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Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate

Susan M. Wolf*

INTRODUCTION

Were any of us offered a choice between unrelieved agony at life's end and assisted suicide,¹ we would probably choose the latter. And if we were further assured that there was already a widespread practice of physicians directly and intentionally causing death, we would fail to see why law should block the relief we sought.

Then how is it that many of us continue to oppose legalizing the practice? To a large extent, the answer lies in the facts. In reality we will not face that binary choice, as physicians can relieve virtually all pain, certainly if they can sedate patients to unconsciousness. And there is no real evidence of a widespread practice of physicians directly and intentionally causing death. Termination of life-sustaining treatment could be done to kill, but there is no evidence it usually is. Similarly, we have no persuasive evidence that physicians usually administer pain relief or sedation to terminal patients with the intent to end life. Indeed, it is not even clear that giving pain relief in high doses or heavy sedation actually hastens death.

* Associate Professor of Law and Medicine, University of Minnesota Law School, and Faculty Member, Center for Bioethics, University of Minnesota. A.B., Princeton University; J.D., Yale Law School. Thanks to Phil Frickey for initial encouragement and later comments; to George Annas, John Arras, Martin Benjamin, Gene Borgida, Meg Campbell, Jim Chen, Dan Faber, Kathleen Foley, Larry Jacobs, Sandy Johnson, Jeff Kahn, Joanne Lynn, Jim Foradek, Russell Portenoy, Mike Tonry, and Bob Truog for helpful critique and advice; to the University of Minnesota Law School Faculty Workshop for insightful suggestions; to my fellow panelists for thoughtful remarks at the Association of American Law Schools meeting at which we presented this symposium; to Ryan Johnson for able research assistance; and to the University of Minnesota Center for Bioethics for support.

1. Throughout this Article, I use "assisted suicide" to mean physician-assisted suicide.
I discuss these factual issues below. But the point is that facts matter. They do not alone resolve the outcome of the assisted suicide debate; normative controversy figures large. But they certainly alter the arguments and thus may affect that outcome, by showing some claims to be based on clinical realities and others not. For in deciding whether to legalize assisted suicide by statute or strike down state bans challenged on their face, that aggregate reality counts more than the idealized or imagined case. Yet this seemingly obvious truth is deeply contested in the assisted suicide debate.

Nothing shows this more clearly than the litigation of Washington v. Glucksberg and Vacco v. Quill. Abstract rhetoric 2. In Glucksberg and Quill the aggregate reality is more relevant than any individual case because most of the Justices saw these as facial challenges to the state statutes and none of the Justices saw them as challenges to statutes "as applied" to specific named patients. The majority in Glucksberg characterized the original suit as a facial challenge. See Washington v. Glucksberg, 117 S. Ct. 2258, 2261 (1997). However, the Court noted that the Ninth Circuit had held the challenged statute unconstitutional "as applied to terminally ill competent adults . . . " Id. at 2262 (quoting Compassion in Dying v. Washington, 49 F.3d 790, 837 (9th Cir. 1996) (en banc)). The Court thus proceeded to find Washington's statute constitutional both "on its face . . . [and] 'as applied to competent, terminally ill adults . . . ." Id. at 2275 (quoting Compassion in Dying, 79 F.3d at 838). Justices O'Connor and Stevens treated the challenge as facial. See id. at 2203 (O'Connor, J., concurring) and 2204-05 (Stevens, J., concurring). But see id. at 2275 n.2 (Souter, J., concurring) (challenge is "as-applied," not facial). Yet even the "as applied" construal of Glucksberg in the Ninth Circuit and by the Supreme Court majority would consider the statute's application to a group rather than named individuals, raising the question of what circumstances obtain in the aggregate for the group. See id. at 2262 n.6 ("[d]eclaring a statute unconstitutional as applied to members of a group is atypical but not uncommon" (quoting Compassion in Dying, 79 F.3d at 798 n.9)). In Quill the majority clearly regarded the challenge as facial. See Vacco v. Quill, 117 S. Ct. 2293, 2297 (1997).

As Justice Stevens noted, "The appropriate standard . . . [for] facial challenges . . . has been the subject of debate within this Court." Glucksberg, 117 S. Ct. at 2304. See generally Michael C. Dorf, Facial Challenges to State and Federal Statutes, 46 STAN. L. REV. 235 (1994); Sylvia A. Law, Physician-Assisted Death: An Essay on Constitutional Rights and Remedies, 55 MD. L. REV. 292 (1996). Justice Stevens argued that the Court had rejected the strict standard of United States v. Salerno, 481 U.S. 739, 745 (1987) ("no set of circumstances exists under which the Act would be valid"), and that the Court instead had concluded in Glucksberg that the statute "is not invalid . . . in all or most cases in which it might be applied." 117 S. Ct. at 2304-05. "[A]ll or most cases" again brings the aggregate reality to the fore. Cf. id. at 2309 (Stevens, J., concurring) (focusing on "the usual case").

When a legislature decides whether to legalize assisted suicide, it obviously must consider the circumstances arising in the aggregate, rather than specific individual cases.

ric warred with clinical data. At one level, all agreed on the
importance of facts. Yet the Second Circuit ignored the fac-
tual issues involved in deciding whether New York's distinc-
tion between termination of treatment and assisted suicide
was rational. The Ninth Circuit attended to some empirical
data, such as whether physicians already perform assisted
suicide covertly, but then based much of their reasoning on as-
sumptions without factual underpinning. In the Supreme
Court, respondents adverted to empirical work on some issues,
especially on the Dutch situation and what they called
"terminal sedation." Yet they advanced core arguments un-
supported or contradicted by the data. Petitioners also made
uneven use of the data, but at least announced their impor-


4. Petitioners and respondents, the circuit courts, and the Supreme
Court Justices all adverted to data on some points in their respective briefs
and opinions. This general agreement on the relevance of data distinguishes
the assisted suicide debate from a number of other debates in which the ex-
erts and academics have urged the importance of data, but that urging has
fallen on deaf or hostile ears. See, e.g., Mark H. Moore, Learning While Do-
ing: Linking Knowledge to Policy in the Development of Community Policing
and Violence Prevention in the United States, in INTEGRATING CRIME
PREVENTION STRATEGIES 301, 302-03 (Per-Olof H. Wikström et al. eds., 1995).
Several factors probably encourage what may be unusual agreement on the
relevance of data in considering assisted suicide. First, data from the Nether-
lands have been a consistent focal point in the debate. See MARGARET PABST
BATTIN, THE LEAST WORST DEATH 130 (1994). Second, this is a debate about
what physicians do now and how they would act if assisted suicide were legal;
questions about physician behavior are now routinely addressed with data.
See, e.g., TROYEN A. BRENNAN & DONALD M. BERWICK, NEW RULES:
REGULATION, MARKETS, AND THE QUALITY OF AMERICAN HEALTH CARE 116-
20, 200-06 (1996). Third, an entire industry of health services research gen-
erates copious data on medical practice. See generally Andrew F. Coburn, The
Role of Health Services Research in Developing State Health Policy, 17
HEALTH AFF. 139 (1998); John M. Eisenberg, Health Services Research in a
Market-Oriented Health Care System, 17 HEALTH AFF. 98 (1998). And fourth,
state and federal government entities are regularly both health care regula-
tors and payers, giving them an established and financial interest in health
care data. See generally Lawrence D. Brown, Knowledge and Power: Health
Services Research as a Political Resource, in HEALTH SERVICES RESEARCH:
KEY TO HEALTH POLICY 20 (Eli Ginzberg ed., 1991); Coburn, supra; Eisenberg,
supra; Daniel M. Fox, Health Policy and the Politics of Research in the United
States, 15 J. HEALTH POL'Y, Pol'y & L. 481 (1990) (starting in the 1980s, re-
search became important to governmental entities making health policy).
tance. It really fell to the amicus briefs to offer a fuller empirical picture.

The Justices then struggled openly with questions of empiricism. It was a problem they never solved; as in prior cases, the Justices remained vexed by the role of data. They used it inconsistently and sometimes ignored it altogether. Yet Justice Souter clearly indicated the importance of the empiricism problem and Justice Stevens explicitly identified the troubling gap between clinical reality and the ideal case. Even among the other Justices, concern about clinical realities moved them away from acontextual rhetoric. For many of the Justices, the facts or sheer factual uncertainty drove them to send the assisted suicide question back to the legislatures.

In spotlighting the empiricism problem, the Court demonstrated a sensitivity to data in these cases that it has often failed to show in the past. It remains to be seen, however, whether the legislatures and broader electorate will get the message. Yet how they now approach the question of whether

5. See Brief for the Petitioners at 40, Glucksberg (No. 96-110), available in 1996 WL 656349.


8. Many analysts have argued that data rarely determine governmental policy making, though they may serve a general "enlightenment function." See, e.g., Richard Lempert, "Between Cup and Lip": Social Science Influences on Law and Policy, 10 L. & POL'Y 167, 183-86 (1989); Carol H. Weiss, Ideology, Interests, and Information: The Basis of Policy Positions, in ETHICS, THE SOCIAL SCIENCES, AND POLICY ANALYSIS 213 (Daniel Callahan & Bruce Jennings eds., 1983). However, as I note above, there are reasons to think that health care data have become influential, particularly beginning in the 1980s. See supra note 4.

