

1997

## Physician-Assisted Suicide: Three Crucial Distinctions

Norton Spritz

*Chief Consultant in Forensic Medicine for the Veterans Administration and Professor of Medicine, New York University School of Medicine. M.D., University of Maryland School of Medicine, 1952; J.D., Fordham University School of Law, 1987.*

Follow this and additional works at: <https://ir.lawnet.fordham.edu/ulj>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Norton Spritz, *Physician-Assisted Suicide: Three Crucial Distinctions*, 24 Fordham Urb. L.J. 869 (1997).

Available at: <https://ir.lawnet.fordham.edu/ulj/vol24/iss4/16>

This Article is brought to you for free and open access by FLASH: The Fordham Law Archive of Scholarship and History. It has been accepted for inclusion in Fordham Urban Law Journal by an authorized editor of FLASH: The Fordham Law Archive of Scholarship and History. For more information, please contact [tmelnick@law.fordham.edu](mailto:tmelnick@law.fordham.edu).

# PHYSICIAN-ASSISTED SUICIDE: THREE CRUCIAL DISTINCTIONS

Norton Spritz\*

## Introduction

Legalization and general acceptance of Physician-Assisted Suicide (PAS) has the potential to produce serious negative effects on an already unstable and inequitable healthcare system. The basis for this concern includes a broad range of professional, ethical, and policy issues that have been repeatedly aired in the debate concerning PAS and have been well presented by professional groups that have considered the matter. These include, among many others, the New York State's Task Force on Health and the Law<sup>1</sup> and the American Medical Association.<sup>2</sup>

Rather than attempting to address each of these many policy issues, this article considers three crucial distinctions at the heart of the debate. First, can we define an ethically and legally valid distinction between the established right of patients to refuse life-sustaining treatments and their proposed right to seek physician assistance in their suicide? Second, can we limit PAS to its literal construct, the act of suicide carried out by the patient assisted by physicians,<sup>3</sup> or will distinctions between PAS and various forms of euthanasia prove to be impossible to sustain? Third, if we accept the right to PAS in the "ideal" circumstance, *i.e.*, "an uncoerced, mentally competent, terminally ill adult,"<sup>4</sup> can a regulatory struc-

---

\* Chief Consultant in Forensic Medicine for the Veterans Administration and Professor of Medicine, New York University School of Medicine. M.D., University of Maryland School of Medicine, 1952; J.D., Fordham University School of Law, 1987. The views expressed are not necessarily those of the Veterans Administration.

1. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994).

2. See AMERICAN MEDICAL ASSOCIATION COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL ETHICS (1996).

3. See, *e.g.*, *Compassion in Dying v. Washington*, 79 F.3d 790, 840 (9th Cir. 1996) (*en banc*) (Beezer, J., dissenting) (distinguishing between euthanasia, the withdrawal or refusal of life-sustaining treatment, and physician-assisted suicide), *rev'd sub. nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

4. See *Compassion in Dying v. Washington*, 49 F.3d 586, 590 (9th Cir. 1995), *aff'd.*, 79 F.3d 790, 840 (9th Cir. 1996) (*en banc*) (Beezer, J., dissenting) (distinguishing between euthanasia, the withdrawal or refusal of life-sustaining treatment, and physician-assisted suicide), *rev'd sub. nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

ture be crafted that would distinguish between this defined group and other persons who would claim a right to PAS?

Fundamentally, support of PAS, both on legal and ethical grounds, depends ultimately on denying that a distinction exists between the refusal of life-sustaining treatments and PAS and accepting the second and third distinctions, both of which presume a regulatory structure in which PAS can be contained. In this paper, I shall argue that the right of patients to refuse life-sustaining treatments differs significantly from PAS and I will deny the second and third distinctions.

