

AGAINST ASSISTED SUICIDE -- EVEN A VERY LIMITED FORM

by YALE KAMISAR

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Professor Robert Sedler is a leading constitutional law professor and a well-known civil liberties lawyer. I think he is right about most things. To cite but one example, I think he was right when he led the ACLU's successful legal attack on certain University of Michigan restrictions on "hate speech". But I cannot agree with him about physician-assisted suicide, no matter how narrowly he frames the issue. WHAT IS THE QUESTION? Professor Sedler did not earn all the civil liberties victories he has won without being a very effective advocate. And as a good advocate he is well aware that, as Justice Frankfurter once said, "on the question you ask depends the answer you get." So to get the answer he desires, Sedler frames the issue very narrowly. He speaks only of a "right" or "liberty" to assisted suicide for "terminally ill patients" and only for such patients who are "in the end stages of terminal illness." (But is there any principled way to so limit such a right or liberty?) Sedler does not want us to think about the impact on our society of establishing a right or liberty to physician-assisted suicide, however limited (at first). He does not want us to think about other situations where the case for assisted suicide may be equally strong. He only wants us to focus on a very narrowly circumscribed set of circumstances. Why is that? I think it is because Sedler and his colleagues are well aware that a heavily restricted right to assisted suicide would cause less alarm and command more support than a broader one. Most of us balk at the notion of actively intervening to promote or to bring about the death of innocent persons. But if only the terminally ill and, still more narrowly, only those in the final stage of their terminal illness, were afforded a right to assisted suicide, we could still reassure ourselves that such a development constituted only a very, very slight deviation from our social norms. Thus, a proposal for a rigorously circumscribed right to assisted suicide or a claim that the Constitution protects a very limited form of a right to assisted suicide is quite inviting, one might even say, seductive. And, if I may quote Justice Frankfurter again, "the function of an advocate is to seduce."

On second glance, Professor Sedler's proposal may be even more narrowly circumscribed than I have indicated up to now. Although early in his talk, he speaks only of the end stages of terminal illness, later on he seems to require another factor -- unbearable pain and suffering. On two occasions, for example, he asks whether the government can force terminally ill persons to suffer until they have breathed their "last agonizing breath." I do not deny that one may imagine situations, or recall actual ones, which constitute very dramatic, very compelling, cases for assisted suicide (or active voluntary euthanasia for that matter). But I do not believe that a narrow exception to the current prohibition against assisted suicide would or could remain a narrow exception for very long. As I shall try to show, I do not believe there is any principled way to limit the right to physician-assisted suicide to the terminally ill or to those suffering unbearable or

great physical pain. More generally, I share the conclusion of the New York State Task Force on the Life and the Law that, although acts of assisted suicide or active euthanasia may be "morally acceptable in exceptional cases," such cases cannot justify explicit changes in existing legal or moral rules. As might be expected, the twenty-four members of the New York Task Force had different views about individual acts of assisted suicide and euthanasia. Some members believed that "assisted suicide is ethically acceptable in certain cases." Nevertheless, these members joined their colleagues in unanimously recommending that existing law should not be changed to permit assisted suicide (or active voluntary euthanasia). Every member of the Task Force concluded that "the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved." And the dangers would be the greatest for the elderly, the poor and the socially disadvantaged: [I]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error or indifference are the poor, minorities, and those who are least educated and least empowered. This risk 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. ***

[Many patients] in large, overburdened facilities serving the urban and rural poor... will not have the benefit of skilled pain management and comfort care. Indeed, a recent study found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain. Many patients will also lack access to psychiatric services. Furthermore, for most patients who are terminally or severely ill, routine psychiatric consultation would be inadequate to diagnose reliably whether the patient is suffering from depression. Not long ago (February, 1992), the ABA House of Delegates rejected a resolution by the Beverly Hills Bar Association that would have supported a California ballot initiative to legalize physician "aid-in-dying." (The "aid-in-dying" label covered both physician-assisted suicide and physician-administered active voluntary euthanasia.) The opposition to the Beverly Hills resolution was led by John Pickering, the Chair of the ABA Commission on Legal Problems of the Elderly. I think a point Mr. Pickering made on that occasion is worth repeating: [The resolution] calls for "voluntary aid in dying...without undue influence or duress...." Before there can be such truly voluntary choice to terminate life, there must be universal access to affordable health care. The lack of access to or the financial burdens of health care hardly permit voluntary choice for the many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts.

IF A "RIGHT" OR "LIBERTY" TO PHYSICIAN-ASSISTED SUICIDE WERE ESTABLISHED, WOULD (COULD) IT BE LIMITED TO THE "TERMINALLY ILL"?

As I understand it, the basic argument for assisted suicide is "personal autonomy" or "self-determination" or, as Professor Sedler puts it, paraphrasing the language in *Planned Parenthood v. Casey*, "the right to define one's own concept of existence and to make the most basic decisions about bodily integrity." But if one believes that respect for "self-determination" and "personal autonomy" entitles a person to decide for herself whether, when and how she chooses to end her life, I do not see any principled way in which this right or liberty can be limited to the "terminally ill," let alone persons in the end stage of a terminal illness. According to Sedler, "obviously, the terminally ill person will not seek to hasten inevitable death until the end stage of the terminal illness has been reached." This is not at all obvious to me. It would not be surprising, for example, if someone in the early stages of Alzheimer's disease, anticipating and fearing mental deterioration some years down the road, would seek assistance in ending her life before the disease progressed any further. This, essentially, describes the plight of Janet Adkins, Dr. Kevorkian's first "suicide patient." But someone in Janet Adkins' situation would not satisfy Professor Sedler's criteria because she would not be "terminally ill" as that term is usually defined; if Adkins had not availed herself of Kevorkian's services, she "might easily have lived for many more years." (Terminal illness is commonly defined as a condition that will produce death "imminently" or "within a short time" or in six months or a year.) If there is some constitutionally protected right or liberty to decide whether, when and how to end one's life -- "to determine the timing of [one's] death" -- surely it would or should apply to someone in Adkins' situation. Why should she have to wait until the final phase of Alzheimer's disease? Does personal autonomy apply to matters of life and death, or doesn't it? Dr. Timothy Quill, an extraordinarily effective and eloquent proponent of physician-assisted suicide, would not limit it to the terminally ill. As he explains, he does not want "to arbitrarily exclude persons with incurable, but not imminently terminal, progressive illness..." But why stop there? Is it any less arbitrary to exclude the quadriplegic? The victim of a paralytic stroke? The mangled survivor of a road accident? If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide, why exclude those with non-terminal illnesses or disabilities who might have to endure greater pain and suffering for much longer periods of time than those who are expected to die in the next few weeks or months?