Some have voiced similar skepticism about whether data play much of a role in shaping public attitudes. See, e.g., CHARLES E. LINDELOM, INQUIRY AND CHANGE 27, 60-61, 214, 216-30 (1990) (arguing, however, that science should still play a role in supporting "lay probing" to yield "more thoughtful
to legalize assisted suicide hinges to a significant extent on the unresolved question of the role of data. For buried in the current debates over policy and constitutional law is a deeper struggle. It is a struggle between abstract argument that largely avoids the data on end-of-life practices and presents future assisted suicide in idealized terms, and argument that places assisted suicide in the context of data, tethering claims to the realities of the clinic.\(^9\)

This, of course, is a struggle with implications far beyond assisted suicide. It involves the degree of abstractness and generality with which we frame rights,\(^10\) and the role of facts—especially what have been called "legislative facts"—in policy and constitutional disputes.\(^11\) It has animated a widespread


9. Though I am arguing that some of the core arguments offered by respondents and embraced by the Second and Ninth Circuits fell into the trap of acontextualism in Glucksberg and Quill, advocates on both sides of the assisted suicide debate are perfectly capable of severing the normative argument from the underlying facts. Conversely, there are advocates on both sides who pay careful attention to the clinical facts. Arguments for and against assisted suicide that demonstrate marked sensitivity to clinical realities include Howard Brody, Assisted Death—A Compassionate Response to a Medical Failure, 327 New ENG. J. MED. 1384 (1992) and Ezekiel J. Emanuel, The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy, 82 MINN. L. REV. 983 (1998) [this Symposium].


11. See, e.g., Faigman, supra note 7; Dean M. Hashimoto, Science as Mythology in Constitutional Law, 76 OR. L. REV. 111 (1997); Rachael N. Pine, Speculation and Reality: The Role of Facts in Judicial Protection of Fundamental Rights, 136 U. PA. L. REV. 655 (1988). For further analysis of "legislative facts"—broader questions of fact beyond the adjudicative facts peculiar to the case at hand—see, for example, Dean Alfange, Jr., The Relevance of Legislative Facts in Constitutional Law, 115 U. PA. L. REV. 637 (1966); Kenneth Culp Davis, An Approach to Problems of Evidence in the Administrative Process, 55 HARV. L. REV. 364 (1942); Ann Woolhandler, Rethinking the Judicial Reception of Legislative Facts, 41 VAND. L. REV. 111 (1988). Monahan and Walker have offered an alternative conceptualization, maintaining that courts creating a rule of law should regard social science data as "social authority." John Monahan & Laurens Walker, Social Authority: Obtaining, Evaluating, and Establishing So-
revival of interest in pragmatism and its associated empiricism, in the legal academy and beyond. The "call to context" is now widely heard.

That call has a special significance in the world of health care, particularly at the end of life. The way our medical in-
stitutions and personnel care for patients facing death is among the most thoroughly studied of all issues in patient care. It has generated more empirical literature than practically any other area. It is at least peculiar, then, to see core assertions in the debate over assisted suicide put forward as if none of this information existed. Assisted suicide thus becomes an imagined practice with no context. Scholars, advo-

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16. This copious and growing literature, researching everything from do-not-resuscitate (DNR) orders to the use of advance directives, includes reports from the SUPPORT study, the largest ethically driven empirical study to date. See, e.g., Jan C. Hoffman et al., Patient Preferences for Communication with Physicians About End-Of-Life Decisions, 127 ANNALS INTERNAL MED. 1 (1997); D.J. Murphy & L.E. Cluff, SUPPORT: Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment: Study Design, 43 J. CLINICAL EPIDEMIOLOGY 15 (Supp. 1990); The SUPPORT Principal Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT), 274 JAMA 1591 (1995); Correction, 275 JAMA 1232 (1996).


For such studies in the Netherlands, see, for example, M.T. Muller et al., Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?, 42 J. AM. GERIATRICS SOC'Y 624 (1994); Loes Pijnenborg et al., Life-Terminating Acts Without Explicit Request of Patient, 341 LANCET 1196 (1993); P.J. van der Maas et al., Euthanasia and Other Medical Decisions Concerning the End of Life, 22 HEALTH POLY 1 (1999); Paul J. van der Maas et al., Euthanasia and Other Medical Decisions Concerning the End of Life, 338 LANCET 669 (1991); Paul J. van der Maas et al., Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995, 335 NEW ENG. J. MED. 1699 (1996); G. van der Wal et al., Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?, 9 FAM. PRAC. 135 (1992).

cates, and judges alike proceed as if the normative policy and constitutional questions could be answered with little grounding in clinical reality.¹⁷

Yet few commentators have directly addressed the role of empiricism and data in the assisted suicide debate.¹⁸ Rarely named and openly confronted, the confusion over the role of facts is the ghost in the machine. It ensures the debate will continue, even if only because the debaters talk past each other, giving different weight to abstraction and data, yet never confronting the issue.

This Article is an attempt to face directly the problem of empiricism's role in the assisted suicide debate. Part I argues that there are strong reasons to insist on pragmatism and empirical analysis in confronting assisted suicide. Not only are the data copious, but the life-and-death stakes demand careful attention to context and current practice. Beyond that, experience has taught us that abstract, lawyerly conceptions of rights and transactions work poorly at death's door. The only way actually to enlarge human freedom and diminish human suffer-

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¹⁷. In making this claim, I do not intend to fall into the positivist trap of mistaking scientific data for fundamental truth. Instead, I am making the pragmatist's claim that what is important is what is likely to work (in the context of assisted suicide, what is likely to work in patient care settings), and that empirical data are a useful indication of that. On different ways of understanding empiricism, see, for example, David M. Trubek, Where the Action Is: Critical Legal Studies and Empiricism, 36 STAN. L. REV. 575 (1984).

As I indicated above, I am also not claiming that empiricism obviates the need for normative analysis or that science should substitute for law. See generally Nancy K. Rhoden, Trimesters and Technology: Revamping Roe v. Wade, 95 YALE L.J. 639 (1986); Laurence H. Tribe, Seven Deadly Sins of Straining the Constitution Through a Pseudo-Scientific Sieve, 36 HASTINGS L.J. 155 (1984). Instead, I am suggesting that normative analysis—here, of assisted suicide—will fail us when it has little grounding in the lives of patients and pays scant attention to what seems to work for those patients.

In making that argument below I cite to the relevant data sources without revisiting all the numbers here. I am offering a meta-argument on the role of data, and in any case have written extensively on the data themselves before. See Susan M. Wolf, Facing Assisted Suicide and Euthanasia in Children and Adolescents, in REGULATING HOW WE DIE (Linda L. Emanuel ed., forthcoming 1998); Susan M. Wolf, Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia, in FEMINISM & BIOETHICS: BEYOND REPRODUCTION 282 (Susan M. Wolf ed., 1996); Susan M. Wolf, Physician-Assisted Suicide in the Context of Managed Care, 35 DUQ. L. REV. 465 (1996). Ezekiel Emanuel reviews some of the key data elsewhere in this symposium. See Emanuel, The Future of Euthanasia, supra note 9.

¹⁸. An exception is Fins et al., Framing the Physician-Assisted Suicide and Voluntary Active Euthanasia Debate, supra note 15.
ing at the end of life is to pay careful attention to what is going on and build from there.

Part II then evaluates the debate leading up to the Supreme Court decisions in *Glucksberg* and *Quill*. I claim that the advocates for a constitutional right to assisted suicide in that litigation, as well as the Ninth and Second Circuits, failed to heed the call of pragmatism. They showed this in their framing of the right involved and their claim that constitutional protection of that right would increase patient liberty. They further showed it in asserting that there was no real difference between assisted suicide and the already accepted practice of terminating life-sustaining treatment as well as what some have called "terminal sedation." I argue that by offering an abstract view of death with little grounding in the data, they went astray, misdescribing the problem that patients face and misprescribing a faulty solution.

Part III turns to the Supreme Court's handling of the empiricism problem. The oral argument was haunted by this issue. The Justices never resolved it, but they took an important step forward. Justice Rehnquist's opinion for the Court in *Glucksberg* went a long way toward embracing contextualism and data by framing the right at stake more cautiously than respondents and looking to real practice. Justice Souter's concurrence struggled explicitly with the empiricism issue, though he threw up his hands at the complexity of the data at hand and called for legislative action instead. And Justice Stevens emphasized the critical gap between the usual case and the

ideal one. Ultimately, of course, the Court turned the assisted suicide question back to the state legislatures and democratic process. But the Justices signaled that the electorate and their representatives need to sort abstract, ungrounded visions of life's end from those rooted in actual practice and data.

Finally, Part IV considers where we stand after Glucksberg and Quill and turns to the debate we now face in the states. I argue that acontextualism remains an enormous problem. The sweeping rights that respondents advocated in the Supreme Court litigation sound appealing in the abstract. It is only when one begins investigating the underlying factual assumptions and the realities of care at the end of life that the picture becomes more complex. Thus, I argue that empiricism is a critical component of responsible democratic debate. The Supreme Court implicitly urged careful attention to data and context. Yet we now risk democratic decisionmaking driven by abstract slogans, euphemisms, and acontextual fantasies. That fails to meet the criteria for true democratic deliberation, and it risks great harm to the sickest among us.