### I. Is There a Sustainable Distinction Between Withholding or Withdrawing Life-sustaining Measures and PAS?

In *Compassion in Dying*, the Ninth Circuit found that the Fourteenth Amendment's liberty interest supports a Constitutional right to PAS concluding that "*Cruzan*, by recognizing a liberty interest that includes the refusal of the artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death."<sup>5</sup>

Similarly, the Second Circuit found in *Quill v. Vacco* that patients who request PAS are similarly situated to those who refuse life-sustaining treatments and therefore have an Equal Protection claim.<sup>6</sup> Nevertheless, they were seen not to possess a comparable fundamental constitutional right since both PAS and refusal of treatment comprised a conscious decision to hasten one's death.<sup>7</sup> While rejecting the Ninth Circuit's substantive due process reasoning, the Second Circuit utilized its "similarly situated" argument to find that the "equal protection" right made it unconstitutional for states to legislate against PAS.<sup>8</sup> The court found the state's interests in continuing the life of these patients or interdicting suicide<sup>9</sup> to be insufficient to overcome the constitutional issue, explaining that: "But what interests can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interests lessens as the potential for life diminishes."<sup>10</sup>

---

5. *Compassion in Dying*, 79 F.3d at 816.

6. See *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

7. *Id.* at 724-25.

8. *Id.* at 730.

9. *Id.*

10. *Id.* at 729.

Both of these circuit courts and many of those who favor legalization of PAS fail to appreciate the deep seated and crucial distinctions between PAS and refusal or rejection of life-sustaining measures. The right of patients to accept or refuse treatments, including those that sustain their lives, clearly follows from long held rights to protect themselves from unwanted physical contact and invasion.<sup>11</sup> This would seem to define a right to privacy that is based on "being left alone" and its distinction from the active involvement of a third party, the physician, to, by design, end a life that would continue without specific life-supporting procedures.

These constitutional interpretations go against long traditions of common law and a wide range of the judicial background that legitimized the right to refuse life-sustaining treatment.<sup>12</sup> The language of support for that right, e.g., that of Justice O'Connor in *Cruzan v. Director, Missouri Department of Health*,<sup>13</sup> emphasizes that the right relates not directly to absolute control of the time and mechanism of death but rather the right to control treatment:<sup>14</sup> "[r]equiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment."<sup>15</sup>

As indicated by the Michigan Supreme Court in *People v. Kevorkian*,<sup>16</sup> the right to commit suicide is neither "implicit in the concept of ordered liberty [n]or deeply rooted in our nation's history and traditions."<sup>17</sup> Of particular interest is the question of the right's being "deeply rooted in our nation's history." The state's interest in preventing suicide has long roots in the common law and has statutory definition in the great majority of states.<sup>18</sup>

Perhaps the distinction between the right to reject treatment and the right to enlist others in choosing the moment of death can be illustrated by looking at the perspective of those who defined this new right in *In re Quinlan*.<sup>19</sup> Karen Quinlan, a young woman in a persistent vegetative state, was thought to be dependent on mechanical ventilation for continued life. It was with that pre-

---

11. *Id.* at 723.

12. *See generally id.* at 724-25 (discussing the Supreme Court's expansion of fundamental rights doctrine).

13. 497 U.S. 261 (1990) (O'Connor, J., concurring).

14. *See id.* at 289.

15. *Id.*

16. 527 N.W.2d 714 (Mich. 1994).

17. *Id.* at 730.

18. *See id.* at 732.

19. 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976).

sumption that, in 1976, the Supreme Court of New Jersey made new law by defining the right of patients (or in this case the surrogate) to refuse life-sustaining measures.<sup>20</sup>

Interestingly enough, however, medical predictions had been incorrect and after removal of the respirator, Ms. Quinlan lived for another nine years.<sup>21</sup> When removal of the "life support" did not lead to the patient's death, there was no movement or plea to more actively hasten the end.<sup>22</sup> All concerned had no problem understanding that *Quinlan* stood for the right of patients to refuse treatments and not the right specifically to choose the time and means of their deaths.<sup>23</sup> There was no sense that a new right emerged from the failure of removal of the respirator to end this tragic life - the right to have some third party actively intervene. Clearly, this newly proposed right cannot be said to have had its origins or to be a natural outgrowth of the right to reject life-sustaining treatments as defined in its germinal case.

