Physician Assisted Suicide: A Bad Idea

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Physician-Assisted Suicide

A bad idea

The following essay is a shorter version of an article that is being published in the October 1996 issue of Issues in Law and Medicine. That article in turn is based on a talk given at the 1996 Annual Meeting of the American Psychiatric Association in May at New York.
It would be hard to deny that there is a great deal of support in this country — and ever-growing support — for legalizing physician-assisted suicide (PAS). Why is this so? I believe there are a considerable number of reasons. I shall discuss five common reasons — and explain why I do not find any of them convincing.

I.

The compelling force of heartrending individual cases

Many people, understandably, are greatly affected by the heartwrenching facts of individual cases, e.g., a person enduring the last stages of A.L.S. ("Lou Gehrig's disease"), who gasps: "I want . . . I want . . . to die." In this regard the media, quite possibly inadvertently, advances the cause of PAS.

A reporter often thinks that the way to provide in-depth coverage of the subject of assisted suicide and euthanasia is to provide a detailed account of a particular person suffering from a particular disease and asking: "How can we deny this person the active intervention of another to bring about death?" Or "What would you want done if you were in this person's shoes?"

But we should not let a compelling individual case blot out more general considerations. The issue is not simply what seems best for the individual who is the focal point of a news story, but what seems best for society as a whole.

Every one interested in the subject of PAS and active voluntary euthanasia (AVE) has heard emotional stories about people suffering great pain and begging for someone to kill them or help them bring about their death. But people like Kathleen Foley, the Memorial Sloan-Kettering Cancer Center's renowned pain control expert, and Herbert Hendin, the American Suicide Foundation's executive director, can tell very moving stories, too — stories militating against the legalization of PAS and AVE. They can tell us how suicidal ideation and suicide requests commonly dissolve with adequate control of pain and other symptoms — or how, for example, after much conversation with a caring physician, a suicidal patient — one who would have qualified for PAS if the procedure had been legal — changed his mind, how his desperation subsided, and how he used the remaining months of his life to become closer to his wife and parents.

I can hear the cries of protest now. Let terminally ill people (and perhaps others as well) do what they want. They're not bothering anybody else. Letting them do what they want won't affect anybody else. But I am afraid it will. We are not merely a collection of isolated individuals; we are connected to each other in many different ways. Therefore, PAS and AVE are social issues and matters of public policy.

Suppose a healthy septuagenarian, who has struggled to overcome the hardships of poverty all his life, wants to assure that his two grandchildren have a better life than he did. So he decides he will sell his heart for $500,000 and arrange to have a trust fund established for his grandchildren. This does not strike me as an irrational or senseless act. But would "society" allow this transaction to take place? I think not. But why not?

How can a prohibition against selling one's body parts be reconciled with the view that we have full autonomy over our lives and our bodies?

It is noteworthy, I believe, that although, when it issued its report in 1994, the New York Task Force on Life and the Law recognized that PAS or AVE "may be morally acceptable in exceptional cases," all of its twenty-four members concluded that compelling exceptional cases did not justify changing the law governing assisted suicide and voluntary euthanasia.
But we should not let a compelling individual case blot out more general considerations. The issue is not simply what seems best for the individual who is the focal point...

Late last year, a member of the Task Force, philosopher and bioethicist John Arras, looked back on his work on the project and recalled that he and his colleagues were deeply moved by the sufferings of some patients, but that all twenty-four members were ultimately convinced that these patients "could not be helped in a public way," that is to say, could not be given publicly-sanctioned assistance in committing suicide, without endangering a far greater number of highly vulnerable patients.

Professor Arras noted that he and the other members of the Task Force were painfully aware that whether they maintained the total prohibition against PAS and AVE or whether they lifted the ban for any group of patients, "there were bound to be victims." He added: "The victims of the current policy are easy to identify; they are on the news, the talk shows and the documentaries, and often on Dr. Kevorkian's roster of 'patients.' But who would be the victims of a more permissive policy?"

Professor Arras then maintained, as had the Task Force, that whatever criteria and procedures for justifiable PAS and AVE are ultimately chosen, "abuse of the system is highly likely to follow." If PAS were legalized, many requests for PAS would not be sufficiently voluntary "given the highly predictable failure of most physicians reliably to diagnose and treat reversible clinical depression, especially in the elderly population." As for exploring all reasonable alternatives to PAS, "given the abysmal track record of physicians in responding adequately to pain and suffering, we can also confidently predict that in many cases all reasonable alternatives will not have been exhausted."