Ultimately, this Article is about how we choose to face death. There is a long history of denial and retreat into fantasy. Many have tried to beat the Reaper with grand rhetoric before. And we lawyers can hardly be blamed for trying to force death into the regime we know, the world of rational rights-bearers, documents, and arm's length transactions. But decades of work on death and dying place us now in a new position. Armed with data, facing death no longer behind closed doors but in the more public light of the hospital and nursing home, we can start using what we know. We can try to look


squarely at death, facing the needs of real patients and caregivers, insisting on pragmatism at life’s end.

I. WHY PRAGMATISM AT DEATH’S DOOR?

The revival of interest in pragmatism is not without controversy. The careful attention to data, actual practice, and context that are characteristic of pragmatism’s inductivism also prompt concern. Critics charge that pragmatism is antitheory, mindlessly enslaved to facts. They claim it is so tethered to the world as we know it that it supports only small tinkering with the status quo rather than the abrupt changes that are sometimes needed.

Yet pragmatism is being embraced in health law, bioethics, and analysis of clinical care generally in a way that mutes some of these concerns. Pragmatism’s flowering in these areas is demonstrated by the rise of a vigorous empiricism, the replacement of a principle-driven deductivism with a panoply of more inductive approaches, and an insistence that legal and ethical prescriptions for clinical behavior withstand empirical evaluation. But this is not the mindless submersion in data that critics of pragmatism deplore. Instead, this new empiricism is anchored by the long-standing normative commitment to patient autonomy and welfare that pervades bioethics, health law, and clinical care itself. Much as some have defended pragmatism generally by insisting that its “call to context” has normative content in refocusing attention on the powerless at the bottom, pragmatism in health care can be defended by citing its commitment to the patient.

After Passage of Medicare’s Prospective Payment System: A National Study, 320 NEW ENG. J. MED. 433 (1989).


25. For analysis of this charge, see, for example, Cornel West, The Limits of Neopragmatism, in PRAGMATISM IN LAW AND SOCIETY, supra note 12, at 121, 122.


27. See Wolf, Shifting Paradigms, supra note 15.

28. See Minow & Spelman, supra note 13, at 261 ("[T]he call to context... reflects a critical argument that prevailing legal and political norms have used the form of abstract, general, and universal prescriptions while often neglecting the experiences and needs of women..., people of color, and people
Efforts to improve care at the end of life have, in fact, been the cornerstone of the new empiricism and pragmatism in bioethics. As noted above, end-of-life issues have provoked an outpouring of data, more than any other issue in bioethics or health law. Those data have already taught us important lessons bearing on the assisted suicide debate.

They have taught that an abstract, lawyerly model of patients' rights and autonomy does not bear much resemblance to clinical reality. While many bioethicists promoting patients' rights are taking this to heart, some advocates for legalizing assisted suicide are not. The latter embrace a model that depicts patients as independent rights-bearers making decisions at the end of life free from undue pressure and coercion. Yet there are numerous problems with this vision.

First, patients actually exercise little control over end-of-life care. For one thing, nature intercedes. Death, after all, is a physiological process; there is much we cannot control. Physicians cannot even reliably say who is terminally ill and when they will die. It is hubris to pretend that patients and physicians can truly control the dying process.

Beyond the realm of nature, in the domain that human beings more readily influence, patients themselves actually exercise little control. Far more powerful than patient choices in affecting end-of-life care are preexisting patterns of care, differences among health care systems, and the setting in which the patient finds herself. And though setting, at least, may seem to be something that patients control, in fact they do not

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control it to any great extent. Moreover, physicians seldom elicit patient preferences early enough in the terminal process to have a substantial effect. By the time most decisions about life-sustaining treatment must be effectuated, patients have already lost decisional capacity. Even when a patient has left an advance directive, which is in the minority of cases, the directive may be ignored or overridden in the clinic.

One might respond that this shows the affirmative need for a normative vision of patients' rights to improve practice. Yet a normative vision is useless unless it bears some relationship to the reality it seeks to change. All too often the normative vision proposed for clinical care regards the patient and health professional as if they were bargaining over widgets in an arm's length commercial transaction. In reality, patients are profoundly dependent on health professionals, with many patients reporting that they want their physician to make treatment decisions for them. Even patients who write advance directives, surely among those patients most interested in directing their own care, may say they want their directives


33. See The SUPPORT Principal Investigators, supra note 16.

34. See Nicholas G. Smedira et al., Withholding and Withdrawal of Life-Support from the Critically Ill, 322 NEW ENGL. J. MED. 309 (1990).


to serve only as general guides rather than being effectuated literally.\textsuperscript{39}

Beyond the overestimation of patient control at the end of life, the vision of patients as independent and fully voluntary decisionmakers is challenged by data on pain and depression. Pain is widely undertreated in the United States, especially among children, the elderly, women, and minorities.\textsuperscript{40} Yet, as one might expect, pain is correlated with significant distress and, in a number of studies, with requests for assisted suicide.\textsuperscript{41} Indeed, acute concern about the abysmal failure to treat pain and provide appropriate palliative care (to address other discomforts such as dyspnea that differ from frank pain) has provoked an outpouring of studies and reform efforts.\textsuperscript{42} The research shows, however, that depression is even more strongly correlated with requests for assisted suicide than pain is.\textsuperscript{43} Yet patients routinely face inadequate diagnosis and treatment of depression.\textsuperscript{44} Given these data, a patient requesting assisted suicide may actually be seeking relief from depression or pain.\textsuperscript{45}

These realities suggest that the problem with the abstract vision of patients' rights is not merely the often-seen gap between norms and practice. There is a deeper problem. Terminal patients are quite unlike independent rights-bearers freely negotiating in business transactions. Instead, they are pro-


\textsuperscript{40} See Charles S. Cleeland et al., Pain and Its Treatment in Outpatients with Metastatic Cancer, 330 NEW ENG. J. MED. 592, 594-95 (1994); Anne B. Fletcher, Pain in the Neonate, 317 NEW ENG. J. MED. 1347 (1987); Mary D. Tesler et al., Postoperative Analgesics for Children and Adolescents: Prescription and Administration, 9 J. PAIN & SYMPTOM MGMT. 85, 90 (1994).

\textsuperscript{41} See Kathleen M. Foley, The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide, 6 J. PAIN & SYMPTOM MGMT. 289 (1991); van der Maas et al., LANCET, supra note 16, at 672; van der Wal et al., FAM. PRAC., supra note 16, at 138.


\textsuperscript{43} See Susan D. Block & J. Andrew Billings, Patient Requests to Hasten Death: Evaluation and Management in Terminal Care, 154 ARCHIVES INTERNAL MED. 2039 (1994); Breitbart et al., Interest in Physician-Assisted Suicide, supra note 16; Emanuel et al., Euthanasia and Physician-Assisted Suicide, supra note 16; Jacobson et al., supra note 16.

\textsuperscript{44} See, e.g., Eliseo J. Pérez-Stable et al., Depression in Medical Outpatients: Underrecognition and Misdiagnosis, 150 ARCHIVES INTERNAL MED. 1083, 1086 (1990); Wolf, Physician-Assisted Suicide in the Context of Managed Care, supra note 17, at 466 (analyzing the data on patients in managed care).

foundly dependent, often at the mercy of health professionals for everything from toileting to life-saving care, and may be experiencing too much pain, discomfort, or depression to make independent and truly voluntary decisions.\textsuperscript{46} They may not even know that relief from their depression or pain is available without suicide.

Of course, this critique of the adequacy of traditional rights concepts is not new. Others have argued from the realities of interdependence to suggest revised visions of rights and autonomy outside of medical settings.\textsuperscript{47} But the debate about end-of-life care too often slides back into a simple rights formulation, ignoring questions about how those rights are likely to play out in clinical settings.\textsuperscript{48} Patients obviously should not lose their rights at the hospital admitting office, and patients' rights to make informed decisions about their care and refuse unwanted treatment are basic to anything resembling humane clinical care. But the data caution that we must always ask how proposed rights will function in clinical settings; we must see all these rights in context.

\section*{II. AVOIDING PRAGMATISM}

What does grounding our analysis in context tell us about the claimed right to assisted suicide? It tells us a great deal. It reveals problems in respondents' and the circuit courts' framing of the supposed right and specification of the popula-

\footnote{46. Certainly one can debate whether and when pain and depression actually remove decisional capacity. \textit{See, e.g.}, ALLEN E. BUCHANAN \& DAN W. BROCK, DECIDING FOR OTHERS 56-57, 68-69 (1989); Robert Weinstock et al., \textit{Competence to Give Informed Consent for Medical Procedures,} 12 BULL. AM. ACAD. PSYCHIATRY \& L. 117 (1984). I am not suggesting that they always do. Rather, I am making the subtler point that they may compromise voluntariness. \textit{See generally} TOM L. BEAUCHAMP \& JAMES F. CHILDRESS, \textsc{Principles of Biomedical Ethics} 163-68 (4th ed. 1994). They may also transform the assisted suicide decision into an effort to escape the pain and depression, even though that can be accomplished by nonfatal means. Indeed, patients who get treatment may stop wanting assisted suicide. \textit{See} Foley, \textit{The Relationship of Pain,} supra note 41, at 290 (suicidal ideation and requests for assisted suicide commonly “dissolve with adequate control of pain and other symptoms”). More generally, I am arguing that we should not idealize the circumstances under which patients consider assisted suicide, but rather should face the problems.}

\footnote{47. \textit{See, e.g.}, MINOW, supra note 15, at 227-372; Jennifer Nedelsky, \textit{Reconcepting Autonomy: Sources, Thoughts and Possibilities,} 1 YALE J.L. \& FEMINISM 7 (1989).}

\footnote{48. \textit{See, e.g.}, Susan M. Wolf, \textit{Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia,} supra note 17, at 298-308.}
tion of rights bearers, in their analysis of the consequences of recognizing such a right, and in their formulation of the relationship between assisted suicide and other end-of-life practices.

