1991

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WHEN IS THERE A CONSTITUTIONAL "RIGHT TO DIE"? WHEN IS THERE NO CONSTITUTIONAL "RIGHT TO LIVE"?

Yale Kamisar

When I am invited to participate in conferences on the "right to die," I suspect that the organizers of such gatherings expect me to fill what might be called the "'slippery slope' slot" on the program or, more generally, to articulate the "conservative" position on this controversial matter.

These expectations are hardly surprising. The "right to die" is a euphemism for what almost everybody used to call a form of euthanasia—"passive" or "negative" or "indirect" euthanasia—and some thirty years ago, in the course of raising various objections to proposed euthanasia legislation, I advanced the "thin edge of the wedge" or the "slippery slope" argument with some zest. This roused the ire of the renowned British legal commentator, Glanville Williams, perhaps the leading proponent of euthanasia to be found in academia at the time. Williams disparaged the argument as the "trump card of the traditionalist," one, he asserted, that was used in nineteenth-century England "to resist almost every social and economic change."

* With some modification and amplification, these are the remarks I delivered at a conference on Cruzan and the "right to die" held at the University of Georgia Law School on October 8, 1990. The first Section consists of some general comments on the "right to die" and related matters; the second Section is a response to Professor John A. Robertson's Sibley Lecture, the centerpiece of the Georgia conference. See infra note 27 (citing Robertson's Sibley Lecture Paper, Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients, 25 GA. L. Rev. 1139 (1991)). Although footnoted and revised for publication, the structure and contents of this Paper continue to reflect the occasion and the forum for which it was written.


1 See Kamisar, Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation, 42 MINN. L. REV. 969, 1030-41 (1958). This article has been cited for the proposition that "slippery slope arguments have been employed to argue against [inter alia] all forms of euthanasia." Schauer, Slippery Slopes, 99 HARV. L. Rev. 361, 383 n.16 (1985).

I. "LIBERALS," "CONSERVATIVES" AND SLIPPERY SLOPE ARGUMENTS

In light of the fact that proponents of various forms of euthanasia view themselves as the "liberals" in this debate, I find their disdain for the "slippery slope" argument a bit odd. For in other settings, "liberals" have been most adept at making this very argument. One might even say that, depending upon the circumstances, the argument has been the "trump card" of the "liberal" as much as it has been that of the "traditionalist." At the very least, it is a "card" that liberals have often played.

In a recent article on "slippery slope arguments," Professor Frederick Schauer pointed out that "these arguments appear commonly in discussions about freedom of speech." He continued:

The warning is frequently heard that permitting one restriction on communication, a restriction not by itself troubling and perhaps even desirable, will increase the likelihood that other, increasingly invidious restrictions will follow. The Skokie controversy provides one of the most notorious modern examples of this type of argument in freedom of speech debates. The argument there was not that freedom of speech in theory ought to protect the Nazis, but rather that denying free speech protection to Nazis was likely to start us down a slippery slope, at the bottom of which would be the denial of protection even to those who should, in theory, be protected.4

These arguments are perhaps even more prominent in criminal procedure cases. In this area we are admonished that "[t]he progress is too easy from police action unscrutinized by judicial au-

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3 Schauer, supra note 1, at 363.
4 Id. (footnotes omitted; emphasis in original). See also J. FEINBERG, OFFENSE TO OTHERS 92-93 (1985) (concluding that "the true motivation behind much of the A.C.L.U. opposition to legal action against Nazis" is the concern 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 'falling dominoes argument,' or the 'foot in the door argument,' or the empirical (or political) form of the 'slippery slope argument.' ")
thorization to the police state” and that “what seems fair enough against a squalid huckster of bad liquor may take on a very different face, if used by a government determined to suppress political opposition under the guise of sedition.” Indeed, perhaps the most grandiloquent statement of the “slippery slope” argument ever made, and surely the most famous one, appears in Boyd v. United States, the landmark search-and-seizure case that paved the way for the fourth amendment exclusionary rule. On that occasion, when told by the prosecution that compelling defendants to turn an invoice over to the government was a trivial matter unworthy of the Court’s attention because it lacked “many of the aggravating incidents of actual search and seizure,” Justice Bradley responded for the majority:

It may be that it is the obnoxious thing in its mildest and least repulsive form; but illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure . . . . [The Courts’] motto should be obsta principiis."

