

1996

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## Recommended Citation

Kamisar, Yale. "The Reasons So Many People Support Physician-Assisted Suicide - and Why These Reasons Are Not Convincing." *Issues L. & Med.* 12, no. 2 (1996): 113-31.

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# **The Reasons So Many People Support Physician-Assisted Suicide—And Why These Reasons Are Not Convincing**

Yale Kamisar, LL.B., LL.D.\*

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. In this article, I shall discuss five common reasons and explain why I do not find any of them convincing.

## **The Compelling Force of Heartrending Individual Cases**

Many people, understandably, are greatly affected by the heart-wrenching facts of individual cases, e.g., a person enduring the last stages of ALS (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.

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\*Clarence Darrow Distinguished University Professor, the University of Michigan Law School. A.B., New York University, 1950; LL.B., Columbia University, 1954; LL.D., John Jay College of Criminal Justice, CUNY, 1978. This article is adapted from a presentation given at the annual meeting of the American Psychiatric Association, May 6, 1996, a talk which in turn was based on the author's testimony before the Subcommittee on Constitutional Law of the House Committee on the Judiciary, April 29, 1996. In several places the author has drawn freely from his other writings on the subject.

Everyone 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 had become convinced that suicide or assisted suicide was his best option—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.<sup>1</sup>

I can hear the cries of protest now. "Let terminally ill people (and perhaps others as well) obtain assistance in committing suicide if that is what they want. They're not bothering anybody else. Letting them determine the time and manner of their death won't affect anybody else."

But I am afraid *it will*. "We are not merely a collection of self-determining individuals;" "[w]e are connected to others in many different ways."<sup>2</sup> Therefore, PAS and AVE are social issues and matters of public policy.<sup>3</sup>

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?

This article is being written at a time when the firmly established right to refuse or to terminate lifesaving medical treatment is being used as a launching pad for a right to PAS.<sup>4</sup> However, the issue of assisted suicide is

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<sup>1</sup>See Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. PAIN & SYMPTOM MGMT. 289, 290 (1991); *Hearing before the Subcomm. on the Constitution of the Comm. on the Judiciary, House of Representatives*, Apr. 29, 1996 (prepared statement of Dr. Herbert Hendin at 3-4) [hereinafter *Hearing*].

<sup>2</sup>Martin E. Marty & Ron Hamel, *Part Three: Some Questions and Answers*, in ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE 27, 40 (1991).

<sup>3</sup>See *id.*

<sup>4</sup>This year, in reaching the conclusion that there is a constitutional right to PAS, at least for competent adults who are terminally ill, both the U.S. Court of Appeals for the Ninth Circuit, sitting en banc, and a three-judge panel of the Second Circuit belittled the distinction between assisted suicide and the termination of life support or, as it is often

ultimately resolved, it will reflect society's views about life and death, as did resolution of the debate over disconnecting the respirator and pulling the feeding tube.

Many want to believe—and loose talk about the “right to die” encourages them to do so—that the termination of life support for dying or seriously ill patients, a considerable number of whom are no longer competent, is merely an exercise of individual autonomy. But “[m]edical technology has forced the law to resolve questions concerning termination of medical treatment . . . by making largely social decisions involving our attitudes toward life, and the ways in which society allocates resources best to preserve it and its quality.”<sup>5</sup> That many of us prefer to believe that we have simply been deferring to personal autonomy is hardly surprising. On the one hand, confronting questions about the quality of life “worth” preserving is discomfiting, even frightening; on the other hand, individual autonomy is highly prized in our society.<sup>6</sup> But “this model of mere deference to individual wishes does not ring true in many ‘right to die’ cases.”<sup>7</sup>

Although I sometimes disagree strongly with Professor Charles Baron, a leading proponent of physician-assisted suicide,<sup>8</sup> I share his view that in many, probably most, persistent vegetative state cases “[w]hat actually drives death decisions . . . is an objective test based on the convergence of ‘best interests’ and economic criteria. [But] the extreme discomfort of making death decisions for other people and our fear of the slippery slope . . . lead us to pretend that we are merely complying (however reluctantly) with the wishes of the patient. The result in most states is mere lip service to substituted judgment.”<sup>9</sup>

More generally, as Professor Donald Beschle has pointed out:

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called, “letting die.” See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

<sup>5</sup>Donald L. Beschle, *Autonomous Decisionmaking and Social Choice: Examining the “Right to Die,”* 77 KY. L.J. 319, 365-66 (1988-89). As Beschle points out, *id.* at 364, “the decision to delegate the power [to terminate a patient’s life support] to either relatives or other surrogates itself involves a social choice.”