A. THE DUE PROCESS RIGHT AND RIGHTS-BEARERS

Glucksberg occasioned extensive debate over how to frame the Fourteenth Amendment liberty interest respondents asserted. The Ninth Circuit found a "liberty interest in controlling the time and manner of one's death—... a constitutionally recognized 'right to die.'" But in the Supreme Court respondents opted for less sweeping formulations. Professor Tribe's brief emphasized the right to choose "whether to endure a death marked by intolerable agony, degradation, and suffering." Kathryn Tucker, the other counsel for respondents, similarly emphasized that what they sought was not a right to decide whether to die but how. By framing the right to assisted suicide in these ways, respondents and the Ninth Circuit tried to identify a right likely to be found constitutionally protected because it would be seen as broad enough to include Cruzan's right to terminate treatment and Casey's right to choose an abortion.

Yet these abstract formulations make several assumptions. They assume there is an already existing capacity to control the time and manner of one's death. But as indicated above, there is not. Individual patients assert relatively little control. And even when a patient terminates life-sustaining treatment, that patient then may or may not die. Because patients can

49. Compassion in Dying v. Washington, 79 F.3d 790, 816 (9th Cir. 1996) (en banc).
50. Brief for Respondents at 21, Quill (No. 95-1583), available in 1996 WL 708912. Though Tribe was arguing in Quill, he devoted much of his argument and brief to the substantive due process questions raised by Glucksberg.
54. See, e.g., Margaret L. Campbell et al., Patient Responses During Rapid Terminal Weaning from Mechanical Ventilation: A Prospective Study, CRITICAL CARE MED. (forthcoming 1998); Margaret L. Campbell & Richard W. Carlson, Terminal Weaning from Mechanical Ventilation: Ethical and Practical Considerations for Patient Management, AM. J. CRITICAL CARE, Nov. 1992, at 52; Richard W. Carlson et al., Life Support: The Debate Continues, 109 CHEST 852 (1996) (letter). When Karen Ann Quinlan's ventilatory support was terminated, for example, she defied all predictions by living another nine years. See Edward
survive termination of many life-sustaining treatments, re-
spondents and the Ninth Circuit focused on forgoing artificial
nutrition and hydration, arguing that it led to certain death. Yet some patients may retain the capacity to take food and water orally, so that terminating tube-delivered sustenance does not bring on death if oral nutrition and hydration are still offered. Indeed, a patient forgoing life-sustaining treatment may not be seeking to hasten death, and may be pleased when she con-
continues living. Respondents and the Ninth Circuit further pointed to drugs given for pain relief or sedation in doses that risk hastening death, claiming that this was another form of control already asserted over death. But the data cast doubt on whether these drugs actually terminate life.

In fact, only the practice that respondents championed and
the Ninth Circuit vindicated, assisted suicide, might be claimed invariably to control the time and manner of death. Thus, respondents and the circuit court identified no general practice of which the Cruzan practice was a subspecies. Respondents were arguing for a new practice and right, but trying to frame it abstractly enough to lean on Cruzan and Casey. They failed to frame the new right in a way that includes Cruzan. Yet even their “right to choose” tack, an effort to lean on Casey, was factually problematic.

Respondents’ “right to choose” argument made several im-
important assumptions. It assumed patients were choosing be-


55. See Brief of Respondents at 25-26, Glucksberg (No. 96-110), available in 1996 WL 708925; Brief for Respondents at 1-2, 16, Quill (No. 95-1858), available in 1996 WL 708912; Compassion in Dying, 79 F.3d at 822-23.


57. See Brief for Respondents at 1, 14-16, 40-41, Quill (No. 95-1858), available in 1996 WL 708912; Compassion in Dying, 79 F.3d at 822-23, 828.

58. See Frank J. Brescia et al., Pain, Opioid Use, and Survival in Hospitalized Patients with Advanced Cancer, 10 J. CLINICAL ONCOLOGY 149 (1992); Patrick Stone et al., A Comparison of the Use of Sedatives in a Hospital Support Team and in a Hospice, 11 PALLIATIVE MED. 140 (1997); Vittorio Ventafridda et al., Symptom Prevalence and Control During Cancer Patients' Last Days of Life, J. PALLIATIVE CARE, Autumn 1990, at 7; William C. Wilson et al., Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support from Critically Ill Patients, 267 JAMA 949, 952 (1992). See generally Gina Kolata, When Morphine Fails To Kill, N.Y. TIMES, July 23, 1997, at C7. But note that at least one set of authors suggests a distinction in this debate between opioids and barbiturates, claiming that the latter may hasten death even when the former will not. See Truog et al., supra note 19, at 1680-81.
between “intolerable agony, degradation, and suffering” and death. The Ninth Circuit made this assumption as well. Yet physicians can relieve terrible pain without causing death, through aggressive use of analgesics, sedation sometimes to unconsciousness, nerve blocks, and a host of techniques. Indeed, the data show that pain is not the leading reason why people opt for assisted suicide, both in the United States and the Netherlands.

Often more difficult to administer than pain relief is effective palliative care, relief of discomfort that is not frank pain, such as difficulty breathing or nausea. Yet here, too, a wide range of techniques including sedation to unconsciousness is available. It is simply not accurate to say a patient must choose between intolerable agony and death; in reality, there are other options.

Respondents’ real complaint was that one of these methods of pain relief and palliative care, specifically sedation to unconsciousness, was unacceptable. Rejecting it as degrading and undignified, they reduced the choice to agony or death. But that was a “choice” of their own creation. A patient who is unconscious will not experience anything as degrading and undignified. And while some patients contemplating sedation to unconsciousness might prefer to avoid that, much as some patients are horrified to consider a colostomy or amputation, that does not eliminate the option.

Respondents and the Ninth Circuit further assumed a fictive rights-bearer choosing freely and independently. They overlooked the influence of depression and the realities of extreme patient dependency. As noted above, the data tell us that depression, more than pain, is the reason patients opt for

59. Brief for Respondents at 21, Quill (No. 95-1858), available in 1996 WL 708912.
60. See Compassion in Dying, 79 F.3d at 814.
61. See ROBERT TWYCROSS, PAIN RELIEF IN ADVANCED CANCER (1994); Ventafridda et al., supra note 58.
62. See supra note 43 and accompanying text.
63. On why patients in the Netherlands opt for assisted suicide and euthanasia, see Muller et al., supra note 16, at 626; van der Maas et al., LANCET, supra note 16, at 672; van der Wal et al., FAM. PRAC., supra note 16, at 137-38.
64. See, e.g., Ventafridda et al., supra note 58.
65. See Transcript of Oral Argument, Quill (No. 95-1858), available in 1997 WL 13672, at *55-56 (Jan. 8, 1997) (“[T]he liberty interest... is the liberty... not to be forced by the government to endure a degree of pain and suffering that one can relieve only by being completely unconscious.”).
assisted suicide. Yet we know little about appropriately diagnosing, much less treating, depression at the end of life, despite increasing interest in this problem in recent years. And there are significant systemic barriers to appropriate diagnosis and treatment, with managed care organizations doing a demonstrably inferior job. Add to this picture the tremendous dependency of these sick and depressed patients upon their caregivers, and you begin to see the gap between the rights-bearers that the respondents and the Ninth Circuit depicted and the usual realities. The respondents and the court posited rights-bearers sufficiently independent and free of undue influence to exercise a "right to choose" between unalleviated symptoms and immediate death. But the statistically prevalent reality is a depressed and dependent patient with inadequately treated symptoms, driven to a death that is far from freely chosen.

Even if a patient were an ideal rights-bearer freely deciding, however, respondents' argument was built on unwarranted assumptions about the dying process in another respect. In seeking the right only for the terminally ill, respondents claimed we can identify this group. But they overstated our powers. As discussed above, we cannot predict who will die when, and we cannot tell in advance of death who is "terminal." Certainly there are cases in which physicians can be reasonably sure a patient will die within a few hours, but those are not cases in which assisted suicide is relevant. The Ninth and Second Circuits noted the problem, but dismissed it. The Ninth Circuit treated it as another instance of the small imprecisions commonly tolerated in applying statutes; the Second Circuit simply asserted that doctors would agree who was

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66. See supra note 43 and accompanying text.
68. See Wolf, Physician-Assisted Suicide in the Context of Managed Care, supra note 17.
69. See, e.g., Compassion in Dying v. Washington, 79 F.3d 790, 820-21 (9th Cir. 1996) (en banc) (entirely ignoring depression).
70. See supra note 46.
71. See supra note 30 and accompanying text.
Neither court tackled the substantial uncertainty that actually attends this prediction.