Obsta principiis? For those of us whose Latin is rusty, Wayne LaFave, our leading authority on search and seizure, has provided a rough translation: “Resist the opening wedge! Hold that line!”

II. HAVE WE SEEN THE SLIPPERY SLOPE? A LOOK BACK AT GLANVILLE WILLIAMS’ “MODEST PROPOSALS” AND A LOOK AHEAD

All this is a long-winded way of saying that I shall not disappoint the organizers of this conference. As many good liberals have

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7 116 U.S. 616 (1886).
8 Id. at 635.
9 Id. This passage, or at least significant portions of it, has appeared in more than thirty subsequent cases, but, unfortunately, more often in the dissents of such “liberals” as Justices Brennan and Marshall, than in majority or plurality opinions. See LaFave, The Forgotten Motto of Obsta Principiis in Fourth Amendment Jurisprudence, 28 Am. L. Rev. 291, 294-95 & n.21 (1986).
10 LaFave, supra note 9, at 294. “It is high time,” concludes Professor LaFave, that, in the search and seizure field at least, the present Court “reaffirm the stirring words of Justice Bradley . . . and recall just why it is that the motto obsta principiis makes such eminently good sense.” Id. at 310.
done in other settings, I shall make the “slippery slope” argument in the euthanasia context. But I shall not be content with that. I think I can do better. Three eventful decades have passed since Glanville Williams’ highly influential book,\(^1\) one that may be said to have launched the modern era of the euthanasia movement,\(^2\) first evoked my interest in the general subject.\(^3\) In that time, I think I can show, we have moved down the slippery slope a considerable distance; we have seen the slippery slope.

On rereading Williams’ 1957 book recently, I was struck by the fact that with the passage of years most of the restrictions or conditions he prescribed for euthanasia have faded away.

One provision of Williams’ proposed statute would have permitted a physician, in what he considered an appropriate case, “to accelerate by any merciful means” the patient’s death.\(^4\) Another provision would have allowed the physician “to refrain from taking steps to prolong the patient’s life by medical means.”\(^5\) Williams did not, as some do today, shrink from use of the “E” word. He regarded, and called, both courses of action “euthanasia.”

Despite his uninhibited use of a term that was once a “nice” word (easy, painless death), but somewhere along the way became a “dirty” one, Professor Williams’ proposals seem rather modest

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\(^{1}\) G. WILLIAMS, supra note 2.
\(^{2}\) Although organizations sprang up in England and the United States in the 1930s that dramatized the plight of those suffering a painful and degrading illness and advocated the “right” to obtain a “release” from such a condition, “[f]or the next two decades, the issue remained dormant as a matter of law and public policy.” R. SHERLOCK, PRESERVING LIFE: PUBLIC POLICY AND THE LIFE NOT WORTH LIVING 120 (1987). “The appearance of Glanville Williams’ provocative book... and rejoinders to it... broke the silence forcefully.” Id. See also G. GRISZ and J. BOYLE, LIFE AND DEATH WITH LIBERTY AND JUSTICE 157-58 (1979); Beschle, Autonomous Decisionmaking and Social Choice: Examining the “Right to Die,” 77 KY. L.J. 319, 323-24 (1988-89).

\(^{3}\) In large measure, my 1958 article, supra note 2, was an “essay review” of Williams’ chapter on euthanasia.
\(^{4}\) G. WILLIAMS, supra note 2, at 345 (emphasis added).
\(^{5}\) Id. (emphasis added).
\(^{6}\) See, e.g., THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT 40 (1987) (hereinafter NEW YORK STATE TASK FORCE): Some authors distinguish between “active” or “positive” euthanasia and “passive” or “negative” euthanasia... For the sake of clarity, the Task Force prefers to avoid the active-passive terminology and speak simply of “euthanasia” defined as measures to bring about the patient’s death, as distinct from the “withholding or withdrawal of life-sustaining treatment.”
when compared to those being advanced today. After completing his chapter on suicide, Williams began his chapter on euthanasia as follows:

Whatever opinion may be taken on the general subject of suicide, it has long seemed to some people that euthanasia, the merciful extinction of life, is morally permissible and indeed mandatory where it is performed upon [1] a dying patient [2] with his consent and [3] is the only way of relieving his suffering. According to this view, which will be accepted in the present chapter, a man is entitled to demand the release of death from hopeless and helpless pain, and a physician who gives this release is entitled to moral and legal absolution for his act.17

A. Relieving the Patient’s Suffering

Until recently, it could be said that “[m]ercy for the suffering patient has been the primary reason given by those [favoring] . . . a limited form of euthanasia.”18 But that can no longer be said—as evidenced by the two landmark “right to die” cases of our time: In re Quinlan19 and Cruzan v. Director, Missouri Department of Health.20 There was no evidence that either Karen Ann Quinlan or Nancy Beth Cruzan was suffering any pain. (It is plain, of course, that their families did suffer considerable pain.)