It is important to recognize the distinction between the rejection of life-sustaining measures and PAS is its value in defining two classes of individuals who choose to take actions that terminate their lives. By segregating those who choose to end their lives into two groups, albeit with considerable overlap, the state can exert its general interest in preserving life and preventing suicide where it has the greatest interest and justification in doing so. Those whose death is related to their deep-seeded right to refuse treatment are also more likely to have other characteristics that lessen the state's interest in preserving life and preventing suicide. The patient whose death results from his/her rejection of life-sustaining treatment can be seen as overpowered by disease, since continued life depends on an intervention that the patient would choose to reject. In contrast, while the universe of persons who may ask for PAS may include persons comparably overcome by disease, it also will include a full range of persons who would choose to end life, but in whom the relationship between death and their illness is less imme-

---

20. *Id.* at 663.

21. See Phyllis Battelle, *Quinlan Tragedy Means Hope for Others: Subject of Death and Dying No Longer Swept Under the Rug*, SAN DIEGO UNION-TRIB., June 13, 1985, at D1; *Karen Ann Quinlan Dies at Age 31*; *Coma Case Prompted Historic Ruling Pneumonia Ends 10-year Ordeal in Right-to-Die Case*, WASH. POST, June 12, 1985, at A10.

22. Battelle, *supra* note 21, at D1.

23. See *In re Quinlan*, 355 A.2d 647, 664 (N.J. Sup. Ct. 1976) ("We think that the State's interest . . . 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 the individual's rights overcome the State interest.").

diate or certain, a category in which the state's interest in prolonging life is more compelling.

To argue that crucial distinctions can be drawn between PAS and cessation of life-sustaining treatments is not to deny that the two processes have significant common ground. In both processes there is a risk that patients will take an irreversible step to end their lives which, with a greater opportunity to adapt and cope with their disabilities, they would have rejected.<sup>24</sup> More fundamentally, both patients who request PAS and those who reject life-sustaining treatments share a conviction that death is preferable to life, encumbered by their current or predicted disabilities and suffering.<sup>25</sup>

The argument that the common ground shared by these two groups of persons erases the important distinctions between the two processes is invalid on several grounds. Distinctions such as this one, utilized by states to regulate complex activities in which it has an interest, can never be absolute. In complex issues such as the right of citizens to choose the time and mechanism of their deaths, perfect separation of persons into two categories, those for whom the restriction is reasonable and those whose rights overcome the restriction can never be achieved.

In *United States v. Salerno*,<sup>26</sup> the Supreme Court appeared to have accepted that laws remain constitutional even if potential for infringement of the rights of some persons is implicit in its enforcement.<sup>27</sup> The standard set is that a law is not to be held to be unconstitutional unless "no set of circumstances exists under which the [law] would be valid."<sup>28</sup> Surely, laws criminalizing PAS and thereby separating the right to refuse life-sustaining from PAS meet that test and more.

---

24. See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2273 (1997) ("Thus, legal physician-assisted suicide could make it more difficult for the State to protect depressed or mentally ill, or those who are suffering from unterminable pain, from suicidal impulses."); see also *Quill v. Vacco*, 80 F.3d 716, 729 (2d. Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997).

25. See generally *McKay v. Bergstedt*, 801 P.2d 617, 626 (Nev. 1990) (patient requesting removal of respirator); *Compassion in Dying*, 79 F.3d at 854 (stating that "some patients in extreme distress — such as those suffering from a terminal, painful, debilitating illness — may come to decide that death is preferable to life" and seek PAS). But see Herbert Hendlin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285, 291 (1996) (concluding that a patient who seeks assisted suicide might be "quite different" from a patient "who seeks relief from undue suffering in the last days of life" and "the two groups of patients become hopelessly confused").

26. 481 U.S. 739 (1987).

27. *Id.* at 745.