<sup>6</sup>*Id.* at 349-50.

<sup>7</sup>*Id.* at 350.

<sup>8</sup>See Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996).

<sup>9</sup>Charles Baron, *On Taking Substituted Judgment Seriously*, HASTINGS CENTER REP., Sept.-Oct. 1990, at 7, 8. I also agree with Professor Baron that what upset many critics of *Cruzan v. Director, Missouri Dep’t. of Health*, 497 U.S. 261 (1990) (upholding a state’s power to keep a PVS patient on a feeding tube, over her family’s objection, because there was no “clear and convincing” evidence of the patient’s wishes to end her life in such a setting), was that, unlike many other jurisdictions, “Missouri has taken the substituted judgment test seriously.” *Id.*

One way or the other, . . . society will label certain types of decisions about death as 'right' and others as 'wrong,' some as courageous and noble, others as at least disappointing, possibly cowardly, or even disgraceful. These social labels cannot fail to influence subsequent individual choices. In addition, such attitudes can cause decision makers to interpret the statements and actions of the individual patient in ways that are at least problematic.<sup>10</sup>

The "right to die" is a catchy rallying cry, but here as elsewhere we should "turn up [our] collars against windy sloganeering, no matter from which direction it is blown."<sup>11</sup> The right to die focuses on what is only one aspect of a multi-dimensional problem. I think Seth Kreimer put it well when he summarized the "fearsome dilemma" presented by the assisted suicide issue as follows:

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.<sup>12</sup>

It is noteworthy, I believe, that although some members of the New York Task Force on Life and the Law regarded assisted suicide, and even active voluntary euthanasia, as "ethically acceptable" in exceptional cases,<sup>13</sup> all twenty-four members of the task force concluded that heartbreaking individual cases could not justify significant changes in current law and moral rules.<sup>14</sup> The realities of existing medical practice, observed the task force, "render legislation to legalize assisted suicide and euthanasia vulnerable to error and abuse for all members of society, not only for those who are disadvantaged."<sup>15</sup> "Constructing an ideal or 'good' case is not

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<sup>10</sup>Beschle, *supra* note 5, at 355.

<sup>11</sup>*Cf.* PAUL A. FREUND, *The Court and Its Critics, in THE SUPREME COURT OF THE UNITED STATES: ITS BUSINESS, PURPOSES, AND PERFORMANCE* 171, 189 (1961).

<sup>12</sup>Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevoorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 807 (1995).

<sup>13</sup>THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 120 (1994) [hereinafter TASK FORCE REPORT]. *See also id.* at 102.

<sup>14</sup>*Id.* at 102, 120. The task force included eight medical doctors (two of whom were deans of medical schools), two bioethicists who were not medical doctors, four lawyers, six clergymen (one of whom was also a law professor), the state commissioner of health, the state commissioner on the quality of care for the mentally disabled, and a representative of the New York Civil Liberties Union.

<sup>15</sup>*Id.* at 120.

sufficient for public policy,” added the task force, “if it bears little relation to prevalent medical practice.”<sup>16</sup>

John Arras, a philosopher and bioethicist who served on the task force that issued the aforementioned report on death and dying, recently disclosed that during his work on that project he was one of several members who recognized that in certain rare instances PAS or AVE “might constitute both a positive good and an important exercise of personal autonomy for the individual”—but who nevertheless balked at legalizing these practices “due to fears bearing on the social consequences of liberalization.”<sup>17</sup> Professor Arras emphasized that whether we maintain the total prohibition against PAS and AVE *or whether we lift the ban* for certain groups, “there are bound to be victims.”<sup>18</sup> He continued:

The victims of the current policy are easy to identify; they are on the news, the talk shows, the documentaries, and often on Dr. Kevorkian’s roster of so-called ‘patients.’ The victims of legalization, by contrast, will be largely hidden from view: they will include the clinically depressed 80-year-old man who could have lived for another year of good quality if only he had been treated; the 50-year-old woman who asks for death because doctors in her financially stretched HMO cannot/will not effectively treat her unrelenting but mysterious pelvic pain; and perhaps eventually, if we slide far enough down the slope, the uncommunicative stroke victim whose distant children deem an earlier death a better death. Unlike Dr. Kevorkian’s ‘patients,’ these victims will not get their pictures in the paper, but they all will have faces and they will all be cheated of good months or perhaps even years.<sup>19</sup>

