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Criminal Law

Active v. Passive Euthanasia: Why Keep the Distinction?

Yale Kamisar

In the past two decades, we have witnessed a “sea change in public, medical, and legislative judgments” about “letting die” and the “right to die.”¹ But it is no less true today than it was 35 years ago, when I first wrote about this subject, that in Anglo-American jurisprudence *active* euthanasia (what used to be called “mercy killing”) is murder.²

So far as the law on the books is concerned, it matters not that one who intentionally kills another human being “does so at the victim’s request” or that “his motive is the worthy one of terminating the victim’s sufferings from an incurable and painful disease.”³ As one commentator recently explained it, “So great a value is put on life that a person may not waive his right to life; killing does not become nonculpable because the victim consented.”⁴

But all this may change in the near future. As one of the nation’s most forceful and eloquent opponents of active euthanasia, the University of Chicago’s Leon Kass, observed several years ago, “So-called active euthanasia practiced by physicians seems to be an idea whose time has come.”⁵

Not a few would say that Kass exaggerated the potency of the assault on the long-standing prohibition against “direct” or “active” euthanasia. After all, although most forecasters predicted in

1991 that Washington state would become the first jurisdiction in the Western world to legalize active euthanasia, Initiative 119 (euphemistically called the “death with dignity” or “aid in dying” referendum) went down to defeat. And last November, although once again early polls indicated overwhelming support for a similar proposal in California (Proposition 161), it, too, failed.

At first blush, these political setbacks for the active euthanasia movement seem fairly decisive. But I think not; they can be explained away or at least minimized. I believe that Kass’s concerns are as well founded today as when he first voiced them in 1989.

Jack Kevorkian, the Michigan pathologist who practices as well as preaches assisted suicide, may have significantly affected the outcome in Washington. Less than two weeks before voters went to the polls, Kevorkian used his “suicide” machine twice in one night. From that point on, according to a spokesperson for the Hemlock Society in Seattle, voter support for the “aid-in-dying” measure fell dramatically.⁶ At the very moment Kevorkian swung into action, a TV blitz against the measure hit the airwaves, and “Jack Kevorkian put a face on [people’s] fear.”⁷

But proponents of assisted suicide and active euthanasia have distanced themselves from Kevorkian, noting that the women whose deaths he assisted were not his patients and not terminally ill. They point instead to the “aid-in-dying” performed by Timothy Quill, a

Rochester, New York, doctor who is also a member of the University of Rochester Medical School faculty. Quill was neither indicted nor disciplined by medical authorities for prescribing enough barbiturates to enable a long-standing patient to commit suicide following her refusal of treatment for a severe type of leukemia.⁸

The response to Quill’s action and to the article he wrote in a medical journal spelling out what he had done and why has been “very positive” and has “moved public discussion away from the suicide machine.”⁹ Many who were jolted, or at least greatly troubled, by Kevorkian’s actions supported Quill.¹⁰

Although last November California voters defeated Proposition 161 by a 54 percent to 46 percent margin, support for the measure was impressive—considering that a coalition of 100 organizations (including the Roman Catholic Church, the California Medical Association, and the California Nurses Association) fought the proposal, nearly every major newspaper in the state editorialized against it, and opponents of the proposition outspent proponents by a margin of at least 3 to 1.¹¹

Moreover, opponents of Proposition 161 did not frontally attack the basic notion embodied in the measure as much as they raised fears that it lacked adequate protections.¹² They pointed out that

▶ although the initial directive had to be witnessed by two people not linked financially with the patient, no

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Gary Porter Detroit News/Gamma-Liaison

Dr. Jack Kevorkian and his 'suicide' machine

witnesses were mandated at the time of the actual request for and implementation of euthanasia;

- ▶ although an "enduring request" by a qualified patient was required, it was simply defined as one "expressed on more than one occasion" (perhaps only a day or several hours apart);

- ▶ there was no required "waiting period" after a patient decided to seek help in dying; and