B. THE CONSEQUENCES

Central to respondents' argument and the Ninth Circuit's analysis was the prediction that recognizing a right to assisted suicide will enlarge patients' freedom and improve their care. Further, respondents predicted that state interests in avoiding error and abuse in assisted suicide could be effectively vindicated through regulation, rather than a ban. Both predictions ignored the realities of the clinic.

The consequences of recognizing a right to assisted suicide will depend to a large extent on the context. Over forty million Americans now lack health insurance, and many more are underinsured. All of these people lack the resources to cope with serious illness, much less gain access to sophisticated pain relief and palliative care. Even if they had the resources, we know that most people now die with significant and undertreated pain and discomfort. We also know that unrecognized and undertreated depression is a substantial problem at life's end.

In this context, it is far from clear that simply giving patients and health professionals the option of exiting all of these

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72. See Compassion in Dying, 79 F.3d at 831; Quill v. Vacco, 80 F.3d 716, 731 (2d Cir. 1996). In a similar effort to avoid the problem, respondents suggested that any error would be "in the direction of excessive optimism regarding . . . life expectancy." Brief of Respondents at 36 n.24, Glucksberg (No. 96-110), available in 1996 WL 708925. But the data show the problem is more complex. See supra note 30 and accompanying text.

73. The Ninth Circuit did cite data to show that "allowing the terminally ill to hasten their deaths" was already widespread and widely supported. Compassion in Dying, 79 F.3d at 810-11. Yet because the court defined "hastening their deaths" to include the well-accepted and legally mandated practice of honoring patients' wishes to forego life-sustaining treatment, this showed very little. And the court demonstrated none of the caution in interpreting polling results and self-reported clinical practices that all agree is essential. See, e.g., Kathleen M. Foley, Pain, Physician-Assisted Suicide, and Euthanasia, 4 PAIN F. 163, 171 (1995); Letters, The Role of Critical Care Nurses in Euthanasia and Assisted Suicide, 335 NEW ENG. J. MED. 971 (1996); Colleen Scanlon, Euthanasia and Nursing Practice—Right Question, Wrong Answer, 334 NEW ENG. J. MED. 1401 (1996).


75. See Cleeland et al., supra note 40, at 593, 595; The SUPPORT Principal Investigators, supra note 16, at 1595.

76. See supra note 67 and accompanying text.
problems through assisted suicide represents an enlargement of patients' freedom and improvement in their care. Of course, one could respond that any new option necessarily increases liberty merely by adding a further possible course of action. But that argument pretends that each possible course of action at life's end exists in a vacuum. It ignores their interdependence.

In fact, the only data we now have on the effect of recognizing a right to assisted suicide come from the Netherlands. There we find fewer hospice options than in England, which prohibits assisted suicide. An even stronger indication that recognizing a right to assisted suicide may threaten the welfare of patients at life's end rather than improving care and securing freedom comes from the data on what the Dutch call "LAWER," life-terminating actions without patients' consent. Though Dutch rules firmly require voluntary patient consent for assisted suicide and euthanasia, they have been unable to confine the practices. The substantial incidence of nonvoluntary and involuntary practice shows how serious the question is of whether allowing assisted suicide represents a net gain for patients.

Dutch data, moreover, should underpredict American problems. After all, the Dutch have universal health insurance, a more homogeneous society economically and racially, and a continued tradition of long-standing patient-doctor relation-

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77. Cf. The N.Y. STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 89, 120-21, 134 (1994) [hereinafter N.Y. STATE TASK FORCE] (legalizing assisted suicide may undermine autonomy in practice); J. David Velleman, Against the Right to Die, 17 J. MED. & PHIL. 665 (1992) (increasing options may have a negative effect).


79. See Pijnenborg et al., supra note 16, at 1196-97.


81. On the incidence of nonvoluntary and involuntary practice in the Netherlands, see Pijnenborg et al., supra note 16; van der Maas et al., New ENG. J. MED., supra note 16. Respondents argued that legitimating assisted suicide may neither have created this questionable practice nor worsened it over time. Brief for Respondents at 42 n.21, Quill (No. 95-1858), available in 1996 WL 708912. But they missed the point, that the Dutch have been unable to control practice in violation of their own rules,
ships and even house calls. So Dutch patients should be better able to forge a therapeutic partnership untroubled by racism and economic limitations. They should have fewer difficulties accessing the care they need and finding genuine alternatives to assisted suicide and euthanasia. They should also enjoy greater confidence that their physician can respond to depression, uncontrolled pain and discomfort, and suicidal ideation by demonstrating genuine understanding and commitment to them. Yet even the Dutch have encountered substantial problems in keeping assisted suicide and euthanasia voluntary. Indeed, it appears that for some patient populations, such as newborns, they are giving up.

In the American context, the only plausible prediction is that these problems would be much worse. The Ninth Circuit, however, dismissed these concerns by labeling them "ludicrous." Yet this was simply wishful thinking. Indeed, the Ninth Circuit's consideration of the risks of recognizing a right to assisted suicide made further wishful assumptions. The court found physician involvement in assisted suicide "an important safeguard," basing this conclusion on predictions that physicians would refuse to assist suicide in a number of circumstances and on physicians' supposedly "conservative nature." Yet the court cited nothing to support all of this, and it


83. See COMMITTEE OF THE SECTION ON PERINATOLOGY, DUTCH PEDIATRIC ASSN, To Do or Not To Do? Boundaries of Medical Action in Neonatology (English summary), in DOEN OF LATEN? GRENZEN VAN HET MEDISCH HANDELEN IN DE NEONATOLOGIE 11, 14 (1992) (recommending that "[p]urposeful ending of life [be] . . . possible with the permission of the parents"). For analysis extending beyond newborns to older children and adolescents, see Wolf, Facing Assisted Suicide and Euthanasia in Children and Adolescents, supra note 17.

84. On problems in U.S. health care associated with American heterogeneity, for example, see Council on Ethical and Judicial Affairs, American Medical Association, Black-White Disparities in Health Care, 263 JAMA 2344 (1990).

85. Compassion in Dying v. Washington, 79 F.3d 790, 825 (9th Cir. 1996) (en banc).

86. Id. at 826-27. The court asserted without any support:
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
is difficult to imagine what they could have cited. The court grounded its conclusions in idealizations, not realities.

Finally, the Ninth Circuit and respondents ignored realities in asserting the adequacy of regulation to vindicate state interests in avoiding error and abuse in administering assisted suicide. In fact, the Dutch data have been sobering. The Ninth Circuit disparaged the Dutch data, relegating them to a footnote. But those data are the most rigorous available, and should underpredict American problems, as noted above. Dutch regulation of assisted suicide and euthanasia depends on physicians reporting each instance to state authorities to permit monitoring and investigation. Yet data show that the majority of physicians do not report. Consequently, there is no reliable way to check for error and abuse.

Numerous groups have offered models suggesting how assisted suicide should be regulated in this country. Yet none of them has dealt seriously with the predictable gap between written rules and human behavior. The lawyer's assumption reigns, that prescribing on paper makes it so in real life. Yet we know that is not true.

C. ASSISTED SUICIDE VERSUS OTHER PRACTICES

Finally, respondents and both circuit courts challenged the distinction between assisted suicide and the accepted end-of-life practices of forgoing treatment and aggressive pain relief. Indeed, the rationality of the distinction between assisted sui-
cide and termination of treatment was the critical question posed by the equal protection claim in *Quill*. Respondents further argued that a practice of "terminal sedation" is indistinguishable from assisted suicide. But the proffered analysis of all these practices largely avoided the matter of data.

Respondents and the courts first maintained that termination of treatment could not be rationally distinguished from assisted suicide because of several claimed similarities. Both practices were "hastening death" and implicated the "interest in controlling the time and manner of one's death." Yet the courts merely asserted this, without acknowledging the reality that termination of treatment does not invariably precipitate death, though assisted suicide does. Respondents and the courts further asserted that termination of treatment acts as the cause of death as surely as assisted suicide, rejecting the argument that termination of treatment allows the underlying disease or disorder to take its course. But the very fact that some patients survive termination of treatment challenges this analysis and suggests that termination of treatment does leave the patient's death to be determined by the underlying physical condition. Respondents and the courts lastly suggested that physicians' intent in both terminating treatment and assisting suicide is to bring about death. But that partly empirical claim was supported by no data. Respondents and the courts never rebutted the common view that physicians remove life-sustaining treatment to honor patients' wishes and their right to be free of unwanted treatment, though physicians will often know that patients may then die.

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92. *Compassion in Dying*, 79 F.3d at 816.
93. Gathering good data on physician intent may prove challenging. Physicians may be reluctant to report an intent to end life and it may be difficult to design a research instrument that separates intent from foreseeability and related concepts. See *infra* note 121, critiquing two studies. Yet data can be gathered on what physicians report their intent to be in performing various practices. *Cf.* David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 NEW ENG. J. MED. 1374, 1374 (1996) (asking nurses whether they "acted" with the specific intent of causing or hastening... death"); Wilson et al., *supra* note 58, at 950 (asking for "reasons"). And it is those mounting a constitutional challenge to state bans on assisted suicide who must overcome the "strong presumption of validity" that attaches to the legislative distinctions between termination of treatment and assisted suicide. *See Quill*, 117 S. Ct. at 2297 (quoting *Heller v. Doe*, 509 U.S. 312, 319 (1993)).
94. As the Court's opinion in *Quill* reflects, the common view of end-of-life practices continues to allow those practices in which the physician foresees
Because of these difficulties, respondents and the courts focused on the subset of cases in which artificial nutrition and hydration are foregone. Here they claimed forgoing treatment certainly hastens and causes death, and death is intended. Yet again they offered no data on what the outcome is in these cases. They failed to deal with those cases in which patients survive by taking food and water orally. Moreover, they again provided no support for their analysis of physicians' intent. Physicians may well terminate this form of treatment, too, in order to honor patients' wishes and rights to refuse unwanted treatment, even if the health professionals foresee the likelihood of death. What physicians intend versus what they foresee is in part an empirical question.