Although Professor Arras and other members of the task force were deeply moved by the sufferings of some patients, they were ultimately convinced that these patients could not be given publicly sanctioned assistance in committing suicide without endangering a much larger number of vulnerable patients. Thus Arras and others who shared his views joined a report that focused not on the alleged immorality of assisted suicide and voluntary euthanasia, but on consequentialist arguments against these practices, such as the well-founded fear—considering “the pervasive failure of our health care system to treat pain and diagnose and treat depression”—that legalizing PAS and physician-administered voluntary euthanasia “would be profoundly dangerous for many individuals who are

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<sup>16</sup>*Id.*

<sup>17</sup>John Arras, *News from the Circuit Courts: How Not to Think About Physician-Assisted Suicide*, 2 *BIOETHICS* S:171, S:175 (July-Aug. 1996).

<sup>18</sup>*Id.* at S:184.

<sup>19</sup>*Id.* at S:184-85.

ill and vulnerable" (especially "those who are elderly, poor, socially disadvantaged, or without access to good medical care").<sup>20</sup>

### **The Notion That the Only Substantial Objections to Legalizing Assisted Suicide or Active Voluntary Euthanasia Are Based on 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 either hammered away at the Roman Catholic Church explicitly or, somewhat vaguely, attacked those who "think they have the divine right to control other people's lives."<sup>21</sup>

There is nothing new about these tactics. Forty years ago, the British legal scholar Glanville Williams, probably the leading Anglo-American proponent of AVE at the time, maintained that "euthanasia can be condemned only according to a religious opinion."<sup>22</sup> And the eminent philosopher Bertrand Russell, a great admirer of Williams's writings on the subject, called euthanasia "one of the subjects of sharpest conflict between theology and humane feeling."<sup>23</sup>

I agree that if assisted suicide or euthanasia can be condemned only on religious grounds their prohibition should not be imposed on those who do not share these beliefs, but I strongly disagree that the prohibition can only be defended on religious grounds. Indeed, this is the principal reason I first wrote about the subject way back in 1958. (In resisting Professor Williams's

<sup>20</sup>See TASK FORCE REPORT, *supra* note 13, at ix (executive summary). Moreover, warned the task force, *id.* at 125, "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." See generally *id.* at 119-34, 153-81.

<sup>21</sup>Mark O'Keefe, *Oregonians Agree to Go Own Way on Suicide*, DETROIT FREE PRESS, Nov. 24, 1994, at 21A.

<sup>22</sup>GLANVILLE WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* 312 (1957). Professor Williams reminded his readers that "the former religious objections to anaesthetics in surgery and childbirth have been given up, even by Catholics who were the last to express them. Yet Catholics, and a considerable number of members of other religious communions, still object to euthanasia." *Id.* at 313.

<sup>23</sup>Bertrand Russell, Book Review, 10 *STAN. L. REV.* 382, 384 (1958). Russell maintained that Williams had "abundantly proved" that "the intervention of Christian Divines in legislation, at any rate during the last hundred years, has been almost entirely in favour of promoting suffering and against methods of alleviation which were not known in biblical times." *Id.* at 385.

arguments, I took pains to call my article *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*,<sup>24</sup> and, so far as I know, I have never made a religious objection to either PAS or AVE.)

I think many people share Professor Williams's view and that proponents of PAS and AVE have done their best to exploit this feeling.<sup>25</sup> But I believe the New York Task Force Report amply demonstrates that any jurisdiction prohibiting assisted suicide and euthanasia can advance substantial justifications for the ban that go well beyond the law's conformity to religious doctrine or "morality." Nonreligious concerns were what led task force members to reach the unanimous conclusion that the total ban against assisted suicide and voluntary euthanasia should be kept intact.

### **Physicians Are Doing It Anyway, So We Might as Well Legalize It—And Regulate It**

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?"<sup>26</sup> 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?<sup>27</sup>

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<sup>24</sup>42 MINN. L. REV. 969 (1958).