I realize that there is not universal agreement on this point. But the amicus brief of the American Academy of Neurology in support of Nancy Cruzan’s “right to die” stated (one is tempted to say, conceded) that “PVS [persistent vegetative state] patients are permanently unconscious and devoid of thought, emotion, and sensation.”21 This reflected the position adopted a year and a half earlier by the Executive Board of the Academy of Neurology.22

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17 G. WILLIAMS, supra note 2, at 311 (bracketed numbers and emphasis added).
18 Bok, Euthanasia and the Care of the Dying, in THE DILEMMA OF EUTHANASIA 2 (1975).
21 Brief of Amicus Curiae, American Academy of Neurology, in support of the petition at 3, Cruzan (No. 88-1503) [hereinafter Brief of American Academy of Neurology].
22 Id. app. A at 2a (“Persistent vegetative state patients do not have the capacity to experience pain or suffering . . . . [P]atients who are permanently and completely unconscious cannot experience these symptoms.”). See also Council on Scientific Affairs and Council on Ethical and Judicial Affairs, American Medical Association, Persistent Vegetative State
B. The Request or Consent of the Patient

Another one of Glanville Williams' limiting factors or conditions was the consent or request of the patient. Shortly before the Quinlan case, "the most important" safeguard, contained in various proposals to legalize euthanasia, was said to be "[t]he requirement that the patient should have requested or consented expressly to the act of euthanasia." About the same time, one of the ablest proponents of voluntary euthanasia rejected "the most serious argument" against such a proposal—"that it would eventually lead to involuntary euthanasia"—on the ground that "[s]o long as careful attention is paid to the capacity of a person to request euthanasia, there is a large gap between voluntary euthanasia and involuntary elimination of social misfits."

Although the Quinlan case was widely reported and discussed as a "right to die" case, Karen Ann Quinlan lacked the capacity to request anything. She did not (and in her condition, of course, could not) consent to her death or ask anyone to let her die. Nor had she made a living will or executed any other directive requesting that she be allowed to die without medical intervention. Indeed—although this feature of the case went largely unreported—both the trial court and the Supreme Court of New Jersey agreed that Karen's previous conversations with friends on this general subject were so "remote and impersonal" as to lack "significant probative weight."

Nancy Cruzan's views, when still a vibrant person, on whether and when life-sustaining treatment should be withdrawn is a matter of some dispute. But as Professor Robertson noted earlier,

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and the Decision to Withdraw or Withhold Life Support, 263 J. A.M.A. 426, 428 (Jan. 19, 1990) ("Pain cannot be experienced by brains that no longer retain the neural apparatus for suffering.").

23 Bok, supra note 18, at 4.

24 Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 Rutgers L. Rev. 228, 261 (1973).


26 At least they were at the time the Supreme Court decided the case. Two months later, Nancy's parents asked the state probate court for a second hearing. At this new hearing, three of Nancy's former co-workers recalled conversations in which she said she never would want to live "like a vegetable" on medical machines. See N.Y. Times, Nov. 2, 1990, §A, at 14, col. 3. Since the State of Missouri withdrew from the case and Nancy's court-appointed guardian sought to disconnect the feeding tube, see N.Y. Times, Dec. 7, 1990, §A, at 24, col. 1, all remaining parties agreed that artificial nutrition and hydration should cease. A week
there was no claim that [when] competent she had issued a written directive against treatment if she became incompetent.”

Nor was there any claim that she had appointed a surrogate to make life-and-death decisions for her in the event she became incompetent. In some conversations with friends, Nancy indicated that “if sick or injured she would not wish to continue her life unless she could live at least halfway normally,” but these conversations “did not deal in terms with withdrawal of medical treatment or of hydration and nutrition.”