"Forbidding [assisted suicide] leaves some citizens with the prospect of being trapped in agony or indignity from which they could be delivered by a death they desire. But permitting such assistance risks the unwilling or manipulated death of the most vulnerable members of society, and the erosion of the normative structure that encourages them, their families, and their doctors to choose life."

II.

Objections to legalizing PAS or AVE are limited to religious grounds

Another reason I think the assisted suicide-active voluntary euthanasia movement has made so much headway is that its proponents have managed to convince many that the only substantial objections to their proposals are based on religious doctrine.

In November of 1994, Measure 16, the Oregon ballot initiative, was narrowly approved by the voters and Oregon became the first state to legalize PAS. According to press reports, Oregon Right to Die and other proponents of PAS hammered away at the Roman Catholic Church or, a bit vaguely, at those who "think they have the divine right to control other people's lives."

I can only say that, so far as I know, I have never made a religious objection to PAS or AVE. Indeed, the primary reason I first wrote about this subject way back in 1958 was that I strongly disagreed with the view of British law professor Glanville Williams, the leading Anglo-American proponent of active voluntary euthanasia at the time, who maintained that "euthanasia can be condemned only according to a religious opinion." (In resisting Professor Williams' proposals, I took pains to call my article "Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation.")
I think many people share Professor Williams’ view and that proponents of PAS and AVE have done their best to exploit this feeling. But I believe the New York State Task Force Report is strong evidence that Glanville Williams and other proponents of PAS are wrong. The Report spells out many nonreligious objections to legalizing PAS, a number of which were summarized by Professor Arras, whom I quoted earlier. It was these nonreligious concerns that led all twenty-four members of the Task Force to reach the unanimous conclusion that the total ban against assisted suicide should be kept intact.

III.

PAS and AVE are facts of modern life, so we ought to legalize and regulate them

Another argument for PAS that appeals to a goodly number of people goes something like this: A significant number of physicians have been performing assisted suicide anyway, so why not legalize it? Wouldn’t it be better to bring the practice out in the open and to formulate clear standards than to keep the practice underground and unregulated?

It is not at all clear how prevalent the underground practice is. As Daniel Callahan (President of the Hastings Center) and Margot White (a lawyer specializing in bioethics) have pointed out in a recent article, however, if it is truly the case that current laws against euthanasia (and assisted suicide) are widely ignored by doctors, “why should we expect new statutes to be taken with greater moral and legal seriousness?” Evidently no physician has ever been convicted of a crime for helping a suffering patient die at her request. But, as Callahan and White ask, why should we expect that there will be any more convictions for violating the new laws than there have been for violating the laws presently in effect?

What Dr. Herbert Hendin said this spring in testimony before a Congressional subcommittee about the impact of legalizing euthanasia applies to the legalization of PAS as well: Absent “an intrusion into the relationship between patient and doctor that most patients would not want and most doctors would not accept,” no law or set of guidelines covering euthanasia (or assisted suicide) can protect patients. Adds Hendin: “After euthanasia [or assisted suicide] has been performed, since only the patient and the doctor may know the actual facts of the case, and since only the doctor is alive to relate them, any medical, legal, or interdisciplinary review committee will, as in the Netherlands, only know what the doctor chooses to tell them. Legal sanction creates a permissive atmosphere that seems to foster not taking the guidelines too seriously. The notion that those American doctors— who are admittedly breaking some serious laws in now assisting in a suicide— would follow guidelines if assisted suicide were legalized is not borne out by the Dutch experience; nor is it likely given the failure of American practitioners of assisted suicide to follow elementary safeguards in cases they have published.”

IV.

There is little difference between ending life support and intervening to promote death

This March, in the course of ruling in a case called Compassion in Dying v. Washington that mentally competent, terminally ill patients, at least, have a constitutionally protected right to assisted suicide, an 8-3 majority of the U.S. Court of Appeals for the Ninth Circuit (covering California, Washington, Oregon and other western states) wrote that it could see “no ethical or constitutionally cognizable difference between a doctor’s pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life.” According to the Ninth Circuit, the important thing is that “the death of the patient is the intended result as surely in one case as in the other.”

The Ninth Circuit found the right to assisted suicide grounded in the Due Process Clause. A month later, in a case called Quill v. Vacco, a three-judge panel of the U.S. Court of Appeals for the Second Circuit (covering New York, Connecticut and Vermont) struck down...
New York's law against assisted suicide on equal protection grounds. The Second Circuit was no more impressed with the alleged distinction between “letting die” and active intervention to bring about death than the Ninth circuit had been. It “seem[ed] clear” to the Second Circuit that “New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for being attached to life-sustaining equipment, are not allowed to [do so].”