28. *Id.*

Similarly, if the rights of patients to control the time of their deaths is limited to those who do so by rejecting life sustaining treatments, then the right is limited to a subset of patients whose illness is clearly "terminal" and whose mode of death relates most directly to their underlying fatal illness. Certainly patients who request PAS may also be burdened by a terminal illness. However, the patients who make such requests also will comprise a far wider group of individuals for whom the state has a greater interest in preventing their suicide. As discussed below, regulatory definition of the group in whom PAS is appropriate will prove to be impossibly elusive, while those dependent for life on a procedure for which they can deny consent is largely self-defined and narrow.

## **II. Can We Maintain a Distinction Between the Right of a Patient to Have His or Her Physician Assist in Suicide and a Direct Role of the Physician in Various Forms of Euthanasia?**

In both the Second and Ninth Circuit rulings, the cases considered were those of physically, as well as mentally competent persons, who, if given medications that could cause death would administer the suicidal potion themselves—literal PAS.<sup>29</sup> By extending patient autonomy to include purposeful termination of life to avoid suffering, a right to choose the time and means of death and the right to recruit physicians in the life-ending process will have been created. Having established this broad right, the exclusion of those physically or emotionally capable of carrying it out themselves is untenable.

Dr. Timothy Quill, one of the plaintiffs in the Second Circuit case, illustrates through the progression of his own positions, that, having accepted the underlying rationale, the extension from PAS to euthanasia inevitably follows. In 1992, a *New England Journal of Medicine* article entitled "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide" in which he was one of three authors contains the following:

The balance of power between doctor and patient is more nearly equal in physician-assisted suicide than in euthanasia. The physician is counselor and witness and makes the means available, but ultimately the patient must be the one to act or not act. In voluntary euthanasia the physician both provides the

---

29. See *Compassion in Dying*, 79 F.3d at 840 (Beezer, J., dissenting) (distinguishing between euthanasia, the withdrawal or refusal of life-sustaining treatment, and physician-assisted suicide); *Quill*, 80 F.3d at 729.

means and carries out the final act, with greatly amplified power over the patient and an increased risk of error, coercion, or abuse.

In view of these distinctions, *we conclude that legalization of physician-assisted suicide, but not of voluntary euthanasia is the policy best able to respond to patients' needs and to protect vulnerable people.*<sup>30</sup>

By 1994, Dr. Quill quite correctly came to understand that this and other limitations were incompatible with the basic premise of physician assisted death - purposeful ending of the patient's life is among the legitimate means for physicians to relieve suffering. In an article in the same journal in 1994, now with five co-authors, patient administration of the fatal medication is no longer seen as a goal of regulation.<sup>31</sup> The 1994 article, entitled "Regulating Physician-Assisted *Death*"<sup>32</sup> contained the following: "To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so."<sup>33</sup>

This change in position is not cited to suggest that Dr. Quill's support of PAS is anything but thoughtful, compassionate and sincere. His progression from the acceptance of PAS to euthanasia as means to relieve suffering based on ethical considerations illustrates that such a progression is inevitable. While this progression is based on ethical principles of beneficence and autonomy, the same progression from PAS to euthanasia will follow from the arguments that underlie a constitutional right to PAS.

The terminally-ill, mentally-competent patient, who is physically unable to administer the life-ending procedure, must be seen to have equal constitutional rights to the patients with the same characteristics, but who is physically capable. If, in fact, a constitutional right to PAS is defined by the Supreme Court, the physically incapable patient is certain to be seen as "similarly situated" and the equal rights analysis of the Second Circuit<sup>34</sup> or the substantive due process view of the Ninth Circuit<sup>35</sup> will not allow for reasonable

---

30. Timothy Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1384 (1992) (emphasis added).

31. Frank Miller et al., *Regulating Physician Assisted Death*, 331 NEW ENG. J. MED. 1656, 1658 (1994).

32. *Id.* (emphasis added).

33. *Id.*

34. *Compassion in Dying*, 79 F.3d at 790.