Leaving termination of treatment, respondents and the circuit courts next seized on pain relief medication, claiming that physicians already administer such medication in high doses hastening death. Yet, as discussed above, this overlooks the debate about whether such medication actually brings about death. It also assumes without support that high-dose medication reliably causes death in these cases, as assisted suicide would. Respondents and the courts further claimed that physicians giving these medications intend to cause death, as in assisted suicide. But they offered no substantial data to
support this, citing one ambiguous study and ignoring the other.95

Finally, respondents pointed to a practice of "terminal sedation," arguing its equivalence to assisted suicide. This claim is based on a small literature asserting that such a practice exists and has use.96 That literature, however, is confusing, referring sometimes to sedating patients to unconsciousness and waiting for death, sometimes to sedating them and having them die in response to the medication, and sometimes to the combination of sedation and forgoing artificial nutrition and hydration. It was the last of these definitions that respondents seized upon, arguing that the combination cannot be distinguished from assisted suicide.

But respondents never confronted the empirical issues here. They never indicated how often sedation to unconsciousness is coupled with forgoing artificial nutrition and hydration in an effort to cause death. Thus, they never distinguished the clinical cases in which a patient chooses to forgo artificial nutrition and hydration, the health professional honors that choice, and sedation is used not to end life but to ensure the patient feels no discomfort. When the physician intends to honor the patient's refusal of treatment and assure comfort, she is not directly intending and engineering death.

The analysis offered by respondents and the circuit courts thus lumped too much and avoided empirical questions. It assumed that in clinical medicine, unlike other areas of life, there is no real difference between incurring risk, foreseeing, and intending. Beyond that, it ignored the relevance of data on what clinicians actually do risk, foresee, and intend. Yet there are few settings in which those distinctions are more important. Physicians frequently engage in acts that risk death, such as high-risk surgery; they must, for the health of their patients. Similarly, physicians must perform interventions such as withdrawing refused treatment, even if they foresee the strong possibility of death. Yet in both cases their intent can and should be not to kill, but rather to improve the patient's condition or to honor the patient's treatment wishes. Indeed, it is because we recognize that physicians who perform risky surgery or honor patients' wishes to refuse treatment are not killing that physicians are able to serve their patients in

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95. The first study is Asch, supra note 93; the second is Wilson et al., supra note 58. On the limitations of these studies, see infra note 121.
96. See supra note 19.
these fundamental ways. Yet respondents and the circuit courts swept these clinical realities aside.

Looking back, then, at how respondents and the two courts in *Glucksberg* and *Quill* framed the right at issue, depicted the rights-bearers, assessed the consequences of recognizing the claimed right, and compared other end-of-life practices, the overall picture is that at critical junctures they largely avoided the facts. Indeed, the Second Circuit opinion offered almost no engagement with the data. The Ninth Circuit opinion was more detailed, with extensive footnotes and professed attention to "existing circumstances." Yet a careful examination shows that both circuit courts as well as respondents avoided the actual circumstances in the clinic. Instead, they relied on a vision of independent rights-bearers freely exercising a right to choose, driven by agony at life's end, with physicians already engaged in practices indistinguishable from assisted suicide. But those are not the realities at life's end.

III. THE SUPREME COURT'S STRUGGLE

Against the background of these circuit court opinions and respondents' argument, it is no surprise that the Supreme Court struggled with the relevance of data throughout the oral argument and then in the Justices' published opinions. But that struggle actually showed progress, as neither circuit court had wrestled as directly with the problem of empiricism. Though the Supreme Court ultimately failed to wrestle the problem to the ground, a careful reading of the Justices' opinions shows that they signaled the importance of data and the significance of the gap between the usual case and the ideal.

Several of the Justices in oral argument tried to ascertain how empirical data bore on the constitutional questions at hand, what those data showed, and whether empirical uncertainty remained so great that it militated in favor of deference to the state legislatures for now. Justice Breyer remarked, "[W]e've had submitted ... a gigantic Brandeised brief, which

97. *Compassion in Dying*, 79 F.3d at 803.
98. Perhaps because of this avoidance, respondents and the circuit courts never directly presented the contextual argument that the reality of second-best care for many patients—including poor pain relief, palliative care, and treatment for depression—requires the availability of assisted suicide. Of course, petitioners might well have replied that the state has a compelling interest in assuring good practice, rather than entrenching bad care that drives the most vulnerable to assisted suicide by neglecting their needs.
presents all kinds of empirically based judgments by those who know. Justice Kennedy made similar remarks. But Justice Souter was the most explicit and troubled in confronting the empirical issues. He asked, “[W]hat methodology should I pursue? ...? ... [T]here’s ... an empirical component ... a prediction. ... What empirical basis do I have for evaluating that argument?”

These questions about the role of data and implications of empirical uncertainty plagued the Justices in evaluating both the claimed liberty interest in assisted suicide and countervailing state interests. Justice Kennedy confronted Professor Tribe with the New York State Task Force report on assisted suicide, characterizing it as “a Brandeis brief for the proposition that the autonomy ... that you wish to create, is illusory, ... that there will be less autonomy ... if you allow the option. ... In fact, you will be introducing fear into medical care facilities. You will diminish the choices, not increase them.” Tribe responded with no data, but the assertion that fear already stalks medical facilities, as physicians covertly cause death by increasing pain relief medication and administering “terminal sedation” with few safeguards. Yet that debatable description of current realities failed to answer the Justice’s query about the likely effects of legalizing assisted suicide and whether the claimed liberty interest would actually contract not expand patients’ liberty.

Further colloquy took up the empirical questions on the other side of the equation, the states’ countervailing interests. As noted above, Justice Souter explicitly addressed the question of what data supported the prediction of abuse and other harms that would justify state action. The Assistant Attorney General of Washington pointed to the Dutch data and German

100. See id. at *47-48.
103. Id. at *48-49.
104. Acting Attorney General Dellinger, for example, stated, “We do not know any basis for the conclusion that pain medication is being deliberately offered in excess of what is necessary to relieve pain in order to cause death.” Id. at *30.
experience between the World Wars, with Justice Ginsburg adding that the Australian experience might be relevant.\textsuperscript{105} The Assistant Attorney General emphasized the problem of involuntary deaths in the Netherlands.\textsuperscript{106} Yet here again the discussants did not engage substantively with the data.

Debate over the risks of legalizing assisted suicide led to argument over the likely efficacy of safeguards. Acting Solicitor General Dellinger emphasized the lack of data: "[T]here's no experiential basis for the conclusion that there could be adequate safeguards. . . ."\textsuperscript{107} Justice Souter suggested that the Court should therefore wait to render "ultimate judgment."\textsuperscript{108}

Ultimately, Justice Souter despaired of empirical uncertainty. He challenged counsel for respondents, saying, "[I]t may be impossible for a court to assess . . . [the substantive due process question] until there is more experience out in the world. . . . It would just be guesswork."\textsuperscript{109} More than any other Justice, he pinpointed the need for a grounding in clinical reality. In the oral argument he emerged as the advocate for pragmatism.

The published opinions made clearer the differences among the Justices in their views of the role of data and clinical realities. For the most part, they muddled through, relying on the data in some places and ignoring the data in others. But a number of them also gave clear indication that the data were important.

The Chief Justice, writing for the Court in \textit{Glucksberg}, emphasized that the claimed liberty interest should not be seen abstractly.\textsuperscript{110} But he relied more on the long history of legal prohibition than on any empirical analysis of the practice.\textsuperscript{111}


\textsuperscript{106} See id. at *60.

\textsuperscript{107} Id. at *22.

\textsuperscript{108} Id. at *23.

\textsuperscript{109} Id. at *44.

\textsuperscript{110} See \textit{Glucksberg}, 117 S. Ct. at 2270 ("The right assumed in \textit{Cruz}-zan. . . . was not simply deduced from abstract concepts of personal autonomy."); see also Quill, 117 S. Ct. at 2301 ("[O]ur assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract 'right to hasten death' . . . ." (citations omitted)).

\textsuperscript{111} See \textit{Glucksberg}, 117 S. Ct. at 2271 ("The history of the law's treatment of assisted suicide in this country has been and continues to be one of. . . . rejection. . . . That being the case, . . . the asserted 'right' . . . is not a fundamental liberty interest protected by the Due Process Clause.").
It was not until he assessed whether Washington's ban was "rationally related to legitimate government interests" that he addressed the data. There he noted research showing that depression, although an important risk factor for assisted suicide, is often undertreated, and that many people stop seeking assisted suicide once their depression and pain are treated. He similarly explored "the real risk of subtle coercion and undue influence in end-of-life situations." But his engagement with the data did not become pronounced until he reviewed the Dutch research showing that the risk of abuse has become a reality there, as the legitimation of voluntary euthanasia and assisted suicide has led to euthanasia and drug overdoses without patient consent. It was the Dutch data that led him to contrast abstract argument with real experience: "It turns out that what is couched as a limited right... is likely, in effect, a much broader license, which could prove extremely difficult to police and contain."

