The “Disparate Impact” Argument Reconsidered: Making Room for Justice in the Assisted Suicide Debate

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In “Should We Impose Quotas? Evaluating the ‘Disparate Impact’ Argument Against Legalization of Assisted Suicide,” Ronald Lindsay argues that it should make no difference to the debate over legalizing assisted suicide whether the risks associated with legalization would fall disproportionately on the poor, people with disabilities, racial minorities, or any other especially vulnerable social group. Even assuming such an inequitable distribution of risks would occur, he maintains, attempting to avoid such an outcome is not a good reason to deny assisted suicide to “competent persons who truly voluntarily choose it.” 1

Those of us who worry that legalization will differentially burden already disadvantaged segments of society have generally taken it for granted that the possibility of such disparities raises significant public policy concerns. By insisting on an explanation of this assumption — and, in so doing, making explicit the tension between autonomy and equality that underlies the assisted suicide debate — Lindsay has significantly advanced the ongoing conversation. While I disagree with his analysis, I commend him for a thoughtful, provocative, and important contribution to the literature.

The purpose of this commentary is not to defend the specific argument that Lindsay criticizes in his article. Thus, I will not attempt to persuade the reader that assisted suicide should remain illegal because legalization would “have a disproportionately adverse, or ‘disparate,’ impact on various vulnerable groups.” 2 Instead, my goal is to make the case that, in the debate over legalizing assisted suicide, equality matters: In addition to identifying the benefits and burdens associated with various policy options, it is crucial to consider how those benefits and burdens are likely to be distributed among various social groups. This approach need not lead one to the conclusion that assisted suicide should be prohibited; indeed, as discussed below, an argument can be made that considerations of equality point in precisely the opposite direction. Rather, my claim is simply that the question of legalizing assisted suicide is as much about justice as it is about autonomy. That is one of the many reasons the debate has proven so difficult to resolve.

AN ABSOLUTE RIGHT? THE ROLE OF RISK-BENEFIT ASSESSMENT

Of course, whether legalization of assisted suicide will exacerbate inequality matters only if one believes that the risks associated with legalization are a relevant consideration. Yet, at various points in his article, Lindsay appears to suggest that only the potential benefits of legalization are relevant. If assisted suicide is a “critical life choice,” 3 he implies, it must be legalized without any consideration of the possibility that the practice may be abused.

That at least is what he appears to be saying when he challenges the “moral assumption” that “it is proper to deny assisted suicide to those competent persons who truly voluntarily choose it, including persons who are members of the vulnerable groups in question, in order to protect others against being pressured into choosing assisted suicide.” 4 If, by disputing this assumption, he means that it would never be proper to deny assisted suicide to those competent persons who truly voluntarily choose it, including persons who are members of the vulnerable groups in question, in order to protect others against being pressured into choosing assisted suicide. 5

pected benefits. The implications of this suggestion are extraordinary.

For example, assume that we could determine that legalizing assisted suicide would lead to approximately 100 additional cases of assisted suicide each year, 1 of which would be based on a voluntary choice by a competent individual and 99 of which would be the result of mistake, coercion, or other factors incompatible with genuine informed consent. Assume also that it would be impossible to devise regulations that would effectively limit the practice to the one “authentic” case.1 Would Lindsay insist on legalizing assisted suicide for the sake of the one autonomous decisionmaker, knowing that doing so would lead many other people to inappropriately hastened deaths? Even if there were other options for relieving the suffering of the competent person who genuinely wanted to die? (Note that I am not suggesting that these numbers bear any relationship to reality; I am simply attempting to draw out the implications of Lindsay’s analysis.)

If this is indeed what Lindsay believes, his discussion of “disparate impact” is beside the point: If the potential risks associated with legalization are irrelevant, the way those risks are distributed across society is obviously irrelevant as well. Such an approach, however, would be difficult to reconcile with the way that public policy is usually made in our society. The law often limits voluntary choices by competent individuals if doing so is necessary to prevent serious harm. For example, drug laws are designed (at least partly) to protect people from the harmful effects of addictive substances, but they apply even to people who take drugs for religious or medicinal purposes without becoming addicted. Age-of-consent laws prohibit minors from being coerced into sexual relationships with adults, but these laws extend even to mature minors who are capable of providing voluntary consent. In both of these situations, the law relies on a global assessment of a policy’s risks and benefits, even though doing so prevents some people from making autonomous choices that may have great importance to them.