If the terminally ill do have a right to assisted suicide, doesn't someone who must continue to live what she considers an intolerable or unacceptable existence for many years have an equal -- or even greater -- right to assisted suicide? If a competent person comes to the unhappy but firm conclusion that her existence is unbearable and freely, clearly and repeatedly requests assisted suicide, and there is a constitutional right to some form of assisted suicide, why should the competent person who has a persistent desire to obtain the aid of another in ending her life be rebuffed because she does not "qualify" under somebody else's standards? Isn't this an arbitrary limitation of self-determination and personal autonomy? As Daniel Callahan has observed: How can self-determination have any limits? [Assuming a person is competent and determined to commit suicide with the assistance of another,] [w]hy are not the person's desires or motives, whatever they may be, sufficient? There is another reason I very much doubt that if a right to

assisted suicide were established for the terminally ill it could and would remain limited to the terminally ill for very long. As I understand the position of Sedler and other proponents of a right to assisted suicide, one should have the same right to enlist the aid of others to commit suicide as one presently has to refuse or to withdraw life-sustaining medical treatment. Professor Sedler puts it quite strongly. He sees no "principled difference, in terms of constitutional doctrine and precedent," between the alleged right to assisted suicide and the established right to terminate life support. (Nor did Barbara Rothstein, Chief Judge of the U.S. District Court in Seattle, who earlier this year became the first federal judge to strike down, as violative of the Fourteenth Amendment, a state law prohibiting all assisted suicide.)

But if, as proponents of assisted suicide maintain, there is no significant difference between the right to assisted suicide and the right to reject unwanted life-saving treatment, it is fairly clear that, once established, the right to assisted suicide would not be limited to the terminally ill. For the right of a person to reject life-sustaining medical treatment has not been so limited. One need only recall the Elizabeth Bouvia case, one of the best known "right to die" cases in this country (probably the third most famous case in its field, behind only the Quinlan and Cruzan cases). At the time of the litigation Ms. Bouvia, a young woman afflicted with severe cerebral palsy, had a long life expectancy. Nor was she unconscious or mentally retarded. Indeed, she was "intelligent" and "alert." Nevertheless, she was granted the relief she sought -- the right to remove the nasogastric tube keeping her alive against her will. To be sure, neither the Bouvia case nor other cases upholding the right of non-terminally ill persons to reject life-saving treatment were decided by the U.S. Supreme Court. But Bouvia and these other cases have been well received by bioethicists and medico-legal commentators. As Professor John Regan pointed out at this conference, the highest court of New York and courts across the land have come to recognize that patients have "a virtually absolute right to refuse life-sustaining treatment, so long as they are competent in making that choice." In an effort to draw a bright line between the terminally ill and all others who might seek help in committing suicide, Professor Sedler contends that the state "cannot assert any conceivably valid interest" in requiring a terminally ill person to wait until death comes naturally because "there can be no valid interest in 'preserving life' when there is no 'life left to preserve'" and "for the terminally ill there is no life left to preserve."

I must say I do not understand this argument. A terminally ill person, for example, a cancer patient who is likely to die despite our best medical efforts in a number of months, is still a "person" or a "human being." Moreover, a terminally ill patient's mental powers can hardly be greatly impaired if she retains the decision-making capacity necessary to invoke the right to assisted suicide. (For the present, at least, proponents of assisted suicide are not contending that incompetent persons should be entitled to enlist the assistance of others in committing suicide.) Thus, if a right to assisted suicide for the terminally ill were established, it could only take place if the person seeking such a death were capable of making a voluntary, informed choice. How can it be said that such a person has "no life left to preserve"? To be sure, a terminally ill person may feel or honestly believe that what is left of her life is not a "life" worth preserving. But so too may many others suffering from serious illnesses or disabilities, who are not terminally ill. A person paralyzed from the neck down may forcefully argue that although she has a long life expectancy she has less "life" to live than a terminally ill person who, though

seriously ill, is still better able to function in society in the months she has left. The same argument may be plausibly made by a multiple sclerosis patient who, though not terminally ill, is so debilitated by the illness that she cannot move from her bed in a nursing home or eat or perform bodily functions without the assistance of others.

Indeed, earlier this year, Professor Sedler discussed the constitutional status of the multiple sclerosis patient described above (I simply reproduced his description) and concluded that she, as well as a terminally ill person, had a constitutional right to suicide. At this conference Professor Sedler has painted a bright line between the terminally ill and all others who seek assistance in committing suicide. But earlier this year he grouped together the terminally ill and those who, though they "may live for some additional years," are "so physically debilitated that for them life has become unendurable," maintaining that those falling into either category should have a constitutional right to obtain the assistance they need to end their lives by suicide. Is it any wonder that I do not believe that a right to assisted suicide for the terminally ill will be confined to the terminally ill for very long?