Different people will assign different weight to Nancy’s conversations with her friends. But whatever one makes of these conversations, I think it fair to say that they fall well short of the unequivocal consent or explicit request that yesteryear’s proponents of voluntary euthanasia had in mind.

C. A “Dying” or “Terminally Ill” Patient

Recall another limitation on Glanville Williams’ euthanasia proposal—that the patient be “dying” or “terminally ill.” There is a good deal of confusion on this point. Many people would say—indeed, did say—that at the time of the litigation both Nancy and Karen were “dying” or “terminally ill.” I think not—not as these terms have usually been defined.

Of course, if you favor refusing or withdrawing life-sustaining treatment, it is good advocacy to characterize the patient as “dying” or “terminally ill.” Then, when you remove or withhold the life support you may say that you are not terminating a life, but only preventing the “drawing out of the natural death process.”

Not “drawing out” or “prolonging” death has a nice ring to it, but it is a spongy, seductive term. Glanville Williams once observed, somewhat bitterly, I think it fair to say, that the statement

later, the probate judge ruled that there was “clear evidence” that the “intent” of Nancy, “if mentally able, would be to terminate her nutrition and hydration” and that there was “no evidence of substance” to the contrary. He then authorized the cessation of nutrition and hydration. See N.Y. Times, Dec. 15, 1990, §1, at 1, col 2. Twelve days later, and nearly eight years after she had lost consciousness and a feeding tube had first been implanted in her stomach, Nancy Cruzan died.


Cruzan v. Director, Missouri Dep’t of Health, 110 S. Ct. 2841, 2846 (1990).

Id. at 2847.
that a doctor must "prolong life" but need not "prolong death"
"has become a cliche in orthodox medical circles, where it is appar-
ently thought to solve the whole problem of euthanasia." I think
Professor Williams' unhappiness with this "formula," one might
say "escape," is justified. In any event, this "escape" was not avail-
able either in the Quinlan or the Cruzan case.

When, during the oral argument in the Supreme Court of New
Jersey, the Quinlan family's lawyer maintained that the respirator
was serving no purpose "except to thwart the death process" and
that the respirator was causing Karen "to debilitate to the point
where she will ultimately die," one of the state justices pressed
him on this point. The Quinlan family's lawyer then agreed that
Karen's condition had "reached . . . a plateau" and that there had
been "no further debilitation . . . for some time."

Karen Ann Quinlan probably could have been kept alive for
many years if her respirator had not been removed. Indeed, as
many of you know, she stayed alive for nine years after the respi-
ator was disconnected.

The view that all that was at stake was whether to drag out or
cut short the "dying process" is even harder to sustain in the
Cruzan case. As the state supreme court, adopting many of the
trial court's findings, described Nancy's condition: "She is not
dead. She is not terminally ill. Medical experts testified that she
could live another thirty years."

In general, living-will statutes provide that the directive only be-
comes operative after its maker has become "terminally ill." As
many states, including Missouri, define this term, it means a con-
dition that will shortly result in death regardless of the utilization of
available medical treatment.

30 G. Williams, supra note 2, at 337.
31 2 In the Matter of Karen Quinlan: The Complete Briefs, Oral Arguments and
Opinion in the New Jersey Supreme Court 225 (1976).
32 Id. at 226.
33 Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988). See also Brief of American Acad-
emy of Neurology, supra note 21, app. A at 2a:
Patients in a persistent vegetative state may continue to survive for a pro-
longed period of time . . . as long as the artificial provision of nutrition and
fluids is continued. These patients are not "terminally ill."
34 See, e.g., Cantor, The Permanently Unconscious Patient, Non-Feeding and Euthana-
sia, 15 Am. J.L. & Med. 381, 405-06 (1989); Francis, The Evanescence of Living Wills, 14 J.
Because a "terminal illness" or "terminal condition" requirement greatly restricts the impact of living-will legislation, several states have recently adopted provisions defining a "terminal" condition as one that would cause death in the absence of medical intervention. This strikes me as going too far in the other direction. A great many illnesses would be "terminal" without medical treatment. Would anyone say that a pneumonia patient is in a "terminal" condition or that her death is "imminent" because she would die (assuming she would) if antibiotics were not available? I think most would respond: But antibiotics are available.