35. *Quill*, 80 F.3d at 729.

arguments that will exclude the right from certain individuals because of their physical disability. The Americans with Disabilities Act seems to codify the right of disabled persons to voluntary euthanasia comparable to those with physical capacity to PAS.<sup>36</sup>

It seems paradoxical that legal and ethical reasoning which finds no distinction between PAS and the right to refuse life-sustaining treatment will maintain a distinction between PAS for the physically competent and euthanasia for the physically disabled but mentally competent. Taken together, the Second Circuit's "equal protection" argument and the special rights of the disabled assure that constitutional protections for those with mental capacity will come to include those with physical incapacity for whom the active causation of death will rest on others.

### **III. Once PAS Is Defined as Acceptable and as a Right Can it Be Limited to the Terminally Ill, Competent, Intractably Suffering Patient?**

In both the Second and Ninth Circuit cases, the patient plaintiffs were terminally ill, competent, and intractably suffering.<sup>37</sup> In its analysis of the balance between the state's interest in limiting the right of persons to PAS and the individual right to choose the time and means of one's death, the presence of these characteristics negated or minimized the state's interest in preserving life and preventing suicide.<sup>38</sup> In reality, however, each of these characteristics is elusive, largely subjective, and would defy regulatory definition.

For instance, would a patient qualify as "terminally ill" who has metastatic cancer, but who, at the time of the request for PAS is active and free of symptoms? Frequently patients with ultimately fatal illnesses feel most hopeless upon first learning of the diagnosis and decide to have his or her life ended rather than face the unknown course of the disease.<sup>39</sup> The overwhelming majority of such patients come to terms with their situation and choose to live out their illness.<sup>40</sup> Estimates of duration of life in such patients are very inaccurate and estimates based on the average survival in such

---

36. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat 327 (1990).

37. See *Quill*, 80 F.3d at 729; *Compassion in Dying*, 79 F.3d at 790.

38. *Compassion in Dying*, 79 F.3d at 790.

39. See *Quill*, 80 F.3d at 729.

40. *Id.*

cases can seriously underestimate duration of life in the individual instance.<sup>41</sup>

Another major problem in estimating a definition of “terminally ill” that would provide a reasonable regulatory criterion has to do with those patients who suffer with their disease, but in whom duration of life is largely unaffected. This category would include patients with disabling neurological disease, but whose prognosis for life is indefinite. Even more troubling would be the patient with profound and prolonged depression. These patients have traditionally provoked steps by medicine and the society in general to prevent suicide. Would they now qualify for PAS? Even more troubling, could the legal and ethical principles underlying PAS be accepted without extending them to the tormented demented patient who lacks decisional capacity become but for whom euthanasia is the most merciful choice?

Could a regulatory structure be crafted that would sort out those who ask for PAS but whose suffering is deemed by his or her physician or by a board of experts to be insufficient? In *Compassion in Dying*, the Second Circuit mistakenly sees the problem in the selection of patients to be whether or not physicians act responsibly.<sup>42</sup> The majority puts it this way:

We believe that most, if not all, doctors would not assist a terminally ill patient to hasten his death as long as there were any reasonable chance of alleviating the patient's suffering or enabling him to live under tolerable conditions. We also believe that physicians would not assist a patient to end his life if there were any significant doubt about the patient's true wishes.<sup>43</sup>

This view of the problems and risks in deciding who is eligible for PAS fails to take into account the ambiguity, ambivalence, and fluctuating nature of patients' despondency and inability to cope.<sup>44</sup>

Proposed regulatory mechanisms to deal with the complex issues involved in defining each component of the “terminally ill, competent, and intractably suffering” are certain to be inadequate. These have included waiting periods and the involvement of physicians other than those primarily responsible for care.<sup>45</sup> While these mechanisms may provide some limits, they will be ultimately asked

---

41. *Id.*

42. *Id.*

43. See *Compassion in Dying*, 79 F.3d at 790.

44. See generally *id.*

45. See Peter Daniels, *An Illinois Physician Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 779-80 (1997).

to define the undefinable. In a patient care structure in which purposeful ending of life is accepted as an ethical and constitutional right, limitations that conflict with the individual patient's own sense of his or her suffering will not be able to shape the ordered and regulated system envisioned by those who support PAS.