- ▶ the proposal did not require a psychiatric evaluation to rule out treatable depression as a basis for the request.¹³

Public Acceptance

Most opponents of Proposition 161 hammered away at its inadequate safeguards rather than its basic idea probably because they were well aware that "the marked increase in public acceptance of killing terminally ill patients . . . has been striking."¹⁴ According to public opinion polls, not only does a large majority of U.S. citizens now support laws allowing terminally ill patients to refuse or stop life-sustaining treatment,¹⁵ but many Americans now favor

active euthanasia for incurable and comatose patients.¹⁶

According to a close observer of the Proposition 161 contest, "The ranks of those voting no swelled as the opposition coalition focused its advertising during the final weeks on what worked a year earlier to bring down a similar measure in Washington state by a nearly identical margin (54-46): voters' fears that mistakes would be made."¹⁷ But only six months before Proposition 161 went down to defeat, surveys showed that 75 percent of California voters supported the basic idea of physician aid-in-dying, 54 percent strongly so.¹⁸

Thus, Alexander Morgan Capron, the former executive director of the President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research, now professor of law and medicine at the University of Southern California, had good reason to issue the following warning:

Proposition 161's defeat should not obscure the remarkable fact that millions of people are so fearful of how

they think they'll be treated by the health care system when they're very ill that they'd rather be dead. . . .

Average people are . . . so dismayed at how death occurs in this country and so distrustful of physicians' ability or willingness to give them a "good death" that they will consider overturning thousands of years of medical ethics and societal prohibitions to legalize direct killing by physicians.¹⁹

I noted earlier that Leon Kass observed recently that active euthanasia appears to be "an idea whose time has come."²⁰ But he was quick to add, "In my view, it is a bad idea whose time must not come—not now, not ever."²¹

I agree. I was pleased when Washington's Initiative 119 went down to defeat in 1991 and when California's Proposition 161 met a similar fate last year.

But proponents of these measures are not easily discouraged. They can be expected to try again (perhaps in Oregon or Florida or in Washington a second time) with more finely honed versions of the measures that failed. And I share Professor Capron's concern that unless

health care providers who oppose active euthanasia "change those aspects of the system that make a quick death such an attractive alternative, support for legalizing euthanasia is sure to build and eventually to prevail."²²

In resisting the active euthanasia movement in the years ahead I shall be aligned with, and rooting for, Capron, Kass, and such other well-known commentators and spokespersons as Daniel Callahan, Arthur Caplan, Albert Jonsen, John Pickering, and Susan Wolf.²³ But the law and politics of euthanasia make strange bedfellows. My anti-active-euthanasia confreres are favorably disposed toward, or at least willing to accept, what used to be called, and I still call, passive euthanasia—a practice that has gained wide acceptance. But I have always been greatly troubled by it.

I have reexamined the earlier writings of my "allies" and read their most recent contributions to the literature.²⁴ Insofar as they maintain that individual acts of "direct" or "positive" or "active" euthanasia are fundamentally different from the "passive" or "negative" variety—that the former is unacceptable or intrinsically immoral while the latter is permissible—I find many of their arguments unpersuasive and none of them convincing.

As Dean Guido Calabresi of Yale Law School has pointed out, when we have to make "tragic choices"—choices that confront us when fundamental beliefs clash—"we look for solutions which seek to cover the difficulty and thereby permit us to assert that we are cleaving to both beliefs in conflict."²⁵ A good example is how we have dealt with death, dying, and euthanasia.

Beliefs in Conflict

Two sets of beliefs are in conflict. On the one hand, we want to respect patients' wishes, relieve suffering, and put an end to excessively burdensome and seemingly futile medical treatment. On the other hand, we shrink from the concept of a life not worth living. We want to affirm the supreme value of life. We want to maintain the salutary principle that the law protects all human life, no matter how miserable a person appears or how worthless she happens to feel.