I agree with Lindsay that, at least in some situations, assisted suicide can appropriately be considered a critical life choice. (Indeed, many people who express concern about the distribution of the risks associated with legalization emphasize the strength of the autonomy interest at stake; it is simply not true that the disparate impact argument “is persuasive only if we already assume that the option of assisted suicide is immoral or relatively unimportant.”) Yet, just as the potential for exacerbating inequality is simply one element of a multifactorial risk-benefit analysis, so too is the fact that prohibiting assisted suicide significantly limits the autonomy of those who would voluntarily choose the option if the law allowed. As a matter of public policy, neither the risks nor the benefits of legalization are themselves determinative; each is relevant and must be balanced against the other.

DEFINING BENEFITS AND RISKS

It is possible that Lindsay is making a more modest assertion. Rather than claiming that it would never be proper to deny assisted suicide to competent persons making voluntary decisions, his point may be that the circumstances that might justify doing so do not exist. In other words, perhaps there is an implicit risk-benefit assessment in his defense of legalization, reflecting his belief in the strength of the competent person’s autonomy interest and his prediction of a manageable level of mistake and abuse. Yet, while parts of the article suggest such a contextualized assessment, his analysis of the benefits and risks of legalization are extremely one-sided; the result is pre-ordained by the limited factors he considers relevant to the debate.

On the “benefit” side of the equation, Lindsay suggests that assisted suicide may be the only option for those “compelled to live in the irremediably distressing and degrading conditions in which some terminally ill persons find themselves.” Yet, the critical empirical questions necessary for a meaningful analysis of this question — for example, how common are these irremediable situations; how many people in those situations would seek assisted suicide if the law allowed; what other options for relieving their suffering exist — are not even mentioned. It is simply assumed that the “need” for assisted suicide must be considerable, a common assumption among healthy individuals fearful of dying, but one that the data on the desire for assisted suicide among the terminally ill do not clearly support.9

As far as risks are concerned, Lindsay focuses largely on the danger that people will be “manipulated or pressured into choosing assisted suicide,” terms that suggest deliberate — even sinister — efforts to cause people to seek assisted suicide against their own wishes. (Even his reference to “indirect” pressure due to “social circumstances, such as an inability to pursue other health-care choices,” suggests people reluctantly choosing an option they do not want but are forced to accept, as when poverty “compels” people to live on the streets even though they would prefer living in a comfortable apartment.10) Yet, the risk that people will be pressured or manipulated into choosing assisted suicide against their own better judgment is probably the least significant of all the potential dangers associated with legalization. The more serious problem is that, even assuming everyone acts with the best of intentions, our medical system may simply not be equipped to do what proponents of legalization ask for — i.e., make assisted suicide available while ensuring that it is used only for competent persons experiencing unreleivurable suffering who have made a voluntary, informed, and settled decision to die.11

The risk that assisted suicide will be provided in the absence of these minimum ethical prerequisites does not assume that health-care professionals are malicious, uncaring, or incompetent. Rather, it stems from the complex nature of suicidal ideation, particularly among patients confronting a
terminal illness, which makes interpreting and responding appropriately to requests for assisted suicide far more difficult than is often assumed. According to many specialists in end-of-life care, suicidal ideation is common among the terminally ill, yet it usually does not reflect a genuine desire to die. Rather, thoughts of suicide and requests for assistance are generally symptoms of other issues that have not received appropriate attention, such as undiagnosed (but generally treatable) clinical depression, unexplored fears of dying or becoming a burden, or improperly managed physical pain.\(^{14}\) If these underlying issues are properly addressed, most patients no longer want to end their lives.\(^{15}\) The danger is that, given pervasive inadequacies in our system of end-of-life care, the appropriate responses may not be provided.\(^{14}\) Instead, requests for assisted suicide may be taken at face value, without exploring their underlying meaning or considering less drastic ways of meeting the patient’s needs.

