against criminal charges for assisting suicide can be developed by the courts only following careful consideration of the intention of the legislature that enacted the relevant statutes. In many cases, legislative intention could be inferred from the statutes on advance directives and living wills that explicitly do not condone "assisted suicide" in medical contexts;²⁰⁵ therefore, it would be plausible to think that a statutory defense against assisting suicide would not correspond to the legislative intent in those instances. In at least some states, however, the advance directive statutes do not explicitly mention assisted suicide,²⁰⁶ in which cases it would be more plausible to argue that a given legislature did not intend to criminally prosecute the doctors for Prescription.

But even in those states, a statutory defense against criminal charges is a second-best option – a valid defense against a criminal charge is by nature stricter than the decriminalization of Prescription. If a certain act is decriminalized, law enforcement officials cannot bring criminal charges against an individual for having engaged in that act. By contrast, when a defense to criminal liability is made available, criminal charges may still be filed and the defendant bears the burden of

²⁰² *Id.* at 1222.

²⁰³ *See* Commonwealth v. Carter, 52 N.E.3d 1054, 1064 (Mass. 2016). It might have been easier for the Supreme Judicial Court of Massachusetts to imbue that message into the *dictum* of its decision in *Carter* because, as I noted earlier, the Massachusetts statutes do not criminalize assisted suicide, and the state's advance directive statutes do not condemn assisted dying either. *See* Mass. Gen. Laws, c. 201D, § 12.

²⁰⁴ *Morris v. Brandenburg*, 376 P.3d 836, 843 n.1 (N.M. 2016). *See also* Timothy E. Quill, *Physicians Should 'Assist in Suicide' When It Is Appropriate*, 40 J.L. MED. & ETHICS 57 (2012) ("I have assisted many patients to die with their full consent. None of them wanted to die, and all would have chosen other paths had their disease not been so severe and irreversible. To a person, none of these patients thought of themselves as 'suicidal,' and they would have found that label preposterous and demeaning. In fact, the kind of personal disintegration that the label implies is just what is trying to be prevented by those choosing this possibility.").

²⁰⁵ *See supra* note 70.

²⁰⁶ *See* Mass. Gen. Laws, c. 201D, § 12.

pleading the defense. This difference may have a chilling effect on the practice of Prescription.

Limiting the scope of criminal statutes against assisting suicide could prove to be difficult as well. As the supreme court of New Mexico noted, “[O]ur analysis is bound by the statutory language, which broadly defines suicide as ‘the taking of [one’s] own life’ and does not track . . . clinical and emotional distinctions . . . recognized by professionals in the fields of medicine and psychology.”²⁰⁷ This means that the courts willing to adopt this strategy should be willing to make a broad doctrinal leap from the plain statutory language to a brand-new conceptualization of suicide.

Finally, and perhaps most importantly, even under the most favorable conditions there is only so much the judiciary can do about Prescription. Even if courts make it legal (as rejecting legal fictions would imply), they cannot and should not specify in their decisions a detailed protocol of the procedure of Prescription because judges lack the necessary expertise to design this protocol. That question should properly be left to the legislators who are institutionally competent to put in place necessary safeguards, just as they did for Withdrawal procedures. Therefore, the best solution to the Prescription problem would be state statutes legalizing it and providing for detailed procedural regulations. Those laws would be especially apt in anticipation of a potential decision of the United States Supreme Court on the constitutionality of Prescription. The *Obergefell* Court left that question up in the air for the time being.²⁰⁸ At the same time, as analysis of the Canadian experience suggests, if the Court decides to abandon *Glucksberg*’s history and tradition test and instead do a full strict scrutiny of the ban in question, the ban is not likely to survive it. If that happens, the states will be better off if they are prepared for such developments.

Having examined possible new developments of Prescription’s legal regime without legal fictions about intention and causation, let us now turn to Injection.