<sup>25</sup>When the New York Task Force issued its report on the law and ethics of death and dying, an officer of the Hemlock Society immediately disparaged the report by noting that the task force included representatives of religions that prohibit suicide. See Elisabeth Rosenthal, *Panel Tells Albany to Resist Legalizing Assisted Suicide*, N.Y. TIMES, May 26, 1994, at A1 (reporting the response to the report by Sidney Rosoff, president of the Hemlock Society). But only six task force members were clerics; they were greatly outnumbered by physicians, lawyers, bioethicists, and state health officials. The Hemlock Society did not attempt to explain why all twenty-four task force members arrived at the same conclusion.

<sup>26</sup>Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1, 5 (1996).

<sup>27</sup>*Id.*



What Dr. Herbert Hendin warned a congressional subcommittee earlier this year in his testimony 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.<sup>28</sup> Adds Dr. 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.<sup>29</sup>

### **There Is No Significant Difference, the Argument Runs, Between the Termination of Life Support and Active Intervention to Promote or to Bring About Death; In Both Instances the Result Is the Same**

This March, in the course of ruling that mentally competent, terminally ill patients, at least, have a constitutionally protected right to assisted suicide,<sup>30</sup> 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.”<sup>31</sup> 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.”<sup>32</sup> Thus, the Ninth Circuit found “the state’s interests in preventing suicide do not make its interests substantially stronger here than in cases involving other forms of death-hastening medical intervention.”<sup>33</sup>

The Ninth Circuit found the right to assisted suicide grounded in the due process clause. A month later, a three-judge panel of the U.S. Court of

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<sup>28</sup>Prepared statement of Dr. Hendin, *supra* note 1, at 13.

<sup>29</sup>*Id.*

<sup>30</sup>*Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

<sup>31</sup>*Id.* at 824.

<sup>32</sup>*Id.*

<sup>33</sup>*Id.*

Appeals for the Second Circuit (covering New York, Connecticut, and Vermont) struck down New York's law against assisted suicide on equal protection grounds.<sup>34</sup>

Although it ultimately arrived at the same result the Ninth Circuit had via a different route, the Second Circuit did so only after "repudiat[ing] the reasoning of Judge Reinhardt's opinion [for the Ninth Circuit], which [it] found open-ended and unconvincing."<sup>35</sup> Nevertheless, the Second Circuit was no more impressed with the alleged distinction between "letting die" and actively intervening to promote or 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] by self-administering prescribed drugs."<sup>36</sup>

The Ninth Circuit's due process analysis would seem to apply to active voluntary euthanasia as well as PAS.<sup>37</sup> So would the Second Circuit's equal

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<sup>34</sup>Quill v. Vacco, 80 F.3d 716 (1996).

<sup>35</sup>Jeffrey Rosen, *What Right to Die?* THE NEW REPUBLIC, June 24, 1996, at 28, 30. In rejecting plaintiffs' due process argument (which had proved successful in the Ninth Circuit), the Second Circuit held that a right to assisted suicide could neither be "considered so implicit in our understanding of ordered liberty" that justice and liberty would disappear if it were sacrificed nor said to be "deeply rooted in the nation's traditions and history. Indeed, the very opposite is true." Quill, 80 F.3d at 724.

<sup>36</sup>Quill, 80 F.3d at 729.

<sup>37</sup>In describing the liberty interest implicated in cases such as *Compassion in Dying v. Washington*, the Ninth Circuit eschewed the terms "assisted suicide" and "aid in killing oneself" in favor of such broader terms as "the right to die," "controlling the time and manner of one's death," and "hastening one's death." *Id.* at 801-02. Of course, the more broadly a court defines the right or liberty at issue, the more likely is it to be found implicit in the concept of liberty or rooted in the nation's history and tradition. And the more likely is it to topple the law being challenged. Indeed, if a court chooses to define the right or liberty broadly enough, such as "the right to be let alone" or "the right not to conform," a great many laws can be placed in jeopardy, e.g., laws against adultery, prostitution, and incest between adult relatives. See Frank H. Easterbrook, *Abstraction and Authority*, 59 U. CHI. L. REV. 349, 351-52 (1992).

