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The potential slide from physician-assisted suicide of competent, terminally ill patients to physician-mediated death of incompetent patients is a common argument against physician-assisted death.

Physician-Assisted Suicide: The Legal Slippery Slope

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Background: *In Oregon, physicians can prescribe lethal amounts of medication only if requested by competent, terminally ill patients. However, the possibility of extending the practice to patients who lack decisional capacity exists. This paper examines why the legal extension of physician-assisted suicide (PAS) to incapacitated patients is possible, and perhaps likely.*

Methods: *The author reviews several pivotal court cases that have served to define the distinctions and legalities among "right-to-die" cases and the various forms of euthanasia and PAS.*

Results: *Significant public support exists for legalizing PAS and voluntary euthanasia in the United States. The only defenses against sliding from PAS to voluntary euthanasia are adhering to traditional physician morality that stands against it and keeping the issue of voluntary euthanasia legally framed as homicide. However, if voluntary euthanasia evolves euphemistically as a medical choice issue, then the possibility of its legalization exists.*

Conclusions: *If courts allow PAS to be framed as a basic personal right akin to the right to refuse treatment, and if they rely on right-to-die case precedents, then they will likely extend PAS to voluntary euthanasia and nonvoluntary euthanasia. This would be done by extending the right to PAS to incapacitated patients, who may or may not have expressed a choice for PAS prior to incapacity.*

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Introduction

Advocates of physician-assisted suicide (PAS) have long sought its legalization in the United States. While attempts to legalize physician-assisted death failed in California and Washington,^{1,2} in 1995 an Oregon referendum made it legal for physicians to assist in the suicide of their terminally ill patients.³ As a

result, physicians in Oregon can now prescribe lethal amounts of medication for competent, terminally ill patients who request it. Patients can then fill their prescriptions and end their lives by taking the medicine.⁴ Advocates of this practice stress that it is to be used only in cases of terminally ill patients who retain the capacity to make the decision. However, now that PAS has become legal, the door is open to extending it to patients who lack decisional capacity. This paper examines why the legal extension of PAS to incapacitated patients is possible, and perhaps likely. This potential slide from competent-patient PAS to physician-mediated death of incompetent patients can be called the “legal slippery slope.”

Euthanasia and PAS

The debate involving euthanasia and physician-assisted suicide (PAS) has been plagued by imprecise and euphemistic language. Thus, it is important to clarify the terms associated with euthanasia and PAS. Euthanasia is an act whereby a physician intentionally causes the death of a terminally ill patient. For example, a physician performs euthanasia when he or she deliberately injects a lethal amount of potassium chloride into a patient for the express purpose of terminating the patient’s life. Euthanasia is a form of homicide and is illegal in the United States. It differs from murder in that the motive is seen as merciful rather than malevolent. The physician’s intent is to help the terminally ill patient avoid the suffering that often accompanies the process of dying.

When euthanasia is performed with the consent of the patient, it is called voluntary euthanasia. When euthanasia is performed absent patient choice, such as may be the case with incapacitated patients, it is called nonvoluntary euthanasia.⁵ It could also be called non-choice euthanasia. A third form of euthanasia, involuntary euthanasia, refers to performing euthanasia against the patient’s wishes.

Euthanasia differs fundamentally from the act of withholding or withdrawing life-sustaining medical treatment. When physicians forego life-sustaining treatments at the end of life for their terminally ill patients, the patients die of their disease process. With euthanasia, death is caused not by the disease but by the physician. Even though death may occur in close conjunction with a decision to withhold or withdraw treatment, it does so only because there is no longer active resistance to an inexorable dying process. With euthanasia, however, death is immediate because it is directly caused by the physician. Patients who request euthanasia are asking that their

life be taken by a physician before the disease causes their death.