CAN (SHOULD) THE RIGHT TO ASSISTED SUICIDE BE LIMITED TO THOSE UNDERGOING GREAT "PAIN AND SUFFERING"?

Although Professor Sedler's position on the issue is not perfectly clear, a restriction frequently placed on the right to assisted suicide is that the person asserting this right must be experiencing great "pain and suffering" (two classifications commonly lumped together, but hardly identical). If this restriction means great physical pain, very, very few people should qualify for assisted suicide. Although pain is notoriously under-treated in this country, "according to experts in the field of pain control, almost all terminally ill patients can experience adequate relief with currently available treatment." Thus, the Memorial Sloan-Kettering Cancer Center's Kathleen Foley, a well-known expert on pain control, reports that suicide ideation and suicide requests "commonly...dissolve with adequate control of pain and other symptoms." If the "pain and suffering" restriction means "suffering" (including "psychological suffering"), not physical pain, we are no longer talking about a relatively small, easily identifiable group. Physicians can and should relieve physical pain, but "suffering" is a more complex matter: When euthanasia [or assisted suicide] is requested, the doctor is being asked to act upon someone else's subjective suffering -- variable from person to person, externally unverifiable, and always, in principle, reversible.... If a right to assisted suicide were established, how could this right be denied an otherwise eligible person who says, indeed insists, that her "externally unverifiable" suffering is intolerable? As a practical matter, would we not defer to the patient's own assessment of her suffering? As a matter of principle, shouldn't we? So long as a person is competent and her desire to enlist the aid of others in dying by suicide firm and persistent, why should her "right" to end her life in the manner she chooses (if such a right exists) be denied because her suffering does not satisfy someone else's standard? If and when a right to assisted suicide is established, any requirement that the patient experience "unbearable" or "intolerable" suffering (or "pain and suffering") will probably turn on the patient's own view of her suffering -- or drop out entirely.

WILL THE FINE LINE BETWEEN ASSISTED SUICIDE AND ACTIVE VOLUNTARY EUTHANASIA ENDURE FOR VERY LONG?

Active voluntary euthanasia occurs when someone other than the person who dies performs the last act -- the one that actually brings about death. Assisted suicide takes place when someone other than the person who dies provides assistance, but the suicidant performs the last act herself. "Recent decisions draw a distinction between active participation in a suicide [murder] and involvement in the events leading up to the suicide, such as providing the means [assisted suicide]." Because assisted suicide is less widely condemned by the criminal law and the fact that the final act is in the patient's hands is seen as offering more protection against potential abuse, assisted suicide causes less alarm than active euthanasia and commands more support. But I think the two practices are much more alike than they are different -- both involve the active intervention of another to promote or to bring about death. As I have spelled out in some detail elsewhere, one who looks at the media's treatment of the legal and ethical problems raised by death and dying and the professional literature on the same general subject quickly discovers that the line between assisted suicide and active voluntary euthanasia is often blurred and sometimes obliterated. Moreover, the emergence of such phrases as "aid-in-dying" and "physician-assisted death," terms which cover both assisted suicide and active euthanasia, have further smudged the distinction. The distinction is hard to maintain in practice and perhaps even harder to defend as a matter of principle. If a person who resolves to end her life, but is unable to do so without another's help, is entitled under certain circumstances to the active intervention of another to bring about her death, what about the person who is determined to end her life, but unable to perform the last act? Why shouldn't she be entitled to active euthanasia?

If the claim that one has, or ought to have, a right to control the time and manner of one's death is well founded -- if one who is terminally ill has, or ought to have, the right to make the choice whether or not to go on living until death comes naturally -- how can this right be denied to someone simply because she cannot swallow the barbiturates that will bring about death or is otherwise unable to perform the "final act" by herself? Physician-assisted suicide may be less alarming than physician-administered active euthanasia and may be regarded as a lesser deviation from our social norms, but once we cross the line between the rejection of life-sustaining medical treatment and the active intervention of another to promote or to bring about death, I do not see how we would (or why we should) stop short of active voluntary euthanasia. Until recently, Dr. Timothy Quill and Dr. Diane Meier would have disagreed with me. In 1992 they came out in favor of physician-assisted suicide (under certain conditions), but balked at active voluntary euthanasia. Although Quill and Meier recognized that excluding active voluntary euthanasia from "a continuum of options for comfort care" occurs at "a cost to competent, incurably ill patients who cannot swallow or move, and who therefore cannot be helped to die by assisted suicide," they opposed legalizing any form of active euthanasia "because of the risk of abuse it presents." Access to medical care in this country, they pointed out "is currently too inequitable, and many doctor-patient relationships too impersonal, for us to tolerate the risks of permitting active voluntary euthanasia."

When I first read these comments by Quill and Meier, my reaction was: Why can't the very same thing be said about not tolerating the risks of permitting assisted suicide? Shouldn't we either legalize both assisted and active euthanasia or continue to prohibit

both? On reading the comments Quill and Meier made in 1992, it also struck me that their approach to euthanasia was not very different from mine. When it came to assisted suicide, they were what might be called "act utilitarians" and I was what might be called a "rule utilitarian" (one who does not believe that the beneficial consequences of individual acts are decisive when one makes public policy), but when it came to euthanasia, all of us, it seemed, were inclined to be "rule utilitarians." That was 1992. Two years later, both Dr. Quill and Dr. Meier became more consistent "act utilitarians." They no longer defended an absolute prohibition against active euthanasia. Along with four others, they co-authored an article maintaining that "physician-assisted death" should not be limited to assisted suicide. Rather, under certain circumstances, it should include active voluntary euthanasia as well: To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so. The method chosen is less important than the careful assessment that precedes assisted death.