The Ninth Circuit’s due process analysis would seem to apply to active voluntary euthanasia as well as PAS. So would the Second Circuit’s equal protection analysis. If persons off life support systems are similarly situated to those on such systems, why aren’t terminally ill people who are unable to perform the last, death-causing act themselves, but who want the active intervention of another to bring about death, similarly situated to terminally ill people who are able to perform the last, death-causing act themselves and want to enlist the assistance of another in bringing about death?

If a mentally competent, terminally ill person is determined to end her life with the active assistance of another, but needs someone else to administer the lethal medicine, how can she be denied this right simply because she cannot perform the last, death-causing act herself? Applying the reasoning of the Second Circuit, wouldn’t denial of the latter person’s right constitute — and at this point I am quoting the very language the Second Circuit used — a failure to “treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths”?

I think both the Ninth and Second Circuits went awry by lumping together different kinds of “rights to die.” Few slogans are more stirring than the “right to die.” But few phrases are more fuzzy, more misleading or more misunderstood.

The phrase has been used at various times to refer to (a) the right to refuse or to terminate unwanted medical treatment, including life-saving treatment; (b) the right to assisted suicide, i.e., the right to obtain another’s help in committing suicide; and (c) the right to active voluntary euthanasia, i.e., the right to authorize another to kill you intentionally and directly.

Until March of this year the only kind of “right to die” any American appellate court, state or federal, had ever established — and the only right or liberty that the New Jersey Supreme Court had recognized in the Karen Ann Quinlan case (1976) and the Supreme Court had assumed existed in the Nancy Beth Cruzan case (1990) — was the right to reject life-sustaining medical treatment or, as many have called it, the right to die a natural death. Indeed, the landmark Quinlan case had explicitly distinguished between “letting die” on the one hand and both direct killing and assisted suicide on the other.

When all is said and done, both the Second and Ninth Circuit rulings turn largely on the courts’ failure to keep two kinds of “rights to die” separate and distinct — the right to terminate life support and the right to assisted suicide. And their failure to do so indicates that, when faced with the specific issue, they are unlikely to keep a third kind of “right to die” separate and distinct — active voluntary euthanasia.

I believe the Ninth Circuit was quite wrong when it claimed an inability to find any “constitutionally cognizable difference” between a doctor’s “pulling the plug” on a terminally ill patient and his providing a patient with lethal medicine so that she could commit suicide. I think...
the Second Circuit was equally wrong when it concluded that terminally ill patients on life-support systems and those not on such systems are “similarly situated” or “similarly circumstanced.”

The reasons that the cases decided by the Ninth and Second Circuit are so difficult is that they involve two competing doctrines or traditions. The right to terminate life support grows out of the doctrine of informed consent, a doctrine firmly entrenched in American tort law. The logical corollary of that doctrine, of course, is the right to reject medical treatment. The other tradition, which has continued to exist alongside the first one, is the anti-suicide tradition. This is evidenced by society’s discouragement of suicide (indeed, by the state’s power to prevent suicide, by force if necessary) and by the many laws criminalizing assisted suicide.

In the 1990 Cruzan case, the only “right to die” case ever decided by the U.S. Supreme Court up to now, a majority of the Court, perhaps as many as eight justices, evidently decided that the termination of artificial nutrition and hydration was more consistent with the rationale of the cases upholding the right to reject medical treatment. So far as we can tell, only Justice Scalia, who wrote a lone concurring opinion, thought the case implicated the anti-suicide tradition.

Justice Scalia’s opinion in Cruzan was almost totally ignored by his colleagues. The other eight justices all framed the issue in terms of a right to be free from “unwanted medical treatment” or, more specifically, “unwanted artificial nutrition and hydration.” None of them had anything to say about a “right to suicide.”

The Ninth and Second Circuit opinions to the contrary notwithstanding, there are a number of important differences between withholding or withdrawal of life-sustaining medical treatment and active intervention to promote or to bring about death.

For one thing, the refusal of life-sustaining treatment is an indispensable part of medical practice. Approximately 70 percent of all hospital and nursing home deaths follow the refusal of some form of medical intervention. If society prohibited the rejection of life-sustaining treatment, vast numbers of patients would be at the mercy of every technological advance in medicine. Moreover, if people could refuse medical treatment that might turn out to be lifesaving, but not discontinue it once initiated, many would not seek such treatment in the first place.

In short, letting a patient die at some point is a practical condition upon the successful operation of medicine. But the same cannot be said of PAS or physician-administered AVE. This is especially so if patients’ pain is adequately treated (although presently it frequently is not) and patients understand they have a right to refuse treatment or to demand the withdrawal of burdensome treatments (although presently they often do not).