The liberty to determine the time and manner of one's death or the liberty to hasten one's death, the terms the Ninth Circuit deem appropriate, cover assisted suicide as well as the termination of life support, but they also embrace voluntary euthanasia. Moreover, if one does not believe, as the Ninth Circuit does not, that "the state's interest in preventing that additional step [PAS] is significantly greater than its interest in preventing the other forms of life-ending medical conduct that doctors now engage in regularly," 79 F.3d at 824, why would one believe that the state's interest in preventing the next "additional step" (AVE) is

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, and thus need a physician to administer a lethal injection, similarly situated to terminally ill people who *are* able to perform the last, death-causing act themselves?

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 or liberty 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”?<sup>38</sup>

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 lifesaving treatment; (b) the right to commit suicide, at least “rational suicide”; (c) the right to assisted suicide, i.e., the right to obtain another's help in committing suicide; and (d) the right to active voluntary euthanasia, i.e., the right to authorize another to kill you intentionally and directly.<sup>39</sup>

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<sup>40</sup> and the Supreme Court had assumed existed in the *Nancy*

significantly greater than its interest in preventing assisted suicide? Or its interest in preventing other forms of life-ending medical conduct doctors engage in regularly?

At one point, the Ninth Circuit recognizes that “it may be difficult to make a principled distinction” between physician-assisted suicide and physician-administered voluntary euthanasia. *Id.* at 831. Although the court makes the usual point that that question “must be answered directly in future cases, and not in this one,” *id.*, I think it leaves little doubt as to how it would resolve that question in a future case: “We would be less than candid . . . if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. . . . We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end.” *Id.* at 831-32. Of course, in AVE, no less than in PAS, the terminally ill person determines whether his or her life shall end.

<sup>38</sup>*Quill*, 80 F.3d at 727.

<sup>39</sup>See generally Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in *EUTHANASIA EXAMINED* 225-36 (John Keown ed., 1995).

<sup>40</sup>*In re Quinlan*, 355 A.2d 647 (1976).

*Beth Cruzan* case<sup>41</sup>—was the right to reject life-sustaining medical treatment or, as many have called it, the right to die a natural death.<sup>42</sup> 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.<sup>43</sup>

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.<sup>44</sup> 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.”

“As [various] courts have recognized, the fact that the refusal of treatment and suicide may both lead to death does not mean that they implicate identical constitutional concerns.”<sup>45</sup> The right to terminate life support grows out of the doctrine of informed consent, a doctrine “firmly entrenched in American tort law.”<sup>46</sup> “The logical corollary” of that doctrine, of course, is “the right not to consent, that is to refuse treatment.”<sup>47</sup> The other tradition, which has “long existed alongside” the first one, is the anti-suicide tradition.<sup>48</sup> 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

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<sup>41</sup>*Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261 (1990) (discussed in note 9 *supra*).

<sup>42</sup>For the view that the right to forgo or to terminate medical procedures should be “labeled a right to refuse medical treatment, rather than a ‘right to die’” because the former term “is far more neutral, and does not connote death as a positive thing,” see Beschle, *supra* note 5, at 359-60.

<sup>43</sup>See *Quinlan*, 355 A.2d at 665, 670 & n.9.

<sup>44</sup>Compassion in Dying v. Washington, 79 F.3d 790, 824 (9th Cir. 1996).

<sup>45</sup>TASK FORCE REPORT, *supra* note 13, at 71.

<sup>46</sup>*Cruzan v. Director, Missouri Dep’t of Health*, 497 U.S. 261, 269 (1990) (opinion of the Court).

<sup>47</sup>*Id.* at 270.

<sup>48</sup>See *The Supreme Court: 1989 Term*, 104 HARV. L. REV. 259, 262 (1990).

and hydration was more consistent with the rationale of the cases upholding the right to reject medical treatment. Of course, we cannot know for sure what the other eight members of the Court thought, but only Justice Scalia, who wrote a lone concurring opinion, expressed the view that the case implicated the anti-suicide tradition.