In short, we want it both ways. The two sets of beliefs are in conflict, or at least in great tension, but somehow we cling to both.²⁶

We say all human life is inviolate, but

we do not always mean it. We make "quality of life" judgments, but we deny it. We practice a kind of euthanasia in a soft light, subdued by history, but we would rather not examine this practice in the bright spotlight of utmost analytic clarity.

As I see it, the purpose of the distinction between "direct killing" and "letting die" is not (as some claim) to separate deaths caused by human action from those caused by the processes of nature. Nor (as others claim) is it to separate intrinsically immoral practices from permissible ones. Rather, the purpose of the distinction—or at least its

[REDACTED]

*Many physicians fail to use
means that are now
available to relieve
virtually all pain.*

[REDACTED]

effect—is to have it both ways.

For a long time we *have* had it both ways. In the 1940s, 1950s, and 1960s—as the many failures to indict, acquittals, and suspended sentences attest—when "mercy killing" occurred, the law in action was "as malleable as the law on the books [was] uncompromising."²⁷

In the 1970s the distinction between "extraordinary" (or "heroic") and "ordinary" medical treatment proved serviceable.²⁸ Although the terms are so spongy and were used so loosely that the distinction is now widely rejected, in its time this distinction, too, mediated or obscured the conflict between our two sets of beliefs.

Calling a life-sustaining medical procedure extraordinary was more an expression of the conclusion that the procedure could ethically be discontinued than it was a justification for doing so. But the terminology reassured the public that "only certain kinds of lifesaving measures could be, and would be, terminated; that disconnecting an unconscious patient's respirator in some vague way only constitutes a 'slight deviation' from our official morality."²⁹

The extraordinary/ordinary distinction has not fared well in the law of death and dying. Another distinction, one also rooted in Roman Catholic tradition, has proved to have much greater staying power—the distinction between killing and letting die.

Interestingly, an increasing number of

those who defend the distinction are so determined to keep a chasm between the two practices that they insist that the withholding or withdrawal of life-sustaining measures is not passive euthanasia or any other kind of euthanasia and that to use the "E" word in this context only causes confusion.³⁰ (I would say rather that it causes, and ought to cause, concern.)

But I think one of the leading proponents of euthanasia (both active and passive), the renowned British legal scholar Glanville Williams, had it right when, 20 years ago, he said,

A toehold for euthanasia is provided by the practice of letting die, or what is now called passive euthanasia. . . . If this distinction between an act and an omission is thought to be artificial, its artificiality is imposed on us by our refusal to accord the same moral freedom for action as we do for inaction. Pending a change of thought, the concept of an omission is a useful way of freeing us from some of the consequences of overrigid moral attitudes.³¹

I have no doubt that Alex Capron, Daniel Callahan, Leon Kass, and other opponents of active euthanasia draw the line at letting die as a matter of principle. They support the "right to die," but strongly resist direct killing.

Many others, however, have never been happy with this distinction. They were willing to draw the line between letting die and active euthanasia not as a matter of principle but only as a matter of tactics. I count among them the two leading euthanasia proponents of our time—Glanville Williams and the late Joseph Fletcher, the prominent medical ethicist.

For them, the distinction was a serviceable one because it afforded the physician and the patient's family much more room to maneuver than would be possible if one had to proceed by lethal injection—and it gave the rest of us, or most of the rest of us, less cause for alarm. But these people were always committed to the realization of active euthanasia. For them, acceptance of the "right to die" was only a partial victory—a stopgap measure.³²

They are no longer content to have it both ways. They are not, and never were, satisfied with euthanasia in a soft light, subdued by history; they also want it in a bright spotlight.

At a euthanasia conference held nearly two decades ago, Fletcher maintained

that there is no real difference between letting die and active euthanasia: "A deliberate act of omission, when death is the goal or purpose or end sought, is morally the same [as] a deliberate act of commission."³³ He argued that doctors ought to engage in both forms of euthanasia.