Quill and Meier were not the only well-known medical ethicists to shift their position on euthanasia. In 1993 Lawrence Gostin, the Editor-in-Chief of the Journal of Law, Medicine and Ethics, proposed decriminalizing assisted suicide under certain conditions, but not active euthanasia under any circumstances (evidently because he respected the bright line between active killing and "letting die.") But a year later, Gostin signed the same article Doctors Quill and Meier did, concluding that the legalization of "physician-assisted death" could not be limited to those patients who possessed the capacity to carry out the final act themselves. The fact that several participants in the debate on death and dying drew a distinct line between assisted suicide and active euthanasia only to cross that line within two years is further evidence, I think, that the distinction between physician-assisted suicide and physician-administered active voluntary euthanasia is too thin to endure for very long.

LIBERALS, CONSERVATIVES AND "SLIPPERY SLOPE" ARGUMENTS

Professor Sedler wants us, and wants the courts, to focus on a specific and narrow question: Do terminally ill patients have a right to physician-assisted suicide? He does not want us, or the courts, to consider the impact, if any, of an affirmative answer on "our views about death and dying or the sanctity of life." He assures us that "we need not worry about any slippery slope." Professor Sedler has made the point before. Indeed, he has gone so far as to say that the kind of "slippery slope" arguments I have made in the course of defending the absolute prohibition against assisted suicide have "no place" in constitutional litigation and cannot be utilized "to avoid" grappling with the specific and narrow question he and his colleagues have framed. I must disagree. I do not believe a court can responsibly resolve the constitutional issue Sedler and others have presented without considering the general implications of the asserted right. Surely a judge should not put on blinders and forge straight ahead without thinking about the impact of her holding (however, "narrow" and "specific" it may seem at first glance). Surely she should not "buy" a party's argument without thinking hard about what it is she is really "buying."

I share the view that a court should rest its judgment on a principle of general significance that produces like results in like cases. If so, how can a judge avoid considering what other fact situations not presently before the court are (or are not) like cases? Suppose a right to physician-assisted suicide for the terminally ill were established? Is there any doubt that lawyers would soon appear in court arguing that (a)

the new right could not be limited to the terminally ill, but had to apply as well to others who would experience unacceptable suffering for many years; and (b) the new right could not be limited to assisted suicide, but had to include active euthanasia, at least for those severely ill patients who were unable to perform the "final act" themselves? If it is appropriate to transcend the "narrow" and "specific" issue presented in a case once it is decided, and to start building immediately on its implications, why is it improper to anticipate the implications of a soon-to-be-decided case and call the court's attention to them? I am well aware that a court must decide the case before it and not some other one. But -- that does not mean that a case is dissociated from the past and unrelated to the future. We must decide this case with due regard for what went before and no less regard for what may come after.

It is plain that proponents of assisted suicide (and active voluntary euthanasia) consider themselves the "liberals" or "civil libertarians" in this debate. In light of this, I find their disdain for the "slippery slope" argument somewhat unbecoming. For in other settings, "liberals" have been quick to make the "slippery slope" argument. And they have done so with considerable skill. As the author of the leading law review article on the subject has pointed out, "slippery slope" arguments appear frequently in discussions about freedom of speech and the rights of those suspected of crime. I have little doubt, for example, that Professor Sedler and many other "liberals" defended the Nazis' right to march to Skokie largely because they feared that denying them First Amendment protection might start us down a slippery slope -- that "if the swastika and burning crosses are banned today on good grounds, relatively innocuous symbols may be banned tomorrow on not so good grounds." The Skokie case may be viewed as a controversy between "act utilitarians," who wanted to focus on the particular facts of the case, and "rule utilitarians," who preferred to dwell on the long-range implications of denying the Nazis the right to march. But this time it was clear that the "liberals" were the rule utilitarians. Only a day before this conference was held, the New York Times reported that a series of killings by terrorists had prompted the Israeli government to authorize harsher interrogation of suspected Muslim militants and that this decision had aroused the ire of various human-rights groups. The government could point to dramatic individual cases. It could make what has been called the "ticking bomb" argument -- underscoring the need to resort to torture to extract information that could prevent imminent killings. But a goodly number of Israeli "liberals" were unpersuaded that a very few dramatic cases justified an exception to the absolute ban against torture. They feared that once a crack appeared in the flat prohibition against torture, the crack would gradually widen. Most interrogation situations, they emphasized, were "a far cry" from the "ticking bomb" case.

This controversy, too, may be viewed as one between "act utilitarians" and "rule utilitarians." And once again the "rule utilitarians" -- those making the slippery slope argument -- were the "liberals." See the discussion in Guido Calabresi, *Ideals, Beliefs, Attitudes, and the Law* 167n. 240 (1985) and Charles L. Black, Jr., *Mr. Justice Black, the Supreme Court, and the Bill of Rights*, *Harper's Magazine*, 63. Feb. 1961 at 63, 67-68. Both commentators discuss how we should go about deciding whether the police may torture a prisoner to get him to reveal the location of a nuclear bomb when the police knew he has hidden the bomb somewhere in a major city and the bomb is due to explode in a very short time. I am well aware that, as Sissela Bok observed a quarter-century ago,

"slippery slope" or, as they are often called, "thin edge of the wedge" arguments have been "used so often and for such dubious purposes that they tend to be brushed aside as merely rhetorical." But, adds Professor Bok, if these arguments are seen as "expressions of caution in the face of unknown future changes, there must be times when the caution has turned out to be justified." The overuse or misuse of the wedge or slippery slope argument on some occasions does not justify its dismissal in other settings. Whenever it is used, "it will be necessary to test the reasonableness of such a use within the context of the specific conflict."