Euthanasia also differs from PAS in that patients requesting PAS are actively involved in causing their own death. PAS can be defined as an act of self-destruction committed by a patient with the assistance of a physician. The most common example is that of a physician giving a patient a prescription for a lethal amount of medication that the patient later ingests to bring about death. PAS is called suicide because the patient deliberately ends his or her own life. It is physician-assisted because the physician not only agrees to participate in the patient’s plan, but also assists by prescribing a lethal amount of medication. PAS and voluntary euthanasia are similar in that both involve patient choice. However, in voluntary euthanasia, the physician alone is the cause of the patient’s death, whereas in PAS, the patient and the physician work together to bring about death, with the patient taking the final action to end life.

These distinctions have been borne out in case law through a series of court decisions, beginning with the 1976 case of *In re Quinlan*⁶ in New Jersey. In this case, which involved a young woman in a permanent vegetative state, the issue was whether her guardian could authorize doctors to discontinue Quinlan’s mechanical ventilator. The court wrote, “There is a real and in this case determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.” This distinction was echoed in most of the cases that followed in various states. In 1990, when the US Supreme Court ruled on the *Cruzan*⁷ case, which involved disconnecting a feeding tube from a young woman in a persistent vegetative state, it too distinguished homicide and assisted suicide from the constitutional right to refuse unwanted medical treatment. Later, in *Washington v Glucksberg*⁸ and *Vacco v Quill*,⁹ the US Supreme Court made this distinction explicit by stating that “when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”

The Context of the PAS/Euthanasia Debate

The central moral issues in the euthanasia/PAS debate are whether it is ever right to take one’s own life and whether it is ever right for a physician to take the life of a patient who requests it. While these issues

are outside the scope of this paper, it is helpful to recall the basic tension between the long-held view of American medicine and the proponents of legalized physician-assisted death.

The Hippocratic Oath, to which American medicine has traditionally turned for its moral bearings, expressly prohibits PAS and euthanasia. The oath reads, "Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."¹⁰ It is telling to note that during the time of Hippocrates, when medicine's power to effectively treat disease and ameliorate suffering was far less than it is today, assisted suicide and euthanasia were regarded as radically incompatible with the meaning of medicine and physicianhood.¹¹ This at least suggests that those in favor of PAS and euthanasia have different ideas about physicianhood and the moral limits of medicine. It is also telling that the current public interest in PAS comes at a time when the palliative powers of American medicine are greater than they have ever been in the past. This suggests that the public is significantly unaware of the advances and availability of palliative medicine, and it also reflects the fact that palliative care is woefully underutilized.

Numerous studies have documented that medical education on palliative care is sorely lacking.¹²⁻¹⁵ In addition, a number of barriers to palliative care have been identified, including inadequate pain assessment, inadequate use of palliative medications, fear of regulatory or legal action if opioid medications are used, and difficulty in establishing a terminal prognosis. There are also health system barriers that stem from our emphasis on treatment for acute illness rather than palliative care at the end of life.¹⁶ Other barriers include inadequate completion of advance directives, lack of discussion about treatment preferences, and confusion between stopping aggressive treatment and actively hastening death through the use of medication.¹⁷ Some studies indicate that failure to control distressing symptoms and depression is associated with increased requests for PAS.¹⁸⁻²¹ Therefore, a viable middle ground in the PAS debate is to argue for improved utilization of palliative care. Many believe that when palliative medicine is properly taught and implemented, there will be less interest in legalizing PAS and voluntary euthanasia.

However, even if palliative care practices were fully maximized, some would still want PAS legalized as an additional option. Their chief argument is based on the ethical principle of autonomy. They argue that controlling the timing and circumstances of one's death is primarily a matter of personal choice. In their view, many patients will be satisfied to receive palliative care with no thought of ending their own lives. Others, however, while acknowledging the benefits of palliative care, will

still want to have the option of choosing to end their lives with the assistance of their physician. Though this argument sounds reasonable on the surface, it raises the questions of whether it is right for a physician to play an active role in causing a patient's death,²² whether our society should allow physicians to have such power over other human beings,²³ and whether it is wise for our courts to depart from their long-held anti-suicide tradition to allow suicide for the sick and dying segment of our population.²⁴