It is only by recognizing the importance of how physicians and other health-care professionals respond to patients’ thoughts about suicide — indeed, the importance of how terminally ill patients are treated in all their encounters with the health-care system — that one can appreciate why legalization poses disproportionate risks to members of socially vulnerable groups. If one of the primary risks of legalization is that some requests for assisted suicide may be accepted too readily, without fully exploring the patients’ underlying motivations or the alternatives available to relieve the patient’s suffering, the greatest risks are likely to be experienced by those whose lives are already treated with less respect.\(^{17}\) As the New York State Task Force on Life and the Law remarked, the danger that legalization poses for members of disadvantaged populations “does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society — only that they are not exempt from the prejudices manifest in other areas of our collective life.”\(^{18}\) Data showing widespread racial disparities in medical care, even controlling for factors like income level and access to health insurance,\(^{19}\) lend credence to these concerns, as they suggest that unconscious biases play a significant role in how health-care decisions are made.

To the extent Lindsay recognizes these concerns, he dismisses them by arguing that it would be inappropriate to insist that people “choose assisted suicide for the ‘right’ reason.”\(^{20}\) He is right to point out that autonomous choices often are based on mixed motives and that people often make critical life decisions for reasons that may appear misguided to outside observers. However, the factors likely to influence why people request assisted suicide, and why certain requests are granted, are relevant not because it is important for people to choose assisted suicide for the “right” reasons, but because it is important that assisted suicide be based on a voluntary, informed, and settled decision to die. After all, these are the basic premises on which most proposals for legalization rest.

Lindsay misses the point when he suggests that those concerned about the distribution of risks associated with legalization simply want to equalize the number of people from various social groups who “seek assisted suicide.”\(^{21}\) The question is not how many people in a particular group seek assisted suicide, or even how many of those requests are granted, but the proportion of the requests granted that do not satisfy the minimum ethical prerequisites of decisional capacity, voluntariness, and genuine informed consent. Lindsay’s tongue-in-cheek proposal for a quota system reflects this misunderstanding. Even if it were possible to impose quotas on the number of people from various social groups who use assisted suicide, that would do nothing to show whether those persons’ requests for assisted suicide received comparable responses, including adequate screening for depression, full exploration of alternatives, and appropriate medical and social supports.

Once it is recognized that the issue is the potential for disparity in the inappropriate use of assisted suicide, not in “deaths by assisted suicide” generally, the quota argument loses all of its force. It would be ridiculous to impose a quota on the number of cases of assisted suicide that are provided in unethical circumstances. If we could identify those cases in advance, the appropriate response would be to intervene to stop them, not to tally them up until we are confident that members of all social groups are subject to equivalent levels of abuse.

**The Title VII Analogy**

Lindsay devotes considerable space to contrasting the use of the disparate impact argument in the assisted suicide debate with its use in employment and housing discrimination cases. I agree with him that the equality-based arguments against legalizing assisted suicide are different from the way that disparate impact theory has been used in Title VII cases, but I fail to see why that matters. At most, Lindsay has shown that the specific type of disparate impact analysis first articulated by the U.S. Supreme Court in *Griggs v. Duke Power Co.*\(^{22}\) does not apply in this context. No one ever claimed that it did.

In fact, the New York State Task Force on Life and the Law, whose report Lindsay describes as “the most influential statement”\(^{23}\) of the argument he is criticizing, did not even make a disparate impact argument, at least not as that term is generally used in Title VII litigation.\(^{24}\) As the Court explained in *Griggs*, a disparate impact claim challenges a facially neutral policy on the ground that strict enforcement of the policy will disproportionately burden members of protected groups. For example, the plaintiffs in *Griggs* claimed that requiring high school diplomas for entry-level jobs had an adverse disparate impact on minorities because minorities were less likely than whites to have graduated from high school. The Task Force’s point, however, was not that strictly
enforcing a facially neutral assisted suicide policy would have a disparate impact on persons from vulnerable populations. For example, it did not claim that the requirement that requests be “competent, fully informed, voluntary, and enduring” would lead to a greater use of assisted suicide by poor or minority patients because such patients are more likely than middle class whites to satisfy those standards.

Rather, its point was that, regardless of the eligibility criteria formally written into the law, “subtle biases that operate in our health care system” would make it impossible to ensure that the formal requirements are adequately enforced in the real world. In other words, rather than making a claim about the potential disparate impact of consistently enforcing facially neutral policies, the Task Force’s concern was that, in many cases, the guidelines written into the law might not be enforced at all.