There are reasons to loosen or to wiggle out of the "dying" or "terminally ill" requirement. But there are also reasons to take the requirement seriously. If death is unpreventable—if the best medical treatment available can only postpone death for a short time—the interest in preserving life seems much weaker. Moreover, if life support is terminated in such a situation, it makes some sense to say that the underlying condition "caused" the death or that discontinuing life support merely permits death to occur or only prevents the "drawing out" of the death process. Whether or not life-sustaining procedures are utilized, the patient is going to die in a short time anyhow. When a patient, though, can be kept alive for many years it is much harder to avoid the conclusion that the removal of life support, rather than the patient's un-

Wisc. L. Rev. 737, 741-42. A number of state courts, however, have rejected the terminal illness restriction, at least for those patients in a persistent vegetative state, and some states have defined the term to mean only that the patient be "incurable" or that her condition be "hopeless." See Gelfand, supra, at 741-47. Moreover, a few state courts have, in effect, held their state's terminal condition requirement unconstitutional. See id.

As noted in Alexander, Death by Directive, 28 Santa Clara L. Rev. 67, 95 (1988), although the California "natural death act," the first living will statute enacted, "was drafted with Karen Quinlan's case in mind, Ms. Quinlan would not have benefited from the Act since her death was not imminent." One reason for this state of affairs may be that the attorney and the spokesperson for the Quinlan family depicted Karen as "terminally ill" or "dying," see supra note 31 and accompanying text, and much of the media described her the same way.

As noted in Beschle, supra note 12, at 335 n.72, "the most commonly used definition of terminal illness" is still the one found in the California statute. That statute defines the term as "an incurable condition . . . which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death . . . ." Cal. Health & Safety Code § 7187(f) (West Supp. 1988).

See Cantor, supra note 34, at 406 & n.81.

See id. at 398-410.
derlying illness, brought about the patient's death. Furthermore, to say that a person who can be kept alive for many years should have her life support disconnected because she is "better off dead" or "might as well be dead"—and at bottom, I think, that is the principal argument for terminating the life-sustaining treatment in cases like Quinlan and Cruzan—is to grapple with "the hopelessly elusive question of a life not worth living."3

Whether, even if we try to combat an illness with every method known to doctors, death is unpreventable and imminent are medical judgments. Whether a person is "better off dead" is not a medical judgment; rather, it is a moral-legal-societal question, and a fundamental one at that.

Although Professor Robertson does not consider the significance of the "terminal illness 'limitation'" in his current paper, a decade and a half ago he did. On that occasion he distinguished the case of terminating lifesaving treatment for the defective infant, who, if treated, can usually live for a substantial period of time, from "the cases of terminal illness."39 I fail to see why the comments Robertson made then about the defective newborn do not apply as well to the elderly patient who is severely debilitated but not terminally ill:

The terminally ill patient will soon die with or without the [lifesaving] procedure. Thus, treatment merely prolongs dying. The defective infant, on the other hand, if treated, can normally live for significant periods. Unless the quality of his life affects its values, a judgment for which there is no legal precedent, the likelihood that treatment means life should justify the procedure.40

38 R. SHERLOCK, supra note 12, at 137. Continues Professor Sherlock: "Moving beyond [the terminally ill patient, as that term has usually been defined] to include the chronically ill, the debilitated, and the comatose will inevitably entail insoluble problems setting forth a proper rule or the abdication of any prohibition of suicide or assisting in suicide when the individual or the family concludes that life is not worth it." Id.
40 Id.
D. Did the Cruzan Court Attach Any Significance to the Fact that Nancy was Neither “Dying” Nor “Terminally Ill”?

There may be a number of things wrong with the Missouri Supreme Court opinion in Cruzan, but I think it was right about one thing: To disregard the fact that a person is neither “dying” nor “terminally ill” and to focus on her “profoundly diminished capacity . . . and [the] near certainty that that condition will not change leads inevitably to quality of life considerations.”

The Missouri Supreme Court gave a good deal of weight to the fact that Nancy was neither “dying” nor “terminally ill.” At the outset of its opinion the Court stated that the “issue presented” was whether “nutrition and hydration [may] be withheld from an incompetent ward in a persistent vegetative state, who is neither dead . . . nor terminally ill.” And the court mentioned or discussed the fact that Nancy was not “terminally ill” five more times in its opinion.