Fletcher's views disturbed some who attended the conference. Another speaker warned that since some do not clearly distinguish between active and passive euthanasia and "since active euthanasia is morally repugnant to so many . . . this confusion has led many physicians to avoid the use of the very desirable, accepted passive form."³⁴ According to this speaker, the distinction between the two forms of euthanasia had to be maintained "so that physicians will continue and in fact increase their use of this age-old passive form" and "to insure that passive euthanasia not be tainted in any way by the active euthanasia movement."³⁵

Fletcher gave this response: "Though the alleged difference between [passive and active euthanasia] is not a real one ethically or philosophically or theolog-ically regarded, it is arguably possible to separate them for pragmatic reasons of

prudence and workability."³⁶

Since that conference was held, doctors have greatly increased their use of the "age-old passive form" of euthanasia. Negative or passive euthanasia—even removal of the feeding tube—is now a fait accompli in modern medicine. *That* battle is over. And there is now more support for active euthanasia than there ever has been—and I fear that that sup-

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*We say all human life is
inviolable, but we do not
always mean it.*
██████████

port will grow even stronger.

Fletcher is no longer with us, but his allies and his followers are, and they are making their presence felt. They no longer feel the need to separate active euthanasia from the passive variety for pragmatic reasons. Passive euthanasia is now so well established that people of Fletcher's persuasion are no longer concerned that it will be "tainted" by the active euthanasia movement.

Proponents of active euthanasia are in a strong position, and they know it. As

they see it, the time has come to upset the compromise between letting die and direct killing. The time has come to move on to the next stage of euthanasia.

Compromise Position

"It is one thing to justify an act; it is another to justify a general practice."³⁷ Thus, those who can imagine individual circumstances where active euthanasia would be hard to condemn (and I certainly can) may still oppose legislation authorizing the practice. We may do so, as Rutgers Law School's Norman Cantor has argued, on the ground that "such a radical alteration" in the legal framework surrounding gravely ill patients "ought not to be instituted unless it is absolutely essential"³⁸—and no such showing has been made.

The reasons laypeople most often give for supporting active euthanasia are that it is inhumane to make patients suffer from intractable pain or that it is inhumane to keep them biologically alive when they seem to have "no life to live." But many physicians fail to use means that are now available to relieve virtually all pain.³⁹ And though advances in medical technology have made it possible, as one commentator has put

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it, to extend existence beyond all "natural bounds," physicians, patients, and families have learned how to resist medical procedures this commentator calls "merely burdensome or degrading medical additions to the unhappy end of a life."⁴⁰

I have been an active participant in the euthanasia debate, but I have also tried to be an objective observer of developments. I am not enamored of the distinction many have drawn between terminating life support and resorting to external death-causing agents, but I have to recognize that this distinction has become an integral part of the medicolegal landscape.

This is not the conclusion I would have arrived at, but it seems to be the compromise position our society has reached in the struggle to preserve as many traditional restraints against killing as we can consistent with taking a humane approach toward seriously ill patients. This is not the way I would have liked to resolve the controversy, and I very much doubt that it is the way most logicians or philosophers would resolve it—but it may nevertheless be a pragmatic and defensible way to do so. □