The better analogy to the Task Force’s argument against legalization of assisted suicide is not the disparate impact theory under Title VII, but the race-related arguments against the death penalty. As the Task Force noted in its report, “Even our system of administering the death penalty, which includes the stringent safeguards of due process and years of judicial scrutiny, has not been free of error or prejudice. For example, blacks who kill whites are sentenced to death at nearly 22 times the rate of blacks who kill blacks and more than seven times the rate of whites who kill blacks.”

In light of these disparities, many people oppose the death penalty even though they might support it if the system were fair. This is not a disparate impact argument, however. It is a challenge to biased decision-making that takes place despite the system’s efforts to prevent it, not to facially neutral policies that, when applied as written, have an unintended discriminatory effect.

Lindsay also argues that, unlike the use of disparate impact theory in the Title VII context, prohibiting assisted suicide “does not appear to have a causal connection with the improvement of social conditions in the same way that the prevention of employment, housing, or educational discrimination does.” There is an obvious reason for this difference. In Title VII disparate impact claims, it is assumed that employment provides valuable social benefits; the plaintiff’s goal is to improve the employment system by changing the criteria the employer uses, not to challenge the employer’s underlying authority to hire people for jobs. The Task Force’s goal, by contrast, was not to improve a system already accepted as legitimate, but to evaluate the consequences of introducing legalized assisted suicide in a society in which assisted suicide had long been against the law. As a plea for maintaining the status quo, the Task Force’s recommendation against legalization was obviously not intended to “improve” social conditions — by definition, maintaining the status quo is unlikely to change things either for better or for worse. Rather, the point of its recommendation was to prevent the introduction of a new social practice likely to harm vulnerable populations. This is certainly a legitimate public policy goal.

Finally, Lindsay suggests that, if the “business necessity” defense were applied to the issue of legalizing assisted suicide, any disparate impact associated with legalization might be justified by the importance of providing assisted suicide to those who autonomously choose this option. That may be true, but the standard for establishing business necessity is far more difficult than Lindsay implies. In the Title VII context, once a plaintiff has established that an employment practice results in a disparate impact, the employer has the burden of showing that the practice is “essential to the business.” Thus, it is not enough to show that the policy is “useful” or “efficient”; the employer “must prove that the goal it seeks to achieve through the practice is crucial to its continued viability and, in turn, that the practice selected is crucial to the achievement of that goal.”

Accordingly, if this standard were applied to the debate over assisted suicide, the question would not be simply whether assisted suicide can be characterized as a “critical autonomy interest.” Rather, the burden would be on the proponents of legalization to show that assisted suicide is essential to a system of compassionate end-of-life care. By shifting the burden of justification to those seeking legalization, the business necessity analogy is entirely consistent with the Task Force’s cautionary approach.

**Justice Matters**

The question remains as to why the distribution of risks should matter in the first place, especially if the absolute level of risks remains relatively small. Certainly, the absolute level of risks is an important consideration — if it is too high, the distribution of those risks is beside the point; if it is extremely small, lack of proportionality might matter less. In general, however, the manner in which the risks and benefits of a particular policy are distributed throughout society is important because it implicates fundamental questions of social justice. It is unfortunate when anyone has to bear the burdens of a change in public policy, but it is especially problematic when the most disadvantaged members of society are saddled with additional burdens in order to provide a benefit that the most privileged will disproportionately enjoy.

This is hardly a radical proposition. Similar concerns animate public policy in numerous other contexts. One area in which the distribution of risks is considered particularly important is research involving human subjects. In the Belmont Report, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research concluded that researchers should not only minimize the risks associated with human experimentation, but they also should avoid imposing those risks on persons who are “already burdened” due to social circumstances.
on the Belmont Report’s recommendations, current federal regulations require institutional review boards (IRBs) to ensure the equitable selection of research subjects; the regulations specifically direct IRBs to be “particularly cognizant of the special problems of research involving vulnerable populations, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons.”

These policies are in large part a response to events such as the Tuskegee syphilis study, in which treatment for syphilis was intentionally withheld from disadvantaged African-American men in an effort to monitor the natural progression of the disease. What made the study particularly egregious was that the burdens fell entirely on a population made vulnerable by racism and poverty. Because of this fact, the study caused far more damage than the injuries inflicted on the individual participants; it sent a lasting message of social subordination and exclusion that continues to affect African Americans’ trust in the health-care system today.