So far as I can tell, however, the United States Supreme Court failed to attach any significance whatever to the fact that Nancy Cruzan was not dying or terminally ill. In his majority opinion, the Chief Justice mentioned this aspect of Nancy’s condition only once—in a footnote quoting from the state supreme court’s detailed description of Nancy’s medical condition. In discussing the problems raised by the case, Chief Justice Rehnquist spoke only of judicial proceedings “seeking to terminate an incompetent individual’s life-sustaining treatment” or “seek[ing] to discontinue nutrition and hydration of a person diagnosed to be in a persistent

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41 Cruzan v. Harmon, 760 S.W.2d 408, 422 (Mo. 1988), aff’d sub nom. Cruzan v. Director, Missouri Dep’t of Health, 110 S. Ct. 2841 (1990). Added the Missouri court: “The argument made here, that Nancy will not recover, is but a thinly veiled statement that her life in its present form is not worth living.” Id.

42 The Missouri living-will statute provides that lifesaving support could be terminated “where . . . death will occur within a short time whether or not” such measures are utilized and provided further that a “terminal condition” is “an incurable or irreversible condition which . . . is such that death will occur within a short time regardless of the application of medical procedures.” See id. at 420 (quoting Mo. ANN. STAT. § 459.010(3) & (6) (Vernon 1991)).

43 Id. at 410.

44 See id. at 411, 412, 419, 422, 424.

45 Cruzan, 110 S. Ct. at 2845 n.1.

46 Id. at 2854.
vegetative state.”

At no point in her concurring opinion did Justice O'Connor attribute any significance to the fact that Nancy Cruzan was not "terminally ill." Indeed, she never mentioned this factor. Moreover, at one point Justice O'Connor observed that "[a] seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures . . . ."48

Dissenting Justice Brennan did observe that if kept on the feeding tube Nancy Cruzan might live for another thirty years.49 In context, however, it is clear that Brennan considered this feature of the case another reason for \textit{terminating} the lifesaving treatment, \textit{not} a reason for continuing it.

The Supreme Court is likely to make plain in a future case what I think is implicit in Cruzan: As a matter of constitutional law there is no distinction between a patient (such as Nancy Cruzan) whose condition has "stabilized" or is not "terminal" (as that term is commonly defined) and a "dying" or "terminally ill" patient, that is, one facing an \textit{unpreventable} and imminent death. To put it another way, if a patient otherwise "qualifies" for the "right to die" (for example, there is clear and convincing evidence of her wish to die under the circumstances), that right can probably no more be denied solely for the reason that the patient is neither "dying" nor "terminally ill" than it can be denied solely on the ground that the life support involved is a feeding tube rather than a respirator.

\section*{III. "A Toehold for Euthanasia Principles is Provided by the Practice of Letting Die"} As I have indicated, the proposals Glanville Williams made some thirty years ago for legalizing euthanasia seem rather modest when compared with those being advanced today. But I have passed over one feature of Professor Williams' proposals that may strike many

\footnote{47 \textit{Id.}}

\footnote{48 \textit{Id.} at 2856. (O'Connor, J., concurring) (emphasis added).}

\footnote{49 Despite Nancy's previous expression of her wish to forgo medical treatment under such circumstances as these, wrote Justice Brennan, "the Missouri Supreme Court, alone among state courts deciding such a question, has determined that an irreversibly vegetative patient will remain a passive prisoner of medical technology—for Nancy, perhaps for the next 30 years." \textit{Cruzan}, 110 S. Ct. at 2863-64 (Brennan, J., dissenting).}
(or, at least at one time struck many) as quite bold. As had most proponents of euthanasia up to that time, Williams advocated active euthanasia.

When Williams returned to the subject a decade and a half later, however, he realized that advocacy of active euthanasia had been a mistake—a mistake, I think it fair to say, in strategy, not in principle. Addressing the British Medico-Legal Society, he observed that "the case for voluntary euthanasia seems to have made little impression upon doctors generally." He then considered, against "this background of medical rectitude or rigidity," "the extent to which the euthanasia movement is likely to make headway in the immediate future".

A toehold for euthanasia principles is provided by the practice of letting die, or what is now called passive euthanasia. The Roman Catholic Church has for over twenty years accepted that whereas the physician may never kill his patient by positive act, there is a limit to the extent to which he is required to fight for the life of a dying patient. At some point he may refrain from what Pope Pius XII called "advanced techniques" as opposed to "conventional medical treatment." The more common phrases used to express the distinction are "extraordinary measures" as opposed to "ordinary measures."