Notes

- 1 Sanford Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 862 (1992).
- 2 Yale Kamisar, *Some Non-Religious Views Against Proposed "Merry-Killing" Legislation*, 42 MINN. L. REV. 969, 970-71 n. 9 (1958) and accompanying text.
- 3 WAYNE LAFAVE & AUSTIN SCOTT, 1 SUBSTANTIVE CRIMINAL LAW 320 (2d ed. 1986).
- 4 Kadish, *supra* note 1, at 858. But a leading medical ethicist has forcefully argued that "the right not to be killed *should* be waivable when the person makes a competent decision that continued life is no longer wanted or a good, but is instead worse than no further life at all." Dan Brock, *Voluntary Active Euthanasia*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 10, 14 (emphasis added).
- 5 Leon Kass, *Neither for Love nor Money: Why Doctors Must Not Kill*, PUB. INTEREST, Winter 1989, at 25, 26.
- 6 See Rebecca Powers, *Some Call Kevorkian Poison to Group's Goals*, DET. NEWS, Feb. 2, 1992, at 4A.
In December 1992, shortly after Kevorkian had assisted in the deaths of two more people, Michigan enacted a law making assisted suicide a felony punishable by up to four years in prison. The law, which takes effect March 30, 1993, prohibits one who has knowledge that a person intends to commit suicide from "intentionally" "provid[ing] the physical means" or "participat[ing] in a physical act" by which that person attempts or commits suicide. (§7(1).) The prohibition does not apply to "withholding or withdrawing medical treatment by a licensed health care professional." (§7(2).)

The new law establishes a commission to study the issue of assisted suicide. The commission is to report to the legislature within 15 months after the statute becomes effective, and the ban is to remain in effect until six months after the commission makes its recommendations. During this time the legislature will decide whether to continue the ban or to deal with the problem in some other way.

Assisted suicide is not quite active euthanasia. The final act, the act that brings on death, is performed by the patient herself, not another person (a physician or relative or friend). And there is always the possibility that the patient may change her mind and not carry out the final act. On the other hand, assisted suicide is certainly something more than passive euthanasia. At the least, it strikes me, it is a bridge between active and passive euthanasia.

- 7 Powers, *supra* note 6; see also Rob Carson, *Washington's 1-119*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 7-9.
- 8 See Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 N. ENG. J. MED. 691 (1991); Lawrence Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at A1; Lisa Foderaro, *New York Will Not Discipline Doctor for His Role in Suicide*, N.Y. TIMES, Aug. 17, 1991, at A25.
- 9 See Altman, *supra* note 8.
- 10 See Kadish, *supra* note 1, at 859 n.11; Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2035-37 (1992); Arthur Caplan, *Two Views of Assisted Suicide*, DET. FREE PRESS, Mar. 19, 1991, at 2B.
- 11 See Lori Olszewski, *Right-to-Die Apparently a Loser*, S.F. CHRON., Nov. 4, 1992, at A12.
- 12 See Paul Jacobs, *California Elections*, L.A. TIMES, Nov. 5, 1992, at 3; Robert Reinhold, *California to Decide if Doctors Can Aid in Suicide*, N.Y. TIMES, Oct. 9, 1992, at A1.
- 13 See Alexander Capron & Vicki Michel, *Proposition 161: What Is at Stake*, COMMONWEAL, Sept. 1992 (spec. supp.), at 2.
- 14 Kadish, *supra* note 1, at 861.
- 15 See Clay Richards & B.D. Colen, *Poll: Most Favor "Right to Die" Laws*, NEWSDAY, June 10, 1990, at 15.
- 16 See Melinda Beck, *The Doctor's Suicide Van*, NEWSWEEK, June 18, 1990, at 47; Andrew Malcolm, *Giving Death a Hand*, N.Y. TIMES, June 9, 1990, at 6; *Should Death Be a Patient's Choice?*, PARADE, Feb. 9, 1992, at 26 (of those surveyed who had a position on the issue, a plurality (49 to 35 percent) favored doctors assisting conscious, rational, dying patients with their suicides).
- 17 Alexander Morgan Capron, *Even in Defeat, Proposition 161 Sounds a Warning*, HASTINGS CENTER REP., Jan.-Feb. 1993, at 32.
- 18 *Id.*
- 19 *Id.*
- 20 Kass, *supra* note 5, at 26.
- 21 *Id.*
- 22 Capron, *supra* note 17, at 33.
- 23 Callahan is the director and co-founder of the Hastings Center, noted for its work in the field of medical ethics. Caplan is the director of the Center for Biomedical Ethics at the University of Minnesota. Jonsen is professor and chair of the Department of Medical History and Ethics at the University of Washington School of Medicine; he was a leading opponent of Washington state's Initiative 119. Pickering is chairperson of the ABA Commission on Legal Problems of the Elderly; he led the opposition to a proposal—defeated overwhelmingly—that

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The Executive Life debacle encouraged a "flight to quality" which drove some less stalwart annuity companies from the market. The remaining players (with an exception or two), retained high ratings, even though the major rating services toughened standards.