In *Quill v. Vacco* the Second Circuit judges looked with favor at Justice Scalia's concurring opinion in *Cruzan*. Judge Miner, who wrote the majority opinion in *Quill*, pointed out that "Justice Scalia, for one, has remarked upon 'the irrelevance of the action-inaction distinction,' noting that 'the cause of death in both cases is the suicide's conscious decision to "pu[t] an end to his own existence."'"<sup>49</sup> Judge Calabresi, who wrote a concurring opinion in *Quill*, referred to "the powerful arguments" Justice Scalia had made against the alleged distinction between "'active' assisted suicide" and the "passive" removal of life supports or feeding tubes.<sup>50</sup>

There is no evidence, however, that any of his eight colleagues on the U.S. Supreme Court thought any of the arguments Justice Scalia made in his separate *Cruzan* opinion were powerful. It is fair to say that Justice Scalia's opinion was ignored by the other Justices. They all framed the issue in terms of a right or liberty to be free of "unwanted medical treatment"<sup>51</sup> or, more specifically, a right or liberty to "refuse lifesaving hydration and nutrition"<sup>52</sup> or to be free of "unwanted artificial nutrition and hydration."<sup>53</sup> None of the other Justices had anything to say about a right or liberty to commit suicide or to enlist the assistance of another in dying by suicide.

Justice Scalia's concurring opinion and the Second and Ninth Circuit majority opinions to the contrary notwithstanding, I believe there are a number of significant differences between the withholding or withdrawal of life-sustaining medical treatment and the active intervention of another to promote or to bring about death. For one thing, as Seth Kreimer has noted, PAS or AVE poses greater dangers to the lives and welfare of persons other than the one before the court than does the rejection of medical treatment:

[A] right to refuse treatment puts at risk only the lives of those who would die without treatment. While this is a considerable number of people, the approval of active euthanasia or assisted suicide would extend the risk to the entire population. Particularly with the

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<sup>49</sup>*Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996).

<sup>50</sup>*Id.* at 741.

<sup>51</sup>497 U.S. at 287 (O'Connor, J., concurring). See also *id.* at 289: "[T]he liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."

<sup>52</sup>*Id.* at 279 (opinion of the Court).

<sup>53</sup>*Id.* at 302 (Brennan, J., joined by Marshall and Blackmun, JJ., dissenting).

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.<sup>54</sup>

For another thing, as Daniel Callahan has indicated,<sup>55</sup> the refusal of life-sustaining treatment is an indispensable part of modern medicine. Approximately seventy percent of all hospital and nursing home deaths follow the refusal of some form of medical intervention.<sup>56</sup> If society prohibited the rejection of life-sustaining treatment, vast numbers of patients would be “at the mercy of every technological advance.”<sup>57</sup> Moreover, if people could refuse potentially lifesaving treatment at the outset, but not discontinue it once initiated, many might not seek such treatment in the first place.<sup>58</sup>

In short, letting a patient die at some point is a practical condition upon the successful operation of medicine. The same can hardly 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).<sup>59</sup>

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<sup>54</sup>Kreimer, *supra* note 12, at 840-41. See also Arras, *supra* note 17, at S:183:

While we should definitely worry about the possibility of error, neglect and abuse in the context of allowing patients to die, it is at least somewhat comforting to realize that just about everyone in this category must be very bad off indeed. By the time physicians get around to discussing forgoing treatment with a patient or family, that patient will usually be well along in the process of dying. But with PAS and euthanasia we can expect that many candidates will be perfectly ambulatory and far from the dreaded scene of painful terminal illness depicted by advocates. Depending on how great the social slippage, this category may well come to encompass ‘merely’ those with an incurable condition but who are not presently ‘terminal,’ such as persons in the early stages of HIV infection or Alzheimer’s disease. It may also come to encompass patients suffering from prolonged and intractable depression who exhibit no other symptoms of physical illness.

<sup>55</sup>DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* 77-78 (1993).

<sup>56</sup>See TASK FORCE REPORT, *supra* note 13, at 74-75.

<sup>57</sup>*Id.* at 75.

<sup>58</sup>As one commentator recently expressed 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. . . .” Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473, 481 (1995).

<sup>59</sup>See *Hearings*, *supra* note 1 (prepared statement of Dr. Herbert Hendin at 9-11).

I share George Annas's view that to say, as the Second Circuit does, that "[t]he ending of life by [the withdrawal of artificially delivered fluids and nutrition] is nothing more nor less than assisted suicide"<sup>60</sup> is to make a "remarkable" statement.<sup>61</sup> Continues Professor Annas:

If one accepts that Nancy Cruzan 'died of starvation' and not of her condition that made continued artificial feeding necessary for survival, one would also have to accept the conclusion that when physicians stop cardiopulmonary resuscitation (CPR) on a patient in cardiac arrest, the patient dies not from the arrest, but rather the physician kills the patient by intentionally stopping the heart beat. Since failure to perform CPR always 'hastens death,' under [both the Second Circuit's and the Ninth Circuit's] analysis, patients who refuse CPR would always be committing suicide (and doctors who write DNR orders would always be assisting this suicide). The failure to distinguish real causes of death from the existence of various medical tools and techniques that may temporarily substitute for particular bodily functions is a fatal one to the logic of both these opinions. Since the vast majority of deaths in hospitals occur after some medical intervention is refused or deemed useless, under the court's logic there is an epidemic of suicide and homicide in the nation's hospitals—a patently absurd conclusion.<sup>62</sup>

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 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."<sup>63</sup>

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<sup>60</sup>Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996).