The social distribution of benefits and burdens is also an important consideration in decisions about environmental policy. In making decisions about the location of landfills or incinerators, for example, it is not sufficient to ensure that the overall amount of pollution does not exceed a certain level. Rather, federal policy also requires regulators to ensure that the burdens of pollution are not borne disproportionately by minority and low income communities. One reason for this requirement is that adopting policies that benefit the majority at the expense of the minority “valu[es] certain people less than others.” Even in the absence of intentional discrimination, policies that have a disparate impact on vulnerable communities undermine the principle that all people should be treated with “equal concern and respect.”

Of course, we do not insist on an equitable distribution of benefits and burdens in all contexts, nor should we. Who could argue with Lindsay’s belief that freedom of choice in marriage should be protected even if “an impetuous person may not be able to marry the person of his choice or marry at all”? The reason is that a policy of individual choice in marriage is enormously important to almost everyone in society, and any costs associated with deferring to individual choice in this context are comparatively small. Lindsay seems to believe that it is inconsistent to oppose legalization of assisted suicide because of the potential impact on vulnerable populations but to support freedom of choice in decisions about marriage, employment, or other aspects of life. Yet, one need not make a choice between autonomy and equality that applies to all circumstances. Even assuming that the option of assisted suicide is as “central to a person’s dignity and autonomy” as freedom of choice in questions of marriage, there are other distinguishing factors to consider, such as the numbers of people interested in exercising each option and the differing levels of associated risks.

The New York State Task Force on Life and the Law emphasized the importance of such a balancing process when it explained why it supported the right to refuse life-sustaining treatment but not a right to assisted suicide, despite similar dangers of mistake and abuse:

The fact that similar risks exist in both situations, however, does not mean that the risks have the same implications for law and clinical practice. The critical question is whether the risks can be mitigated through careful regulation, and, if not, whether they outweigh the reasons advanced for changing the law.

The Task Force emphasized several distinctions between the refusal of life-sustaining treatment and assisted suicide. First, it argued that decisions about assisted suicide would be more difficult to regulate because they are likely to take place outside of the institutional settings where decisions about life-sustaining treatment are generally made. Second, it noted that, with decisions about foregoing life-sustaining treatment, the scope of the risks is inherently limited, as they “extend only to individuals who are suffering from an underlying condition that makes it impossible to live without invasive medical support.” No such built-in limit exists for decisions about assisted suicide, “because anyone who takes lethal drugs will die, regardless of any underlying pathology.”

Most critically, the Task Force concluded that the “individual and societal need for a broad right to refuse treatment is far greater than the need for changing the law to allow physicians to help patients commit suicide with lethal drugs.” If the law prohibited the refusal of life-sustaining treatment, the Task Force observed, “[t]he result — strapping patients down, pumping them with drugs, sticking tubes into them, and cutting them open to perform surgery — would be a brutal assault on individual rights and, in many cases, sincerely-held religious beliefs.” A prohibition on assisted suicide, by contrast, “prevents patients from obtaining a physician’s assistance in escaping a situation imposed by nature, but does not impose any additional harm not caused by the patient’s own injury or disease.” Moreover, the Task Force noted that the number of people affected by prohibitions on assisted suicide is much smaller than the number of people who would be affected by a prohibition on withdrawing or withholding life-sustaining care. Few individuals make competent, informed decisions to seek assisted suicide, but the refusal of treatment “is an integral part of everyday medical practice.”

Reasonable people can disagree with the Task Force’s weighing of the benefits and risks of legalizing assisted suicide. For example, one might challenge the empirical basis of the Task Force’s predictions about the risks associated with legalization, especially in light of the data on the seem-
ingly unproblematic implementation of Oregon’s experiment with legalized assisted suicide. (Of course, such a challenge would depend on the questionable assumption that Oregon’s data are complete — i.e., that those physicians who did not follow the guidelines voluntarily reported their activities to the state Department of Health — and that experience in the years immediately following legalization is a good indication of how the system is likely to operate once the practice becomes more routine.)