Slippery Slope Arguments

A common argument against legalizing PAS is that it will start us on a slippery slope toward voluntary euthanasia and beyond. Indeed, the two referenda that failed in California and Washington proposed legalizing not PAS but voluntary euthanasia. In addition, a number of studies have demonstrated significant public support for legalizing PAS and voluntary euthanasia in the United States.²⁵⁻²⁸ Furthermore, many physicians seem willing to participate in PAS and even voluntary euthanasia via lethal injection.²⁹

This close link between PAS and voluntary euthanasia is consistent with the patient choice rationale that undergirds them. In the eyes of many, choice matters most. According to their logic, the greatest evil in physician-assisted death would necessarily be a death that is not grounded in clear patient choice. This is why proponents of PAS and voluntary euthanasia stress that physician-assisted death must be limited only to patients who are able to choose. For example, Miller and colleagues³⁰ wrote in their proposal for legalized physician-assisted death that, "In order to ensure that physician-assisted death is voluntary, which is the inviolable cornerstone of this policy, only adults with decision-making capacity should be eligible for physician-assisted death." From a pure choice perspective, then, it appears there is little to stop a slide from PAS to voluntary euthanasia. However, a strict adherence to the choice criterion would at least seem to safeguard a slide from voluntary to nonvoluntary euthanasia, since the latter takes place apart from patient choice.

The only bulwarks against sliding from PAS to voluntary euthanasia are (1) adhering to traditional physician morality that stands against it and (2) keeping the issue of voluntary euthanasia legally framed as homicide. As to physician morality, surveys indicate that, far from unified opposition to voluntary euthanasia, there is now significant support for it.^{31,32} As to the legal view of voluntary euthanasia as homicide, much depends on how the issue is framed in future cases and how it is linked to legal precedents. If voluntary euthanasia con-

tinues to be framed as homicide, it is unlikely to be legalized. However, if voluntary euthanasia is framed as a form of health care that patients have a right to receive, then the possibility exists for extending the right to receive it to those who expressed no choice either for or against it. This possible progression from PAS to voluntary euthanasia, and its extension through case law to incapacitated patients, is called the legal slippery slope.

Framing the Issue

The framing issue is critical. If voluntary euthanasia is seen as homicide, it is unlikely to be legalized since merciful motives or individual choices have never justified homicide in American law. However, if voluntary euthanasia is given a more euphemistic name, such as aid-in-dying or physician-assisted dying, and if it is then put forth as a medical choice issue, then the possibility of its legalization exists.

Two Federal courts tried this in the mid-1990s.^{33,34} Both courts tried to strike down laws prohibiting PAS by recasting the right to refuse treatment as a right to hasten death. They then argued that this was a matter of personal medical choice and that this choice was being denied to some patients because current laws unconstitutionally prohibited PAS. Both courts based their arguments on the 14th Amendment of the US Constitution, which states that no state shall “deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.” The Ninth Circuit Court of Appeals held that the state of Washington’s law prohibiting assisted suicide violated the “liberty clause” of the 14th Amendment. They asserted that the right to hasten one’s death is included among the liberties guaranteed by the US Constitution. The Second Circuit Court of Appeals held that the State of New York’s law banning assisted suicide was unconstitutional because it violated the “equal protection” clause of the 14th Amendment. They argued that one group of patients, ie, those dependent on mechanical ventilators, were allowed by law to hasten their deaths by directing their physicians to stop their ventilators, while another group of patients, ie, those not tethered to medical technology, were prohibited from hastening their death because of laws prohibiting assisted suicide. The court concluded that laws prohibiting assisted suicide set up an unequal state of affairs that was in violation of the 14th Amendment’s “equal protection” clause.