If this distinction between an act and an omission is thought to be artificial, its artificiality is imposed on us

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50 See J. Feinberg, HARM TO SELF (1986). Commenting on various bills to legalize voluntary euthanasia that were introduced in American state legislatures from 1906 to 1974 and similar proposals debated in the House of Lords in 1936, 1950 and 1969, Professor Feinberg notes that "[e]ither no distinction was made between active and passive euthanasia, or the definition of euthanasia clearly included taking active steps to end the suffering patient's life." Id. at 367.

51 See supra text accompanying note 14.

52 Williams, Euthanasia, 41 Medico-Legal J. 14 (1973). Williams also commented that "all the efforts of the euthanasia lobby to change the legal position [with respect to active voluntary euthanasia] have met with complete rejection by the medical profession at large." Id. at 16.

53 Id. at 18.

54 Id.

55 Id.
by our refusal to accord the same moral freedom for action as we do for inaction. Pending a change of thought, the concept of an omission is a useful way of freeing us from some of the consequences of overrigid moral attitudes.8

The practice of “letting die” did indeed provide euthanasia principles with a “toehold”—and generated an inspired battle cry—the “right to die” or the right to die “naturally.”

I share the view that the “right to die” “allows and encourages us to believe that when society makes significant and painfully difficult decisions about life and death, we are making no decision at all, but merely deferring to individual autonomy.”57 But I cannot deny that the “right to die” is a most appealing and seductive slogan. As my colleague Carl Schneider has observed, “when we think about a social problem, we in America today tend to think about it in terms of rights, a mode of thinking we find accessible, convenient and comfortable.”58 But, “defining an interest as a right makes accommodation seem to be the breaching of a right or the defining away of a right and thus, a moral and political wrong.”59

Although Glanville Williams is not among them, many who support the “right to die” say they are strongly opposed to active euthanasia. I must say I do not find the arguments made by proponents of this distinction convincing. Least persuasive of all, I think, are the arguments that lifting the ban against active euthanasia would be to “embrace the assumption that one human being has the power of life over another”60 (the withholding or withdrawal of life-sustaining treatment embraces the same assumption) and that maintaining the prohibition against active euthanasia “prevents the grave potential for abuse inherent in any law that sanctions the taking of human life”61 (passive euthanasia, at the very least, presents the same potential for abuse).

Indeed, I venture to say that a law that sanctions the “taking of

8 Id. at 21.
57 Beschle, supra note 12, at 322.
59 Id. at 172.
60 NEW YORK STATE TASK FORCE REPORT, supra note 16, at 42.
61 Id.
human life” indirectly or negatively rather than directly or positively contains much more potential for abuse. Because of the repugnance surrounding active euthanasia—because it is what might be called “straightforward” or “out in the open” euthanasia—I think it may be forcefully argued that it is less likely to be abused than other less readily identifiable forms of euthanasia.

Many a Down’s syndrome baby has been “allowed to die” by not removing an intestinal blockage or otherwise performing relatively simple surgery. Very few would have died if death were by lethal injection—if parents and physician could not deny what they were doing—if they had to accept the responsibility (or should one say “guilt”) for “killing” rather than “letting die.”

Glanville Williams was not enamored of the distinction between an “act” that would end life and an “omission” that would do so. Nor did he deny the “artificiality” of the distinction. But, as I read his remarks, he found the distinction serviceable (I am sure he would say beneficial) because it afforded the physician (and the patient’s family) much more room to maneuver than would be possible if one had to proceed by lethal injection—and it gave the rest of us, or most of the rest of us, less cause for alarm. As subsequent events have made plain, “the concept of an omission,” of withholding or withdrawing life-sustaining treatment, was a pragmatic and most effective way to free euthanasia proponents from the law on the books—and the official morality—against euthanasia (what Williams called “the consequences of overrigid moral attitudes”). But more leeway to decide life-and-death questions and to implement these decisions—and more freedom to evade the ban against euthanasia—means more potential for abuse, not less.