I put it to you that the experience in the Netherlands suggests that the use of the "slippery slope" argument is reasonable in the context of assisted suicide and active euthanasia. A survey commissioned by the Dutch government revealed that in 1990 (the year covered by the survey) there were 1,000 cases of active, intentional termination of life without an explicit request from the patient (nonvoluntary euthanasia). As would be the case in the United States if current proposals were put into effect, the Dutch guidelines for assisted suicide and active euthanasia "are dependent upon the willingness of doctors to report what they do." But "it is evident that most do not, and certainly not those substantial numbers who engage in nonvoluntary euthanasia." Recently, in the Assen case (a case referred to by the name of the city where it was tried), the Dutch Supreme Court extended the nation's toleration for assisted suicide and euthanasia to patients who are suffering psychological distress, but not physical (let alone terminal) illness. As Professor Herbert Hendin, the Executive Director of the American Suicide Foundation, and a close observer of the Dutch scene, pointed out: [T]he Assen case seemed to justify the concerns here as in the Netherlands of a "slippery slope" that moves society inexorably from assisted suicide to euthanasia, from euthanasia for the terminally ill to patients who are chronically ill, from physical suffering to mental suffering, from voluntary requests for euthanasia to killing at the discretion of the physician.

When it comes to assisted suicide (and active euthanasia) the United States is a considerable distance behind (or should one say, ahead of) the Dutch. But developments in this country have not been insignificant. "[I]n only a few years, the debate over euthanasia has moved from acceptance of forgoing life support' to serious consideration of lethal acts." But we need not focus on this recent development. Back in 1988, some time before the legal assault on the distinction between active killing and "letting die" really got underway, Professor Laurence Tribe observed: Recent court decisions have rejected many of the distinctions commentators have proposed in earlier discussions about the right to die: not only the distinction between ordinary and extraordinary... treatment, but also the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease, between withholding and withdrawing life-sustaining treatment, and between the termination of artificial feedings and the termination of other forms of life-sustaining treatment. If, as has well been said, "the history of our activities and beliefs concerning the ethics of death and dying is a history of lost distinctions of former significance," what reason is there to think that history will come to an end when we sanction assisted suicide for the terminally ill? What reason is there to doubt that once we cross the bridge between the forgoing of life-sustaining treatment and the active intervention of another to bring about death, other lines of demarcation will soon become other "lost distinctions of former significance"?

SUICIDE AND ASSISTED SUICIDE VS. "LETTING DIE"

Professor Sedler has challenged those of us who are opposed to any relaxation of the ban against assisted suicide to defend, "in terms of constitutional doctrine and precedent," the distinction between the right to die by refusing life-sustaining medical treatment and the right to die by enlisting the aid of another in committing suicide. In response, I shall like to make several points. First of all, "the major Anglo-American medical associations vigorously maintain this distinction today" and most courts have had little difficulty grasping its legal significance. "As these courts have recognized, the fact that the refusal of treatment and assisted suicide may both lead to death does not mean that they implicate identical constitutional concerns." In *Cruzan*, the only case on death, dying and the "right of privacy" ever decided by the U.S. Supreme Court, the Court "assume[d]" for purposes of the case that a competent person had "a constitutionally protected right" to refuse lifesaving treatment (even nutrition and hydration if artificially delivered), yet seemed to take for granted the constitutionality of laws totally prohibiting assisted suicide. The Court supported its assertion that a state has an undeniable interest in the protection and preservation of human life -- even the life of a person in a persistent vegetative state -- by noting: As a general matter, the states -- indeed, all civilized nations -- demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a state is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death. I share the view that this passage appears to endorse laws prohibiting assisted suicide (as well as laws permitting state intervention to prevent suicide).

A recent statement by the Coordinating Council on Life-Sustaining Medical Treatment Decision Making by the Courts typifies the way many courts and commentators have defended the line between "letting die" and actually intervening to promote or to bring about death: There are significant moral and legal distinctions between letting die (including the use of medications to relieve suffering during the dying process) and killing (assisted suicide/euthanasia). In letting die, the cause of death is seen as the underlying disease process or trauma. In assisted suicide/euthanasia, the cause of death is seen as the inherently lethal action itself. This "bare bones" statement of the argument becomes much more persuasive, I think, when Daniel Callahan, the director and co-founder of the renowned Hastings Center, explicates and amplifies it: [T]here must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology. Nothing but the action of the doctor giving the lethal injection is necessary to bring about death. *** [A judgment that further life-extending treatment is futile] is not... a judgment that a patient ought to be dead, or would be better off dead. It is not principally a judgment about a patient's life at all. It is, instead, a judgment about the limits of medical skills in providing further patient benefit. It is a way of saying that, because the limits of those skills have been reached, the patient may be allowed to die. To call these judgments, and the ensuing omission of treatment, "intending" death distorts what actually happens... [I]f I stop shovelling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby intending a driveway full of snow?.... Since death is biologically inevitable sooner or later, not a consequence

of our actions but outside of them, we can hardly be said to "intend" death when we admit we can no longer stop it.

As Dr. Callahan suggests, "the refusal of life-sustaining treatment is an integral dimension of medical practice." Indeed, as Callahan suggests, it is an indispensable part of medical practice. The distinction between "killing" and "letting die" may not be perfectly logical, but, unlike assisted suicide or euthanasia, "letting die" is a practical condition upon the successful operation of medicine. A society which prohibited the refusal of life-sustaining treatment and enforced such a prohibition with any regularity would not be a pleasant place in which to die (or live). Vast numbers of patients would be "at the mercy of every technological advance." If people could decline possibly lifesaving treatment but not discontinue it once initiated, many would probably not seek such treatment in the first place. In short, as one commentator recently put it, "the only way we can offer patients and doctors the chance to prolong life -- use life-sustaining treatment -- is by also allowing them to decide when to cease such efforts." A prohibition against the refusal of life-sustaining treatment would not only impose a burden on many more people than does a ban on assisted suicide, but would impose a far more severe burden. Although it closes "an avenue of escape," a ban on assisted suicide does not totally occupy a person's life or make "affirmative use of his body."