The Chief Justice engaged less with the role of data in his opinion for the Court in Quill. There, of course, the central question was whether a state could rationally distinguish between assisted suicide and terminating life-sustaining treatment. The question of whether the two practices can be distinguished is a mixed question of logic and data. The Chief Justice relied heavily on traditional formulations of causation and intent to distinguish the two logically, but ignored the relevance of data. The omission was signaled by the Chief Justice's own awkward formulation: "[A] physician who... [terminates treatment] purposefully intends, or may so intend, only to respect his patient's wishes" rather than intending "that the patient be made dead." The Chief Justice relied on the same formulation in distinguishing aggressive pain relief from assisted suicide: "In some cases, painkilling drugs may hasten... death, but the physician's purpose and intent is, or may be, only to ease his patient's pain." He clarified

112. Id.
113. See id. at 2272-73.
114. Id. at 2273.
115. See id. at 2274 ("This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation... may not have prevented abuses... ").
116. Id. at 2274.
117. Quill, 117 S. Ct. at 2298-99 (emphasis added).
118. Id. at 2298-99 (emphasis added). The Chief Justice made no mention of
that he was “not insist[ing] ... that 'in all cases there will in fact be a significant difference ... [in] intent,” but merely that “the State is entitled to act on the reasonableness of the distin-
tinction.”

But data have raised the question of whether health professionals administer the last dose of painkilling drugs in part to hasten death. These data are debatable and raise more questions than they answer. They do indicate, however, the relevance of empirical research. If data were to show that health professionals terminating life-sustaining treatment or administering painkilling drugs often intend to end life, it would at least challenge the reasonableness of the legislative distinction.

Thus, the Chief Justice’s opinions in the two cases failed to use data consistently. Yet he recognized that the debate over assisted suicide concerns its “morality, legality, and practical-

The other Justices similarly struggled with the role of data, some more explicitly than others. Justice O’Connor,
whose vote made a majority of five subscribing to the Chief Justice's opinion, nonetheless wrote her own concurrence. She agreed with the Court "that there is no generalized right to 'commit suicide,'" but delayed to another day the question of whether a competent, suffering person has a constitutionally protected "interest in controlling the circumstances of his or her imminent death." She postponed that question not only because she saw the cases at hand as facial challenges to the two state laws, but also because of an empirical conclusion—that terminal patients in Washington and New York faced "no legal barriers" to pain relief and palliative care. But a substantial literature shows that legal requirements, such as mandated triplicate prescriptions, do discourage this treatment. While Justice O'Connor found no express legal prohibition, she ignored the other ways in which law has been shown to create significant barriers. Thus, she never considered whether the bans at issue work together with other state law to inhibit adequate pain relief and palliative care.

Justice Breyer largely followed Justice O'Connor's lead. He differed with the Chief Justice's formulation of the liberty interest at stake, characterizing it as a "'right to die with dig-

124. Id. at 2303.
125. Id.
126. Id.
127. On the barriers posed by legal requirements, including in New York and Washington State, see, for example, INSTITUTE OF MEDICINE REPORT, supra note 23, at 190-98; N.Y. STATE TASK FORCE, supra note 77, at 171-75; Katherine A. Sigler et al., Effects of a Triplicate Prescription Law on Prescribing Schedule II Drugs, 41 AM. J. HOSP. PHARMACY 103 (1984); Michael Weinstein et al., Consequences of the 1989 New York State Triplicate Benzodiazepine Prescription Regulations, 266 JAMA 2392 (1991); see also C. Stratton Hill, Jr., Government Regulatory Influences on Opioid Prescribing and Their Impact on the Treatment of Pain of Nonmalignant Origin, 11 J. PAIN & SYMPTOM MGMT. 287, 288 (1996); Chris Stern Hyman, Pain Management and Disciplinary Action: How Medical Boards Can Remove Barriers to Effective Treatment, 24 J.L. MED. & ETHICS 338 (1996); Sandra H. Johnson, Disciplinary Actions and Pain Relief: Analysis of the Pain Relief Act, 24 J.L. MED. & ETHICS 319 (1996); David E. Joranson et al., Opioids for Chronic Cancer and Non-Cancer Pain: A Survey of State Medical Board Members, FED'N BULL.: J. MED. LICENSURE & DISCIPLINE, June 1992, at 15; Russell K. Portenoy, The Effect of Drug Regulation on the Management of Cancer Pain, N.Y. STATE J. MED., Nov. 1991, at 13S. Clearly, one could argue that in a perfect world physicians would not be discouraged from providing adequate pain relief by requirements such as triplicate prescription mandates. Thus, one could maintain that such barriers are not so much legal as psychological. But that would be falling into the trap of evaluating law simply as it is written, not as it functions in the world.
nity." But he maintained that the state bans infringe that fundamental right only if they prevent adequate pain relief. He concluded, in a vein similar to Justice O'Connor's, that pain relief is hampered not by state law but by institutional practices. He therefore concluded that the state bans do not infringe a fundamental right. His opinion thus suffered from the same basic flaw as Justice O'Connor's: ignoring the ways in which state law does pose barriers.

Justice Stevens grappled more directly than Justices O'Connor and Breyer with the role of data. He, too, differed with the Court on the proper level of generality at which to formulate the liberty interest at stake, insisting on greater generality. But it was his consideration of the countervailing state interests that led him to practical questions about how people die, what problems the state legitimately addresses, and what life-ending practices physicians already engage in and support. He ultimately came to the conclusion that the state's general policy against assisted suicide "is justified by the fact that the "ideal" case... is not the usual case." He went on to conclude that an individual's "as applied" challenge might later succeed, presumably in a case that was not "usual." Thus, Justice Stevens came close to identifying the pragmatism problem at the heart of these cases. His opinion turned on an empirical judgment—the difference between the ideal case and the usual. He never really illuminated the grounds for his empirical conclusion. But he did point to the empirical problem.

Justice Souter's opinion was by far the most explicit in addressing the role of data, as were his questions at the oral argument. He emphasized the need to ascertain the "level of generality at which to analyze claims and counter-claims," to attend to "detail," and to "examin[e] the concrete application of principles." In this he virtually declared the pragmatist's credo.
Yet after recognizing a liberty interest, he ended up finessing analysis of its ultimate strength, focusing instead on the countervailing state interests, which he found dispositive.\(^{135}\) There he concentrated almost entirely on the state interest in preventing a slide down the slippery slope to involuntary suicide and euthanasia. Justice Souter considered a variety of factors, from the financial incentives impinging on doctors in managed care to physicians' temptation to deliver the life-ending drugs themselves, and found the case for a slippery slope plausible.\(^{136}\) Despite his proclaimed commitment to "detail" and practical considerations, he actually referred to no data in considering those factors. Indeed, not until he considered the Dutch situation did he engage the data, claiming that only the Netherlands has yielded information on how state regulations might affect practice.\(^{137}\) In this claim he was wrong, as American data are relevant as well to the slippery slope question and likely efficacy of regulation, including data on whether doctors already defy prohibitions on assisted suicide and euthanasia and whether they do so in cases of neonates and others incapable of giving voluntary consent.\(^{138}\) Even focusing on the data he acknowledged, Justice Souter was reluctant to conclude much. Despite well-known data from the Netherlands showing that Dutch guidelines are violated by a substantial incidence of "life-terminating acts without consent," including among neonates,\(^{139}\) Justice

\(^{135}\) See Glucksberg, 117 S. Ct. at 2290 ("Whether that [liberty] interest might . . . be seen as 'fundamental' to the degree entitled to prevail is not . . . a conclusion that I need draw here, for I am satisfied that the State's interests . . . defeat the present claim that its law is arbitrary or purposeless."). This contrasts with the Chief Justice's view at oral argument that "if we assume a liberty interest but nonetheless say . . . a state can prohibit it entirely, that would be rather a conundrum." Transcript of Oral Argument, Glucksberg (No. 96-110), available in 1997 WL 13671, at *14 (Jan. 8, 1997).

\(^{136}\) See Glucksberg, 117 S. Ct. at 2291.

\(^{137}\) See id. at 2292.

\(^{138}\) See, e.g., Back et al., supra note 16; Ezekiel J. Emanuel, Euthanasia: Historical, Ethical, and Empiric Perspectives, 154 ARCHIVES INTERNAL MED. 1890, 1898-99 (1994); Emanuel et al., Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences, supra note 16; Wolf, Facing Assisted Suicide and Euthanasia in Children and Adolescents, supra note 17; Death at U.C. Med Center, SAN FRANCISCO CHRON., Mar. 30, 1995, at A20; Doctor Faces Murder Count in Premature Baby's Death, ORLANDO SENTINEL, Nov. 13, 1993, at A20.