#### IV. "Slippery Slopes" and the PAS Debate

The "slippery slope" argument as a basis for making ethical or legal judgments, as a general proposition, is often discredited<sup>46</sup> and for legitimate reasons. Complex questions can be distorted and made emotional when possible, but remote, extensions of the process under consideration are used to promote one or another point of view. In the current PAS debate, arguments that PAS will inevitably lead to widespread euthanasia of vulnerable and unwilling individuals without regard to their individual interests would represent such an unwarranted extension. For this extension to occur, we would have to incorporate into our legal and ethical system concepts that we now reject and which are not implicit in the acceptance of PAS.

Implicit in the PAS debate, however, is the reality that when certain premises are accepted as the basis for a particular policy decision, extensions of that decision are likely to be inevitable when they are based on the same premises combined with established principles of law or ethics. In the case of PAS, the extension of PAS to euthanasia of persons who lack physical capacity to commit the act of suicide has such inevitability. The concept that ending life to end suffering is a professional responsibility and constitutional right of patients cannot, in any logical structure, omit the comparably suffering person who is also burdened with physical incapacity. The special protection afforded to the disabled<sup>47</sup> further assures that PAS flows into euthanasia at least for this group of patients.

Further extensions to involuntary euthanasia of persons, currently without capacity, but with advanced directives to end their lives would almost certainly represent the same inevitable extension - the acceptance of principles underlying PAS combined with the power of patient determinism as an ethical principle.

---

46. See Lois Shepherd, *Sophie's Choices: Medical and Legal Responses to Suffering*, 72 NOTRE DAME L.REV. 103, 156 n.278 (1996).

47. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990).

Involuntary euthanasia of persons without such explicit directives, but who also lack mental capacity would be the next group to be considered. When their surrogates decide that ending such patients' lives becomes appropriate in view of their suffering or lack of dignity, it is not clear that in a society that sees PAS as a constitutional right, what barriers would be able to resist extension of physician assisted death to this group. This progression has clearly occurred in The Netherlands once the nation officially condoned the principal underlying PAS.<sup>48</sup>

### Conclusion

Legalization and general acceptance of PAS, as a mechanism to relieve the suffering of patients, has an immediate appeal to our sense of mercy and the rights of patients to autonomy. While there are certainly individual terminally ill patients for whom PAS provides a reasonable mechanism to end suffering, its establishment as a constitutional right and its widespread application would not be consistent with the fundamental healing and life preserving role of medicine nor would it enhance the crucial effort to provide each patient with the care necessary to minimize suffering.

The Supreme Court ruled on the narrow question of physician assisted suicide for patients who are terminally ill with mental capacity and with physical capacity to, with physician assistance, commit suicide.<sup>49</sup> In operation, however, acceptance of the principles underlying PAS will lead to comparable acceptance of euthanasia as a mechanism to relieve suffering. The "ideal" patient for PAS will lead to comparable consideration of the constitutional right to PAS, representing only one subset of persons who may view their suffering as intolerable. Extension of this "right" to more problematic situations in which societal interest in preventing purposeful ending of life is great would inevitably follow once purposeful death is accepted as a mechanism to relieve suffering.

Complex moral, legal, and clinical policy issues such as the relief of suffering do not lend themselves to easy solutions. Rather than turning toward solutions such as PAS that are, at best, limited, uncertain, and with a serious potential for harm, we should not be diverted from our real task - broad and equitable application of

---

48. Paul van der Maas et al., *Euthanasia, Physicians Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 *NEW ENG. J. MED.* 1699, 1700 (1996).

49. *Quill*, 80 F.3d at 729.

currently available techniques to relieve suffering to those who need help.