However, to deny a person the right to be disconnected from artificial life-support is to force one into -- a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals. It is a life almost totally occupied. The person's body is, moreover, so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of existence -- such as breathing, digesting, and circulating blood -- are forced upon him by an external agency. I share the view of the New York State Task Force on Life and the Law that it is "this right against intrusion -- not a general right to control the timing and manner of death -- that forms the basis of the constitutional right to refuse life-sustaining treatment." Moreover, as Professor Seth Kreimer has observed, so far as the dangers of mistake or abuse are concerned, "a right to refuse treatment puts at risk only the lives of those who would die without treatment," but "the approval of active euthanasia or assisted suicide would extend the risk to the entire population." Adds Kreimer: Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy. The quantitative distinction between some and all can be a legitimate predicate for the qualitative distinction between permission and prohibition.

I realize that many do not consider the arguments made in defense of the distinction between suicide/assisted suicide and the refusal of lifesaving treatment completely satisfying. But the distinction between active killing/promoting death and "letting die" has more to commend it than the inherent persuasiveness of the arguments made on its behalf. For one thing, the distinction represents an historical and pragmatic compromise. As Dean (now Judge) Guido Calabresi has pointed out, when we must make tragic choices -- choices that confront us when fundamental beliefs clash -- we seek solutions that "permit us to assert that we are cleaving to both beliefs in conflict." As good an example as any is the way we have dealt with the law and ethics of death and dying. On the one hand, we want to respect patients' wishes, relieve suffering, and put an

end to seemingly futile medical treatment. (Hence the right to refuse life-sustaining treatment.) On the other hand, we want to affirm the supreme value of life and to maintain the salutary principle that the law protects all human life, no matter how poor its quality. (Hence the ban against assisted suicide and active voluntary euthanasia.) I venture to say that one of the purposes of the distinction between the termination of life support and assisted suicide (or active voluntary euthanasia) -- or at least one of its principal effects -- is to have it both ways. The two sets of beliefs are in conflict, or at least in great tension. Nevertheless, until now at any rate, we have tried to effectuate both sets of beliefs. I realize that drawing a line between assisted suicide (or active voluntary euthanasia) and "letting die" will not please every logician or philosopher. But what line will?

This brings us to another factor at work in this area -- a factor that I think accounts for a good deal of the support for maintaining the "historic divide" between "active killing" and "letting die." Unless we carry the principle of "self-determination" or "personal autonomy" or "control of one's own destiny" to its ultimate logic -- assisted suicide (and active euthanasia) by any competent individual who firmly requests it for any reason the individual deems appropriate -- we have to draw a line somewhere along the way. But where? I submit that no intermediate line, certainly not the one Sedler and his colleagues suggest, would be any more defensible than the one we have now. So why cross the line we have now? I suspect that few, if any, have ever been in a better position than Wayne County Circuit Judge Richard Kaufman to appreciate the difficulties involved in drawing what I have called an "intermediate line." In late 1993, Judge Kaufman became the first American judge ever to hold squarely that there is a constitutional right to assisted suicide (under certain conditions). Although his decision was ultimately overturned, even his critics (and I am one of them) concede that Judge Kaufman wrote a long, thoughtful, well-documented opinion. I deem it noteworthy that Judge Kaufman drew a line neither (a) between terminally ill people seeking to die by suicide and others wishing to do so nor (b) between those experiencing severe "pain and suffering" and others whose pain and suffering was, or could be brought, under control. The key factor, rather, was the presence or absence of an "objective medical condition" that was "extremely unlikely to improve." If an individual's quality of life was significantly impaired by such a medical condition, even though it was not a life-threatening condition, the individual could assert the newly established constitutional right. But if an individual's quality of life was significantly diminished for any other reason (e.g., disgrace, financial ruin, the death of a spouse), she could not invoke the constitutional right -- no matter how competent she was or firm her desire to die. Although there was some confusion about this, the line Judge Kaufman wound up drawing was not a line between "rational" and "irrational" suicide. Rather, it was a line between one category of "rational" suicide -- suicidants whose lives were significantly impaired by irreversible medical conditions -- and other categories of "rational" suicide. Judge Kaufman did not draw the line further down the slope because he feared that "any form of rational suicide that did not include the presence of an objective medical condition would be too close to irrational suicide."

If constitutional protection were extended to all persons who harbored a rational wish to die, he told us, "the possibility that irrational suicide would increase is too great." Therefore, according to Judge Kaufman, a state not only has the power to prohibit all

classes of "irrational" suicide and assisted suicide, but some classes of "rational" suicide and assisted suicide as well -- those where one's quality of life had not been impaired by a permanent medical condition. Judge Kaufman made a valiant effort to find a sensible legal solution to an excruciatingly hard problem. But if a judge can deny constitutional protection to some forms of "rational" assisted suicide out of concern that unless this is done "irrational" assisted suicide might get out of hand, why can't a legislature prohibit all forms of "rational" assisted suicide on the same ground? After all, geriatric psychiatrists (who work with suicidal people every day) and suicidologists (who perform "psychological autopsies" of people who commit suicide) tell us that a suicide rarely occurs in the absence of a major psychiatric disorder and that this observation holds for suicides among the elderly. Moreover, these experts underscore the inability of depressed persons to recognize the severity of their own symptoms and the failure of primary physicians to detect major depression, especially in elderly patients. As one authority has observed, we encourage suicide among the elderly "by our neglect and indifference." As another commentator has put it, "suicidal persons are succumbing to what they experience as an overpowering and unrelenting coercion in their environment to cease living."