One also might take issue with how the Task Force described the benefits and burdens of the existing legal prohibition. If it is true that assisted suicide can be an ethical option for some individuals (a position that some of the Task Force members clearly embraced), laws prohibiting assisted suicide disproportionately deny that option to the less fortunate members of society, who are less likely to have personal connections to physicians willing to provide assisted suicide despite the legal ban. Viewed in this light, considerations of equality might argue in favor of legalization, given the disparate impact of the existing legal ban on disadvantaged persons in society who genuinely want to die but lack the ability to effectuate their goal.

I agree with Lindsay that the potential for adverse disparate impact should not be a “trump that cuts short further discussion” in the debate over legalization of assisted suicide. That does not mean, however, that the manner in which the risks are distributed should play no role at all. Resolving the tension between autonomy and equality is certainly not easy, but ignoring it is not how public policy should be made.

REFERENCES

2. Id. at 6.
3. Id. at 13.
4. Id. at 6.
6. For example, John Arras, who has opposed the legalization of physician-assisted suicide (PAS), acknowledges that “[s]ome pain cannot be alleviated short of inducing a permanent state of unconsciousness in the patient, and some depression is un conquerable. For such unfortunate patients, the present law on PAS/euthanasia can represent an insuperable barrier to a dignified and decent death.” J.D. Arras, “Physician-Assisted Suicide: A Tragic View,” Journal of Contemporary Health Law & Policy, 13 (1997): 361–89, at 367.
7. Lindsay, supra note 1, at 14.
8. Id. at 10.
10. Lindsay, supra note 1, at 10.
11. Id. at 6.
12. At various points in his article, Lindsay portrays the risks associated with legalization in downright positive terms. For example, when he compares the equality-based argument against legalization of assisted suicide to the use of disparate impact theory in employment discrimination cases, he characterizes the risks of legalization as simply “allowing a person to choose assisted suicide” (p. 10) or providing “more freedom of choice in the context of decisions at the end of life” (p. 10).
15. See, for example, C.F. Von Gunten, F.D. Ferris, and L.L. Emanuel, “Ensuring Competency in End-of-Life Care and Relational Skills,” JAMA, 284 (2000): 3051–57, at 3055 (“Clinical experience suggests that most requests for hastened death will resolve if unmet needs are addressed.”).
16. As the New York State Task Force on Life and the Law observed, “Like the availability of pain relief or the skills needed to diagnose depression, the kind of doctor-patient relationship envisioned by those who advocate legalizing suicide will simply be unavailable to many patients.” New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context (New York: New York State Task Force on Life and the Law, 1994), at 130–31.
17. As Patricia King and Leslie Wolf note, “physicians may be too quick to interpret ambivalent statements made by patients as being pleas to die, because at an unconscious level they perceive the patient as not deserving of money, resources, or other efforts that might be needed for care.” P.A. King and L.E. Wolf, “Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience,” Minnesota Law Review, 82 (1998): 1015–43, at 1042. See also S.M. Wolf, “Gender, Feminism, and Death,” in S.M. Wolf, ed., Feminism and Bioethics: Beyond Reproduction (New York: Oxford University Press, 1996), 282–317, at 293 (“In assessing whether the patient’s life has become ‘meaningless,’ or a ‘burden,’ or otherwise what some might regard as suitable for extinguishing at her request, it would be remarkable if the physician’s background views did not come into play on what makes a woman’s life meaningful or how much of a burden on her family is too much.”); M.S. Spindelman, “Some Initial Thoughts on Sexuality and Gay Men with AIDS in Relation to Physician-Assisted Suicide,” Georgetown Journal of Gender and the Law, 2 (2000): 91–105, at 102 (“[L]esbians and gay men may be afforded a right to an autonomous death because dominant cultural norms suggest that death is what they do or should desire.”).
19. See, for example, King and Wolf, supra note 17; S.D. Watson, “Race, Ethnicity and Quality of Care: Inequalities and

20. Lindsay, *supra* note 1, at 12.

21. *Id.* at 11.


23. Lindsay, *supra* note 1, at 6.

24. In the interest of full disclosure, I should note that I served as staff counsel to the Task Force during the production of its 1994 report on physician-assisted suicide and euthanasia, and as executive director of the Task Force during production of its 1997 supplement to that report.


27. *Id.* at 125–26.


30. *Id.* at 430.

31. Lindsay, *supra* note 1, at 10.


38. Lindsay, *supra* note 1, at 13.

39. *Id.* at 13.


41. *Id.* at 16.


44. Lindsay, *supra* note 1, at 9.