2. Withdrawal and Injection

At first it might seem that Withdrawal and Injection are as different from each other as assisting suicide and homicide. There are indeed some real differences between the two in terms of causation: while in Withdrawal the doctor’s conduct is only one condition of the patient’s death, in Injection the doctor’s conduct is the necessary and sufficient condition of the death of her patient. (As I explained earlier, there is no causality-related distinction between Withdrawal and Injection in terms of action and inaction.) From the perspective of intention, if one does not believe in the Doctrine of double effect, the difference between Withdrawal and Injection is not significant, as both methods of the right to die involve desire (purpose) and/or foresight of the patient’s death. Furthermore, as I argued earlier, even from the perspective of the Doctrine, it is plausible to think that the patient’s death may be intended (and not merely foreseen) in Withdrawal—like it is intended in Injection.

The causation-based distinction between Withdrawal and Injection does not make much of a difference when it comes to the state interests in protecting lives, preventing suicide, and protecting innocent third parties. It does make a difference, though, for the integrity of the medical profession. It could be plausibly argued that it is more objectionable for the doctors (or nurses) to engage in conduct that is sufficient to cause the death of their patients (Injection) and less objectionable to engage in conduct that is necessary but not sufficient for the patient’s death to ensue (Withdrawal).

²⁰⁷ *Morris*, at 843 n.1.

²⁰⁸ *See supra* note 129.

Since it is compelling state interests that justify abridgments of individual rights in U.S. constitutional law, the question is whether the governmental interest in the medical profession's morale is strong enough to outweigh the patient's right to privacy and self-determination that is exercised in Injection. In the context of Withdrawal, one of the state courts acknowledged "the existence of the right [to refuse life-saving treatment], even in a nonterminal patient, which overrides the concern for protecting the medical profession,"²⁰⁹ so at least there are some authorities indicating that the interest in medical ethics alone cannot prevail over the patient's right to die.

Furthermore, the state interest in preserving the integrity of the medical profession is inseparable from our understanding of what medicine and excelling in medicine are about. That understanding is a part of a tradition—which, as the *Obergefell* Court recently explained, can change. It is quite plausible that, in light of certain technological advances, the "essence" of medicine will change, and medical ethics will mutate too. For example, in those states where Prescription is legal, medical ethics now embraces physician-assisted dying as one of the legitimate ways of treating terminal patients, which could be seen as a drastic shift from the precept that the doctors are "healers, not killers." Accordingly, if public perception of medical ethics and its standards changes so that Injection becomes an ethical treatment option for patients to choose, then the state interest in preserving the integrity of the medical profession will no longer shield society from the legalization of Injection.

Much like the issue of Prescription, whether "saving medicine's morality" is more or less important than allowing terminal patients to end their lives is a question better resolved in legislatures than in courts. When resolving puzzles about the right to die, however, the decision-makers in legislatures should be intellectually honest with their voters, and they should not cover up their moral preferences with legal fictions about intention and causation.

IV. CONCLUSION

This essay argues that a morally neutral doctrine of the right to die in the United States can be inferred from courts' reasoning about Withdrawal and then applied consistently across the spectrum of other methods of the right to die: Prescription, Sedation, and Injection. That doctrine would include such elements as quality of life, patients' rights, and government's interests, placed in certain lexical order and balanced within formal and institutional constraints. The essay also argues that legal fictions about intention and causation were imputed into the doctrine of the right to die by the courts and, while helping the judiciary reach the results it wanted to reach, distorted the doctrine's moral neutrality and long outlived their utility.

At the same time, examples from Canada and China, on the one hand, demonstrate that reasoning about different methods of the right to die without fictions is possible, and on the other hand, underscore the importance of a morally neutral doctrine of the right to die. Building on those examples, the essay argues that legislatures' and courts' reasoning about the right to die should be emancipated from legal fictions about intention and causation and shows the implications of that approach for Withdrawal, Prescription, and Injection. That new approach to the right to die fits the recent case law of the Supreme Court's rejecting the history and tradition test used to strip the right in question of its constitutional protections. A much-desired consistent legal regime of the right to die for terminally ill patients coming from the legislatures and courts could set an example of impartiality for other areas of U.S. law.

²⁰⁹ *Bowia*, 179 Cal. App. 3d at 1140.