Is it not fair to assume that these pressures will intensify in a society that sanctions assisted suicide (and thereby suicide as well)? Is it not fair to assume that once assisted suicide is a lawful alternative and people are "doing it," and feel free to talk about it, more people, especially the sick, the old and the vulnerable, will see this route as a tempting way to spare both oneself and one's family and friends the burden of serious illness and/or advanced age?

THE "ABORTION CASES": HOW EXPANSIVE IS THE CONCEPT OF PRIVACY?

Professor Sedler and his allies find support for their views in the Supreme Court's abortion cases. In *Roe v. Wade*, the Court informed us that "a right of privacy," which had earlier been invoked to strike down restrictions on the use and distribution of contraceptives, "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." The Court cleared the way for its ultimate holding by rejecting the state's argument that "a fetus is a person" within the meaning of the Constitution -- "the word person", as used in the Fourteenth Amendment, does not include the unborn." Although *Roe* did not involve the termination of a human life (so far as the Court was concerned), Sedler and others have read the case and its progeny very broadly to support a "right" or "liberty," under certain circumstances, to enlist the assistance of others in committing suicide. I agree with Professor Sedler that the constitutional answer to the question he and his colleagues pose "must be found in applicable Supreme Court doctrine and precedent." But what are the relevant precedents? (Why, for example, does Sedler totally ignore *Bowers v. Hardwick*, a case which, so long as it remains on the books, greatly reduces *Roe*'s potential for expansion?) And how should we characterize the applicable doctrine? "The laws struck down under the rubric of privacy have had a peculiar tendency to gravitate around sexuality" -- "not sex" as such, of course, but sexuality in the broad sense of that term: the network of decisions and conduct relating to the conditions under which sex is permissible, the social institutions surrounding sex relationships, and the procreative consequences of sex."

Although the plaintiffs in *Roe* and its companion case did not even challenge the abortion restrictions as sex discriminatory, a growing number of commentators, including

Judge (now Justice) Ruth Bader Ginsburg, have maintained that the best argument for abortion is based on principles of "sex equality," not "due process" or "privacy." As then Judge Ginsburg noted (in a lecture delivered shortly before her nomination to the U.S. Supreme Court), in *Planned Parenthood v. Casey*, which reaffirmed *Roe*, the majority "added an important strand to the Court's opinions on abortion" -- it "acknowledged the intimate connection between a woman's ability to control [her] reproductive li[fe]" and her ability [to] participate equally in the economic and social life of the Nation." "Laws restricting abortion so dramatically shape the lives of women, and only of women," Professor Laurence Tribe has observed, "that their denial of equality hardly needs elaboration." Continues Tribe: While men retain the right to sexual and reproductive autonomy, restrictions on abortion deny that autonomy to women. Laws restricting access to abortion thereby place a real and substantial burden on women's ability to participate in society as equals. Even a woman who is not pregnant is inevitably affected by her knowledge of the power relationships created by a ban on abortion. The more the right to abortion is grounded on "sexual equality," or the more *Roe* is justified on that basis, the less comfort that right offers proponents of a constitutional right to assisted suicide. But even those who continue to view the right to abortion as based on "privacy" or "personhood" must take into account how the scope and meaning of these rather abstract concepts are affected by the decision in *Bowers v. Hardwick*. I would not have joined Justice White's opinion for the Court in *Hardwick*. I agree with former Solicitor General Charles Fried that the opinion White wrote upholding the constitutionality of a state law criminalizing consensual sodomy, as applied to homosexuality, is "stunningly harsh and dismissive." But Justice White spoke for five members of the Court. Any discussion of the breadth and potential for expansion of such concepts as "privacy" and "personhood" which ignores *Hardwick* (as does Professor Sedler, and as did Judge Rothstein when she invalidated an anti-assisted suicide law) is seriously incomplete. "The Court is most vulnerable and comes nearest to illegitimacy," observed the *Hardwick* Court, per White, J., "when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." More specifically, the Court's prior "privacy" cases had recognized three categories of protected activity -- marriage, procreation, and family relationships -- but "[n]o connection" between "homosexual activity" and any of these categories was demonstrated. As Professor Jed Rubenfeld has observed: Justice White neither sought nor found any unifying principle underlying his three categories. It was as if the Court has said, "We in the majority barely understand why even these three areas are constitutionally protected; we simply acknowledge them and note that they re not involved here."...

The device of compartmentalizing precedent is an old jurisprudential strategy for limiting unruly doctrines. The effect here is that, after *Hardwick*, we know that the right to privacy protects some aspects of marriage, procreation, and child-rearing, but we do not know why. By identifying three disparate applications ungrounded by any unifying principle, the majority effectively severed the roots of the privacy doctrine, leaving only the branches.... I do not deny that a tenable argument may be made that the "right of privacy" invoked in *Roe* includes the "right" or "liberty" of a person to choose whether to continue to live until death comes naturally or to hasten death by obtaining the active intervention of another. But a much stronger argument may be made, I think, that the "right of privacy" encompasses the autonomy of sexual activity and relationships. As

Justice Blackmun wrote in *Hardwick*, "sexual intimacy is a sensitive, key relationship of human existence, central to...the development of human personality"; "individuals define themselves in a significant way through their intimate sexual relationships with others" and "much of the richness of a relationship will come from the freedom an individual has to choose the form and nature of these intensely personal bonds." But Justice Blackmun wrote in dissent. I share Justice Blackmun's view that before it can punish its people for their actions, a state "must do more than assert that the choice they have made is an abominable crime not fit to be named among Christians." I agree, too, with another *Hardwick* dissenter, Justice Stevens, that "the fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice."