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the ABA House of Delegates endorse active euthanasia legislation. Until recently, Wolf was at the Hastings Center; she now has a joint appointment in the law and medical schools of the University of Minnesota.

- ²⁴ See, e.g., DANIEL CALLAHAN, WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS 221-49 (1990); Alexander Capron, *The Right to Die: Progress and Peril*, 2 EUTHANASIA REV. 41 (1987); Kass, *supra* note 5; Albert Jonsen, *Beyond the Physician's Reference: The Ethics of Active Euthanasia*, 149 WEST J. MED. 195 (1988); Susan Wolf, *Holding the Line on Euthanasia*, HASTINGS CENTER REP., Jan.-Feb. 1989 (spec. supp.), at 13.

This article was written before I had received galley proofs of Callahan's forthcoming book, *THE TROUBLED DREAM OF LIFE: LIVING WITH MORTALITY* (1993). In it, Callahan makes the most powerful and persuasive defense of the distinction between direct killing and letting die that I have ever read.

- ²⁵ GUIDO CALABRESI, IDEALS, BELIEFS, ATTITUDES, AND THE LAW 88 (1985).
- ²⁶ Cf. *id.* at 87-91. See also GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 172-77 (1982).
- ²⁷ Kamisar, *supra* note 2, at 970-71. See also GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 57 (1978).
- ²⁸ See Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203, 1219-20 (1991).
- ²⁹ *Id.* at 1220.
- ³⁰ See, e.g., NEW YORK STATE TASK FORCE ON LIFE & THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS & APPOINTING A HEALTH CARE AGENT 40-42 (July 1987); Ronald Cranford, *Is Active Euthanasia Justifiable?*, in ACTIVE EUTHANASIA, RELIGION & THE PUBLIC DEBATE 80 (Laurence J. O'Connell ed., 1991).
- ³¹ Glanville Williams, *Euthanasia*, 41 MEDICO-LEGAL J. 14, 18, 21 (1973).
- ³² Cf. DAVID LAMB, DOWN THE SLIPPERY SLOPE 58 (1988).
- ³³ SEVENTH ANNUAL EUTHANASIA CONFERENCE, Dec. 7, 1974, at 5, 8.
- ³⁴ *Id.* at 15-16 (Dr. Alfred Jaretzki).
- ³⁵ *Id.*
- ³⁶ *Id.* at 20.
- ³⁷ TOM BEAUCHAMP & JAMES CHILDRRESS, PRINCIPLES OF BIOMEDICAL ETHICS 138 (3d ed. 1989).
- ³⁸ Norman Cantor, *The Permanently Unconscious Patient, Non-Feeding and Euthanasia*, 15 AM. J. L. MED. 381, 432 (1989).
- ³⁹ The fear of many lay people that the dying process is worse than death itself is justified, observes Capron, *supra* note 17, at 32-33, "given the failure of far too many medical practitioners to understand and apply modern pain management. The reason most lay people don't know that pain can be relieved in virtually every case (usually with means and doses that need not render patients unable to interact with their environment) is that many have themselves gone through illnesses or surgical recoveries without appropriate pain control or, worse yet, have seen loved ones die in unrelieved pain. Physicians, nurses, and other providers can—and must—overcome their cognitive and psychological impediments to providing adequate, patient-centered pain relief."
- ⁴⁰ Leon Kass, *Why Doctors Must Not Kill*, COMMONWEAL, Sept. 1992 (spec. supp.), at 8, 11.