<sup>61</sup>George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQUESNE L. REV. 875, 895 (1996).

<sup>62</sup>*Id.* at 896.

<sup>63</sup>Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 795 (1989). At one point in his concurring opinion in *Quill*, Judge Calabresi refers to Professor Rubenfeld as one of the distinguished scholars who fails to see any valid constitutional difference between "the so-called 'passive' assistance" in dying that New York and other states allow and "the 'active' assistance" that New York and most states forbid by means of anti-assisted suicide laws. *Quill v. Vacco*, 80 F.3d at 738. I think Judge Calabresi is mistaken and that he was misled by Professor Rubenfeld's comment that "[i]f the decision to live or die is said to be so fundamental to a person that the state may not make it for him, then it is difficult to see on what plausible ground the right to make this decision could be granted to those on life support but denied to all other individuals." 102 HARV. L. REV. at 794-95, quoted by Judge Calabresi at 80 F.3d 738 n.11.

To allow a patient to reject 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 resist invasive medical procedures and the right to PAS is a comprehensible one and a line maintained by almost all major Anglo-American medical associations.<sup>64</sup>

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 are not but will have to endure what *they* consider an intolerable life for a *much longer* period. Nor the fine distinction between assisted suicide and active voluntary euthanasia.

Unless we are prepared to carry the principle of “self-determination” or “personal autonomy” or “control of one’s destiny” to its ultimate logic—unless we are prepared to say that every competent adult with a firm desire to end her life the way *she* sees fit for any reason *she* considers appropriate should have the right or liberty to do so—we have to draw a line *somewhere* along the way. So why not adhere to the line we had (or the line many of us

Professor Rubinfeld did say that, but when read in context it is fairly clear that what he was really saying was that *applying the “personhood” version of privacy*—as opposed to the “anti-totalitarian” right to privacy that Rubinfeld prefers—it is difficult “to distinguish persons seeking to disconnect life-support machinery from ‘ordinary’ suicides.” 102 HARV. L. REV. at 794. But Professor Rubinfeld *went on to say*:

The principles developed here [Rubinfeld’s anti-totalitarian theory of privacy], however, suggest an answer to this painful riddle. The cases of ‘ordinary’ suicides and of right-to-die patients look identical only from the formulaic perspective of an analysis that concentrates on the conduct proscribed—that is, the decision to end one’s life, which is the same in both instances. With regard to what is produced, the two cases are utterly dissimilar. For right-to-die patients, being forced to live is in fact to be forced 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.

In contrast, the ‘ordinary’ suicide suffers no such total occupation of his life or affirmative use of his body. An avenue of escape is foreclosed to him, and indeed he may suffer desperate unhappiness from being forced to live. The prohibition of suicide, however, does not, as a rule, direct lives into a particular, narrowly confined course. It does not produce specific, affirmative consequences—for example, remaining in a hospital bed connected to life-sustaining machinery—that largely direct the remainder of a person’s life.

*Id.* at 795-96.

<sup>64</sup>See Kreimer, *supra* note 12, at 834-35; Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 SEATTLE U. L. REV. 509, 517 (1995).



thought we had) until the Second Circuit and Ninth Circuit handed down their rulings earlier this year?

As I have observed elsewhere,<sup>65</sup> 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.

It cannot be denied that the two sets of values are in conflict, or at least in great tension. Nevertheless, until very recently at any rate, we have tried to honor *both* sets of values by permitting a patient to terminate life support but prohibiting active intervention to bring about a patient’s death. We should continue to try to do so.

### **If a Right to Physician-Assisted Suicide Were Established, We Are Assured, It Would Apply Only to the “Terminally Ill”**

Most proponents of the right to PAS speak only of—and for now at least want us to think only about—such a right for *terminally ill persons*. (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 terminally ill persons, 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.”<sup>66</sup>

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.