In 1997, the US Supreme Court unanimously rejected the conclusions of both courts as mistaken.^{8,9} It

held that the 14th Amendment’s “liberty clause” does not include a right to hasten one’s death or receive assisted suicide. The Court also ruled that the right to forgo life-sustaining treatment, which they found supported by the 14th Amendment in *Cruzan*,⁷ is not an act of hastening death. Because there is no right to hasten death, arguments about the unequal treatment of this right in state laws simply fall by the wayside. The two appeals courts erred by confusing the established right to refuse treatment with a merely asserted right to receive assisted suicide. The US Supreme Court, in unanimously rejecting these decisions, strongly affirmed the constitutionality of state laws prohibiting assisted suicide.

Oregon took a different approach to framing the issue of assisted suicide. Rather than redefining the right to refuse treatment, Oregon’s referendum simply allows PAS without defining it at all. The referendum text never labels the activity it allows to occur between doctor and patient. It spells out only what the involved parties can do. Furthermore, in seeking to distinguish this activity from other laws that might relate to it, the referendum asserts that “actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.”³ Interestingly, even though the activity is clearly one of PAS, the referendum asserts that it cannot be labeled as such. However, if this law is challenged, there is nothing to stop a court from properly labeling it PAS and enjoining the laws that pertain to it.

The Legal Slippery Slope

One way to move down the slippery slope involves a challenge of the current Oregon law. The challenge would be made on behalf of a patient who is terminally ill but who lacks decision-making capacity. The plaintiff would have to argue that the incompetent patient has the same right to receive physician-assisted dying as those who retain their decisional capacity. The plaintiff would also need to present evidence that the patient had earlier indicated that he or she would choose physician-assisted dying if terminally ill and unable to interact personally and meaningfully with others. The plaintiff would finally conclude that there is an inequity in the law that allows PAS to competent patients but not incompetent patients.

If the court accepts this framing of the issues, then it will likely remedy the inequity in the law by extending physician-assisted dying to incompetent, terminally ill patients. This outcome is even more likely if the court relies on precedents used in the three decades of “right-to-die” cases, which have consistently held that

the right to refuse treatment exists even when a person loses the capacity to make such decisions.

“Right-to-Die” Reasoning and the Courts

The so-called “right to die” is actually a right to refuse unwanted medical treatment. In a long series of right-to-die cases, courts have often found that a person’s right to refuse medical treatment is not lost even when that person has lost the capacity to exercise the right. This finding, coupled with a strong desire to preserve personal rights, has led courts to find ways for incapacitated persons to be free of unwanted life-sustaining medical interventions.

The view of the courts is that basic rights, such as the right to self-determination, apply to persons per se and thus are not contingent on their capacity to exercise them. In *Quinlan*,⁶ the New Jersey Supreme Court held that Quinlan’s right to choose or refuse mechanical ventilation “should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice.” In *Saikewicz*,³⁵ which involved an adult with mental incapacity, the Massachusetts Supreme Court wrote, “We recognize a general right in all persons to refuse medical treatment in appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.” Clearly, then, one of the tenets of right-to-die reasoning is that incompetent persons have the same right to refuse medical treatment that competent persons have.

What happens when this right cannot be exercised? In a practical sense, a right that cannot be exercised is not a right at all. In *Quinlan*,⁶ the court wrote, “Our affirmation of Quinlan’s independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent.” In *John F. Kennedy Memorial Hospital v Bludworth*,³⁶ which involved an incapacitated terminally ill patient, the Florida Supreme Court wrote, “This right of terminally ill patients should not be lost when they suffer irreversible brain damage, become comatose, and are no longer able to personally express their wishes to discontinue the use of extraordinary artificial support systems.”