\(^{139}\) See, e.g., Pijnenborg et al., supra note 16; van der Maas et al., HEALTH POLY, supra note 16, at 143-45; van der Maas et al., LANCET, supra note 16, at 670; van der Maas et al., NEW ENG. J. MED., supra note 16; see also Wolf, Facing Assisted Suicide and Euthanasia in Children and Adolescents, supra note 17.
Souter found the "evidence...contested." He then concluded that in the face of serious factual controversy, the legislatures rather than the courts are the proper institution to explore and resolve the matter. He decided that the greater institutional competence of the legislatures should stay the Court's hand for now.

Thus the Justices in these two cases demonstrated a range of approaches to the role of empirical data, but they did see the data as important. Justice Souter found empirical uncertainty to be a compelling argument for judicial deference to the state legislatures. Justice Stevens rested his conclusion that state bans are constitutional on the gap between the ideal and the usual case. Justices O'Connor and Breyer regarded the supposed lack of legal barriers to pain relief and palliative care as key to delaying consideration of narrower challenges to state bans. And the Chief Justice found that realities suggested by the data undermined respondents' abstract argument. The Justices thus clearly indicated that data play a critical role in this debate.

In effect, they issued a call to pragmatism. Justice Stevens emphasized the importance of focusing on the usual case. Justice Souter called on legislatures "to obtain the facts." Even the majority opinion in Glucksberg reminded Americans that they were debating the "practicality" of assisted suicide. The Court urged that data inform the legislative and democratic process.

140. Glucksberg, 117 S. Ct. at 2292. Unfortunately, Justice Souter relied on two nonempirical sources here, plus one that failed to analyze euthanasia or assisted suicide without consent but did find that a substantial number of family physicians reported failing to follow the applicable procedural requirements. See van der Wal et al., FAM. PRAC., supra note 16. The relevant question, in any case, is not whether the data showing that "the Dutch guidelines have...failed to protect patients from involuntary euthanasia" are contested. Glucksberg, 117 S. Ct. at 2292. In fact, there is no dispute over whether involuntary euthanasia occurs in the Netherlands; the data are clear. See supra note 139. Equally clear is that Dutch procedural safeguards demanding physician reporting are often ineffective. See van der Wal et al., Evaluation of the Notification Procedure, supra note 88. What is disputed is the normative question of whether this represents a serious problem, and the predictive question of what this augurs for the United States.

141. "We...have a clear question about which institution, a legislature or a court, is relatively more competent to deal with an emerging issue as to which facts currently unknown could be dispositive. The answer has to be...that the legislative process is to be preferred." Glucksberg, 117 S. Ct. at 2293.

142. Id.

143. Id. at 2275.
IV. AFTER GLUCKSBERG AND QUILL: DEMOCRACY OUT OF CONTEXT

The Supreme Court decisions returned the assisted suicide debate to the states. Yet it is worth asking what kind of debate we will now have. Sloganeering campaigns, ballot measures divorced from factfinding, and legislative initiatives uninformed by the realities of dying will ill-serve the patients of this country. The life-and-death question of whether physicians should be allowed to violate the ancient Hippocratic commitment to "give no deadly drug, even if asked" is too serious for anything less than truly deliberative democracy.

Unfortunately, there is ample cause for concern. Three states—California, Washington, and Oregon—have held popular votes on ballot measures to change state law. In all three cases the proposals were ambiguously worded. Both the California and Washington measures used "aid-in-dying" to signify "physician-assisted suicide," even though the euphemism could mean anything from hospice care, to termination of treatment, to lethal injection. Oregon was more direct, but still labeled its proposed statute a "Death with Dignity Act" and even included the obfuscating declaration that "[a]ctions taken in accordance with this Act shall not . . . constitute suicide, [or] assisted suicide." Further, although debate on the measures was vigorous, it is unclear whether data were reaching the public to inform their views. Indeed, one of the standard critiques of direct democracy through the ballot box is that voter knowledge and competency are low.

Oregon voters, of course, have been the only ones to pass an assisted suicide measure. But in the campaign that resulted in initial passage in 1994, some of the focus was di-

145. Each of these states has a process for legislative enactment by popular initiative. See Judith F. Daar, Direct Democracy and Bioethical Choices: Voting Life and Death at the Ballot Box, 28 U. MICH. J.L. REFORM 799, 802-03 (1995).
148. See Daar, supra note 145, at 841 (discussing the "personal nature of the material disseminated and discussed" in the California and Washington campaigns). On the impact data can have on public opinion, see supra note 8.
149. See, e.g., id. at 837-40.
verted from assisted suicide to the role of the Catholic Church. And regrettably, the state's medical association, representing the profession whose role and ethics were directly at stake, failed to take a position. Litigation then delayed effectuation of the new statute, followed by a legislative demand for a popular re-vote. This legislative maneuver so angered the public that reenactment of the assisted suicide measure was widely seen both before and after the vote as a protest of the legislature's lack of respect for the ballot initiative process. One reporter concluded that the Oregon debate was "rarely... as 'earnest and profound' as the [Supreme Court] Justices might have hoped."

Numerous other states have seen assisted suicide bills introduced in their legislatures and surely others will in the future. We have to wonder whether such legislatures will engage in the kind of searching factfinding process that Justice Souter, in particular, envisioned and this question clearly demands.

The U.S. Congress has held hearings, culminating in legislation denying federal funding for assisted suicide. But the

150. See Peter Steinfels, Beliefs, N.Y. TIMES, Oct. 22, 1994, § 1, at 11 (reporting a television spot asking, "Are we going to let one church make the rules for all of us?").
151. See Melinda A. Lee & Susan Tolle, Oregon's Assisted Suicide Vote: The Silver Lining, 124 ANNALS INTERNAL MED. 267, 268 (1996).
153. See, e.g., William Claiborne & Thomas B. Edsall, Affirmation of Oregon Suicide Law May Spur Movement, WASH. POST, Nov. 6, 1997, at A19; William Claiborne, 'Death with Dignity' Measure May Make Oregon National Battleground, WASH. POST, June 27, 1997, at A19 (citing poll showing 81% "felt the legislature was wrong to make Oregonians vote... a second time").
156. On legislative attention to data, especially on health care questions, see supra note 4. The question of what empirical basis the courts may later require when and if they review statutes legalizing assisted suicide is beyond the scope of this Article. See generally Wendy M. Rogovin, The Politics of Facts: "The Illusion of Certainty", 46 HASTINGS L.J. 1723 (1995).
158. Assisted Suicide Funding Restriction Act of 1997, Pub. L. No. 105-12,
question of whether state bans on assisted suicide will be lifted, at least as applied to physicians assisting competent, terminally ill adults, rests with the states.

Whether states will rise to the occasion and engage in what Gutmann and Thompson call "deliberative democracy" remains to be seen. "Deliberative democracy is the opposite of soundbite democracy . . . where insults are traded, slogans proclaimed, and self-serving deals are made . . . ."\(^{159}\) Instead, deliberative democracy promotes the legitimacy of group decisions, a public-spirited outlook, a mutually respectful process, and the ability to correct mistakes as issues are considered.\(^{160}\) A vital part of this has to be getting beyond slogans and acontextual abstractions to the facts necessary for deliberation and a thoughtful policy decision.\(^{161}\)

CONCLUSION

The assisted suicide debate requires a larger discussion that has not yet occurred on the role of data and empiricism in the constitutional and policy questions. In the absence of that discussion, the debate too often veers into ungrounded abstraction. But the data tell an important story. They show that patients need not choose between agony and assisted suicide; numerous techniques for pain relief and palliative care are available, including sedation to unconsciousness. When patients do seek assisted suicide, it is usually because untreated depression or inadequate pain relief drives them. These patients are not independent agents freely choosing an uncoerced option, as in a commercial transaction. And termination of life-sustaining treatment, high-dose pain relief, and sedation to unconsciousness are distinct practices with significant therapeutic uses, each one distinguishable from assisted suicide.

Why do we find the data so often ignored? Motivating public, legislative, and judicial attention to data can be an uphill battle generally. Even in the realm of health care where data dominate, and in the assisted suicide debate

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111 Stat. 23 (codified primarily at 42 U.S.C. §§ 14401-08 (Supp. 1997)).
159. Gutmann & Thompson, Deliberating About Bioethics, supra note 20, at 39.
160. See id.
161. Indeed, Gutmann and Thompson suggest a further condition, that "empirical claims . . . be consistent with relatively reliable methods of inquiry . . . [, allowing] discussion on mutually acceptable terms." Gutmann & Thompson, Democracy and Disagreement, supra note 20, at 56.
where all agree the data are germane, significant barriers remain. Myths about care at the end of life are hard to dispel. And the realities of death itself, as I have suggested, prompt us to flee. Yet there is a further reason for ambivalence toward the data that is embedded in the way we think about facts and empiricism. We are on the cusp, moving from one way of thinking to another. The debate on assisted suicide comes to the fore just as bioethics and health law struggle through what I have argued elsewhere is a paradigm shift from an old deductivism that largely ignored empiricism to a new pragmatism that extols it. The debate on assisted suicide manifests the conflict or, more optimistically, the transition between those two approaches.

We should hope the transition succeeds. Abstract proclamations of patients' rights that bear little relation to clinical reality will accomplish equally little for patients facing death. Bioethics and health law are embracing pragmatism for a reason—to help real patients in the world.

162. Wolf, Shifting Paradigms, supra note 15.