Not only would a prohibition against rejecting life-sustaining treatment oppress many more people than would a ban on PAS, it would impose a much more severe burden. The prohibition against assisted suicide does foreclose an “avenue of escape,” but it does not totally occupy a person’s life or make affirmative use of his body. To deny a person the right to terminate life-support, however, is as Yale Law Professor Jed Rubenfeld has put it, 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.”

To allow a patient to resist unwanted bodily intrusions by a physician is hardly the same thing as granting her a right to determine the time and manner of her death. The distinction between a right to refuse medical treatment and the right to PAS is a comprehensible one and a line maintained by almost all major Anglo-American medical associations.

I am well aware that the distinction I am defending is neither perfectly neat nor perfectly logical. But what line is? Surely not the line between those who are terminally ill and those who will have to endure what they consider an intolerable life for a much longer period. Nor the distinction between assisted suicide and active voluntary euthanasia.

I believe the line between “letting die” and actively intervening to bring about death represents a cultural and pragmatic compromise between the desire to let seriously ill people carry out their wishes to end it all and the felt need to protect the weak and the vulnerable. On the one hand, we want to respect patients’ wishes, relieve suffering, and put an end to seemingly futile medical treatment. Hence we allow patients 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 values are in conflict, or at least in great tension. Nevertheless, until now at any rate, we have tried to honor both sets. We should continue to try to do so.

V.

If a right to PAS were established, it would only apply to the terminally ill.

Most proponents of the right to PAS speak only of — and want us to think only about — such a right for the terminally ill. (Terminal illness is commonly defined as a condition that will produce death “imminently” or “within a short time” or in six months.) Such advocacy is quite understandable. A proposal to legalize PAS, but to limit that right to the terminally ill, causes less alarm and commands more general support than would a proposal to establish a broader right to assisted suicide. A proposal to permit only terminally ill patients to enlist the aid of physicians to commit suicide is attractive because it leads the public to believe that adoption of such a proposal would
constitute only a slight deviation from traditional standards and procedures. And, as Justice Frankfurter once observed, "the function of an advocate is to seduce."

But there are all sorts of reasons why life may seem intolerable to a reasonable person. To argue that suicide is plausible or understandable in order to escape intense physical pain or to end a physically debilitated life but for no other reason is to show oneself out of touch with the depth and complexity of human motives.

A few proponents of assisted suicide have taken the position that it would be arbitrary to exclude from coverage persons with incurable but not terminally ill progressive illnesses, for example, a person in the early stages of Alzheimer's disease. But why stop there? Is it any less arbitrary to exclude the quadriplegic? The victim of a paralytic stroke? One afflicted with severe arthritis? The disfigured survivor of a fire? The mangled survivor of a road accident? One whose family has been wiped out in an airplane crash?

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 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 she be denied the assistance of another to end her life just 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?" If a person is mentally competent and determined to commit suicide with the assistance of another, why aren't her desires or motives — whatever they may be — sufficient?

There is another reason I very much doubt that a right to assisted suicide could or would be limited to the terminally ill for very long — the analyses of the two federal appellate courts that handed down the "right to die" decisions I have discussed earlier. Both the Second and Ninth Circuits seemed to share the view of proponents of assisted suicide who insist that there is 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. The problem is that the right to reject life-sustaining treatment has not been limited to the terminally ill.

One need only recall the Elizabeth Bouvia case, which arose a decade ago. 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 impaired. Indeed, the court described her as both "intelligent" and "alert." Nevertheless, she was granted the relief she sought — the right to remove a nasogastric tube keeping her alive against her wishes.

To be sure, neither the Bouvia case nor other cases upholding the right of non-terminally ill persons to reject life-sustaining 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 Alan Meisel pointed out in the new edition of his treatise on the "right to die," "the right of a competent person to refuse medical treatment is virtually absolute." If so, and if there is no significant distinction between "letting die" and active intervention to bring about death, how can the latter right be limited to the terminally ill?

A Final Remark

Four decades ago, Glanville Williams, a leading proponent of assisted suicide and euthanasia, admitted that he "prepared for ridicule" whenever he described these practices as "medical operations" or "medical procedures." "Regarded as surgery," he acknowledged, these practices are "unique, since [their] object is not to save or prolong life but the reverse." Today, few people chuckle when PAS is classified as a medical procedure — or even when it is called a "health care right."

As my former colleague Robert Burt recently observed, at a time when tens of millions of Americans lack adequate health care and Congress has refused to do anything about it, it would be most ironic if the judiciary were to select PAS as "the one health care right that deserves constitutional status."

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