In order to give meaning to the rights of incompetent persons and to preserve their rights, courts have felt compelled to offer practical solutions that involve having someone else exercise the right of the incompetent person. In *Quinlan*, the court wrote, “The only

practical way to prevent destruction of the right is to permit the guardian and family of Quinlan to render their best judgment.” They concluded that, “Quinlan’s right of privacy may be asserted on her behalf by her guardian.”⁶ In *Bludworth*, the Florida Supreme Court stated that, “The primary concern of these cases is that this valuable right should not be lost because the noncognitive and vegetative condition of the patient prevents a conscious exercise of the choice to refuse further extraordinary treatment.” In order to “ensure this right,” the court held that “the right of a patient, who is in an irreversibly comatose and essentially vegetative state to refuse extraordinary life-sustaining measures, may be exercised either by his or her close family members or by a guardian of the person of the patient appointed by the court.”³⁵

The reasoning process exemplified in these and other court decisions can be characterized by the following syllogism: (1) If a competent person has a basic personal right, then so does an incompetent person, (2) incompetent persons lack the ability to exercise their rights, (3) rights that cannot be exercised are extinguished, (4) rights must be preserved, not extinguished, and (5) to prevent rights from being extinguished, another person must exercise the incompetent person’s right on his or her behalf.

The process by which a person, usually a family member, exercises an incompetent person’s right to refuse medical treatment is called substitute decision making. Substitute decision making has been approached in two basic ways, depending on whether there is evidence that the patient expressed treatment preferences prior to losing competency.

When there is evidence of previous wishes, the substitute decision maker must make the choice that, based on available evidence, the patient would have made if competent. In two cases, *In re Browning*³⁷ (which involved a person in a persistent vegetative state who had a living will) and *Brophy*³⁸ (which involved a permanently incapacitated patient who repeatedly commented that he did not want to be kept alive in a vegetative existence), there was good evidence that both would have refused life-prolonging medical intervention. This process of basing a decision on prior patient wishes is called substituted judgment.

The second approach addresses the common scenario of an incompetent patient who has not previously indicated a preference for or against medical intervention. In these situations, many courts have held that the substitute decision maker, in consultation with the treating physician and others, should make the decision all agree is in the best interest of the incompetent

patient. In *In re Conroy*,³⁹ a relative was given permission to authorize withdrawal of a feeding tube from an elderly woman with dementia because it was deemed to be in the best interest of the patient. This form of substitute decision making is referred to as the "best interest standard." This standard has resulted in decisions to discontinue medical interventions for incompetent persons even in cases where there is little or no evidence that the incompetent person would have wanted to discontinue treatment.

Conclusions

It is clear that if courts frame PAS as a basic personal right akin to the right to refuse treatment and if the right-to-die case precedents are relied on, then courts will likely extend PAS to incapacitated patients. If they do so, two major problems surface. The first involves cases where incapacitated patients have expressed a choice for PAS prior to losing capacity. In these cases, the incapacitated patient cannot commit suicide, which means that the physician must act alone to bring about the patient's death. Thus, we will have moved from assisted suicide to voluntary euthanasia.

The second problem involves cases in which we have no clear prior choices from the now-incapacitated patient. If a substitute decision maker decides that PAS is in the patient's best interest, the physician would again have to act alone, but in this case there would be no clear patient choice on which to base the action. The result would be nonvoluntary or non-choice euthanasia.

The current legal system allows the possibility of a legal slippery slope in moving from PAS to voluntary euthanasia to nonvoluntary euthanasia. As with all valid slippery slope arguments, the conclusion is one of probability.^{40,41} There is no guarantee that our case law will move in this direction; this paper only points out its potential to do so. This potential is to some extent mitigated by the US Supreme Court's ruling that there is no constitutional basis for a right to assisted suicide,²⁴ the Court's emphasis on improving palliative care,⁴² and its assertion that states have an interest in "preventing voluntary and perhaps even involuntary euthanasia."^{8,9} Despite this, the potential for extending PAS to incapacitated patients remains. At a minimum, this scenario of case law extension of PAS to incapacitated patients should at least give pause to true advocates of patient choice. It should prompt them to reconsider the wisdom of continued efforts to legalize PAS, since doing so expands the potential for future legal decisions that will end life based not on patient choice but on the choice of others.

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