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<sup>65</sup>See Yale Kamisar, *Against Assisted Suicide—Even A Very Limited Form*, 72 U. DET. MERCY L. REV. 735, 757-58 (1995).

<sup>66</sup>FELIX FRANKFURTER, *Mr. Justice Jackson*, in FELIX FRANKFURTER AND THE SUPREME COURT 509, 511 (Philip B. Kurland ed., 1970).

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, such as ALS or multiple sclerosis.<sup>67</sup> 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 nonterminal 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 terminally ill persons 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 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?<sup>68</sup>

There is another reason I very much doubt that a right to assisted suicide could or would be limited for very long to persons who are terminally ill—the force of the reasoning contained in the analyses of the two federal appellate courts that handed down the right to die decisions I discussed earlier. Both the Second and Ninth Circuits seemed to agree with those proponents of assisted suicide who maintain 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.<sup>69</sup> The problem is that the right to reject life-sustaining treatment has not been limited to terminally ill people.

One need only recall the *Elizabeth Bouvia* case,<sup>70</sup> which arose a decade ago. At the time of the litigation, Ms. Bouvia, a young woman afflicted with

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<sup>67</sup>See, e.g., TIMOTHY E. QUILL, *DEATH AND DIGNITY* 162 (1993).

<sup>68</sup>"How," asks Daniel Callahan, "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?" Callahan, *supra* note 55, at 107-08.

<sup>69</sup>See, e.g., Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725, 729 (1995).

<sup>70</sup>*Bouvia v. Superior Court* (Glenchur), 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

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."<sup>71</sup> 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 nonterminally ill persons to reject life-sustaining treatment<sup>72</sup> were decided by the U.S. Supreme Court. But *Bouvia* and these other cases have been well received by bioethicists and medicolegal commentators. As Professor Alan Meisel points 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."<sup>73</sup> 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 people who are terminally ill?

If the Second Circuit is right about terminally ill patients being "similarly situated" *whether or not* they are on life support,<sup>74</sup> does it not follow that patients suffering from the same *nonterminal* illnesses are also "similarly situated," regardless of whether they are on life support? If the Second Circuit's equal protection analysis is sound, how can we prevent persons suffering serious but not terminal illnesses from enlisting the aid of another to die by suicide when patients with the same nonterminal illnesses *who are on life support systems* may hasten their deaths by directing the removal of such systems? Are not the "similarly circumstanced" group of nonterminally ill patients *off* life support systems being denied equal protection?

### A Final Remark

Four decades ago, Glanville Williams admitted that he "prepared for ridicule" whenever he described assisted suicide or voluntary euthanasia as "medical operations."<sup>75</sup> "Regarded as surgery," he acknowledged, these practices are "unique, since [their] object is not to save or prolong life but

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<sup>71</sup>*Id.* 225 Cal. Rptr. at 305.

<sup>72</sup>See, e.g., *Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990)(upholding the right of a thirty-six-year-old patient to refuse lifesaving blood transfusions following a cesarean section delivery); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) and *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989)(involving respirator-dependent persons with quadriplegia who apparently had long life expectancies); *Thor v. Superior Court (Andrews)*, 855 P.2d 375 (Cal. 1993) (sustaining the right of a state prison inmate, rendered quadriplegic as a result of a fall while in prison, to reject medication and artificial feeding).

<sup>73</sup>ALAN MEISEL, *THE RIGHT TO DIE* 470 (2d ed. 1995).

<sup>74</sup>*Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996).

<sup>75</sup>Glanville Williams, "Mercy-Killing" Legislation—A Rejoinder, 43 MINN. L. REV. 1, 7 (1958).

the reverse.”<sup>76</sup> Today, few people chuckle when PAS is classified as a medical procedure, or even when it is called a health care right,<sup>77</sup> or even when we are told, at a time when tens of millions of Americans lack adequate health care and Congress has refused to do anything about it, that PAS is *the one* health care right that deserves constitutional status.<sup>78</sup>

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<sup>76</sup>*Id.*

<sup>77</sup>This may be still another reason why so many people say they support PAS.

<sup>78</sup>*Cf.* Robert A. Burt, *Death Made Too Easy*, N.Y. TIMES, Nov. 16, 1994, at A19.