However, as the recent report of the New York State Force on Life and the Law well demonstrates, any state that prohibits assisted suicide can advance justifications for its legislation that go well beyond the law's conformity to religious doctrine or "morality." In *Planned Parenthood v. Casey*, in the course of reaffirming *Roe*, the Court spoke at one point about "the right to define one's own concept of existence" and one's concept of "the mystery of human life" as being "at the heart of liberty." As did Judge Rothstein in *Compassion in Dying*, Sedler finds much solace in this capacious language. The language constitutes the last two sentences of a long paragraph. I would like to quote the entire paragraph, including the first four sentences: Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Our precedents "have respected the private realm of family life which the state cannot enter." These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion of the State.

This paragraph does contain some sweeping language. But I think such language can plausibly be read as explaining why "these matters" -- "personal decisions relating to marriage, procreation, contraception" and "family relationships" or, more summarily, "the private realm of family life" -- have been given constitutional protection. Viewed in isolation, the language about "defin[ing] one's own concept of existence" and "of the mystery of human life" does seem breathtaking. Literally, it would cover the right of terminally ill people to enlist the assistance of another in committing suicide. But literally it would also cover the right of any competent person -- physically ill or not -- to enlist the aid of another in suicide. Professor Sedler maintains that the right to define one's concept of existence (and to make basic decisions about one's bodily integrity) "surely must include" the right of terminally ill persons to obtain assistance in ending their lives, but not the right of anybody else to do so. Why not? I understand how one can read the passage quoted above narrowly (limiting it to reproductive rights and related matters) or read it broadly (including death and dying). But I fail to see how one can read it the way Sedler does. If, as Sedler seems to say, the right to "define one's concept of existence"

includes the right to end one's existence with the active assistance of another, and if, as he also seems to say, the right to "define one's own concept...of the mystery of human life" includes the right to end one's interest in life and its mystery with the active assistance of another, why are these rights limited to the terminally ill? Either the language quoted above refers only to personal decisions relating to marriage, procreation, contraception, child rearing and the like or the language also refers to personal decisions relating to suicide and suicide assistance. If the latter, why doesn't everybody have the right to define his concept of existence or his concept of the mystery of life? Why are these awesome rights denied to the great majority of us because our lives are of "indefinite duration"? Why, if people so wish, can't they change that? Why, if they so desire, can't people bring a life of "indefinite duration" to a definite and abrupt close? Is the choice whether to end one's life and how to do so "central to the liberty protected by the Fourteenth Amendment" or is it not?

A reading of "the right to define one's own concept of existence" language broad enough to cover assisted suicide would be broad enough to cover a great many other things. It would surely cover the autonomy of sexual activity and relationships and it would do so more easily than it would embrace assisted suicide. Moreover, the connection between "homosexual activity" and the categories of activity already protected by the "privacy" cases seems much closer than the relationship between assisted suicide and categories of activity already protected. So far as I am aware, however, nobody has suggested that Casey overrules Bowers v. Hardwick. As a panel of the Ninth Circuit observed, in reversing a federal district judge who had relied heavily on the same spacious language that Sedler and his colleagues do: The language taken from Casey, on which the district court pitched its principal argument, should not be removed from the context in which it was uttered. Any reader of judicial opinions knows they often attempt a generality of expression and a sententiousness of phrase that extend far beyond the problem addressed.... To take [a few lines] out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these [few lines] "almost prescriptive" in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulations of reproduction and the prevention of the promotion of killing a patient at his or her request.

I do not think we should read too much into the soaring language found in one small segment of a long opinion. Although it "pointedly reaffirmed the essential holding" of Roe v. Wade that abortions prior to fetal viability may not be criminalized, "Casey notably retreats from Roe." By upholding several provisions of a state act that imposed restrictions on reproductive freedom that "could not have survived strict adherence to Roe," the Court "once again invited state legislatures to regulate and sharply restrict access to legal abortions." Moreover, in reaffirming Roe, the Casey majority relied heavily on the rule of stare decisis. Absent "the most compelling reason to reexamine a watershed decision," the majority told us, to overrule Roe "under fire" would "subvert the Court's legitimacy beyond any question." Finally, the three controlling Justices, O'Connor, Kennedy and Souter, JJ. (none of whom had been on the Court when Roe was decided) made an extraordinary statement: We do not need to say whether each of us, had we been Members of the Court [when Roe was decided], would have concluded, as the Roe Court did, that [the weight of the State's interest in protecting the potentiality of life]

is insufficient to justify a ban on abortions prior to viability.... The matter is not before us in the first instance, and coming as it does after nearly 20 years of litigation in Roe's wake we are satisfied that the immediate question is not the soundness of Roe's resolution of the issue, but the precedential force that must be accorded to its holding. All things considered, I believe the Court that reaffirmed Roe in 1992 was bent on bringing an old constitutional war to an end -- not getting ready to fight a new one.

A FINAL THOUGHT "[E]very person in Holland has free access to health care" and thus "concern about America's 34 million uninsured citizens -- several times greater than the entire population of Holland -- does not come into the picture." Nor do "the feelings, pressures, and fears of millions of other Americans who may not have adequate coverage to pay for relevant services." I agree with Professor Giles Scofield that -- The moral issue of our day is not whether to enable or prevent a few individuals' dying in the comfort of their home in the presence of their private physicians. The moral issue of our day is whether to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid. As my former colleague, Robert Burt, recently observed, at a time when many millions of Americans lack adequate health care and Congress has refused to do much about it, "it would be ironic if the judiciary selected physician-assisted suicide as the one health care right that deserves constitutional status."