Although she did so unwittingly, of course, recently a strong proponent of the “right to die,” Susan Wolf, confirmed the point I have been trying to make (or so it seems to me). Ms. Wolf made a

62 Perhaps the best-known example is the “Hopkins baby,” the 1971 Johns Hopkins case involving a Down’s syndrome baby born with duodenal atresia, an intestinal blockage. To have fed the child by mouth in this condition would have killed him. The intestinal blockage could have been removed by relatively easy surgery, but the parents (who rejected the child upon learning of his condition) refused to permit the operation. The physician in charge acquiesced in their decision. The baby was put in a dark corner of the nursery where after fifteen days he became dehydrated enough to die a “natural” death. See Gustafson, Mongolism, Parental Desires, and the Right to Life, 16 PERSPECTIVES IN BIOL. & MED. 529, 529-30 (1973).
strong plea for maintaining the prohibition against active euthanasia because if the ban is removed "[t]he courts and prosecutors will rush in"; "[o]ur own ambivalence toward the dying will surge forward"; and "if euthanasia were an accepted option limited to the few," this would likely "exert pressure similarly to confine the right to refuse treatment." According to Ms. Wolf, among the "major benefits" the legal prohibition against active euthanasia has had "for the development of tolerable law and practice for the termination of treatment" are:

First, that prohibition has to a large extent allowed the law to stay out of the way. Judges generally have encouraged those involved in termination of treatment decisions to steer clear of the courts; legal authorities have almost always determined these bedside treatment decisions are not the province of the criminal law; and the states for the most part have avoided requiring a great deal of formality and paperwork. Thus, there has been an overall toleration of relatively informal, nonlegalistic processes and a trust in the commitment of physicians to do no harm.

Second, maintenance of the prohibition has allowed a properly expansive reading by the courts of the right to refuse life-sustaining treatment. The courts have recognized this right for nonterminal patients, including those whose treatment is relatively simple and unburdensome. Dealing with active euthanasia, the courts might have been far more reluctant to reach the nonterminal, less burdened patient. Even the right of incompetents might have been threatened.

Ms. Wolf then spelled out why legalizing active euthanasia would inhibit the expansion of what she calls "termination of treatment" and what I call "passive euthanasia":

Proponents of euthanasia frequently advocate restricting the category of those eligible; the recited require-

64 Id. at 14.
65 Id. at 13.
ments often include competence, terminality, and intractable pain. In contrast, the courts in the termination of treatment cases have gradually recognized that the category of those who can refuse life-sustaining treatment, or have it refused on their behalf, is very broad.

Would vindication of the right to refuse treatment have extended so far if there were a right to euthanasia limited to a narrow set of patients? Theoretically the two groups might be differently delimited, yet this would generate substantial tension.

[The] inclination to restrict the category of those who can refuse life-sustaining treatment has generally been beaten back in the courts. But against the background of a restricted right to euthanasia, the inclination might well have prevailed.\textsuperscript{66}

IV. SHOULD WE DISTINGUISH BETWEEN THE FEEDING TUBE AND OTHER FORMS OF LIFE SUPPORT? BETWEEN “ARTIFICIAL FEEDING” AND “NATURAL” FEEDING?

As indicated by the quotation from his address to the British Medico-Legal Society, Glanville Williams not only turned to a distinction that had its origin in Roman Catholic tradition, that between “killing” and “letting die,” but alluded to another distinction that had its origins in the same tradition, that between “extraordinary” (or “heroic”) and “ordinary” medical treatment.\textsuperscript{67} What treatment is “extraordinary”? It soon became clear that little, if anything, turned on the type of medical treatment in the abstract but much, if not everything, turned on the condition of a given patient. As the Quinlan court observed: “[O]ne would have to think that the use of the same respirator or like support could be considered ‘ordinary’ in the context of the possibly curable patient but ‘extraordinary’ in the context of . . . an irreversibly doomed patient.”\textsuperscript{68}

As the Quinlan court suggested, “extraordinary” medical treatment came to mean, or the term was used widely to mean, medical

\textsuperscript{66} Id. at 14.

\textsuperscript{67} See supra text accompanying note 55.

\textsuperscript{68} In re Quinlan, 70 N.J. 10, 48, 355 A.2d 647, 668 (1976).
treatment that was undesirable or inappropriate under the circumstances. But why was the treatment inappropriate under the circumstances? Because a determination had been made—without regard to the type of life-sustaining treatment involved—that there was no point in keeping the patient alive under the circumstances. Thus, as a presidential commission on the subject noted, the view "that [life-sustaining] treatment is extraordinary is more of an expression of the conclusion than a justification for it."69

The extraordinary/ordinary means distinction has been widely criticized and is now widely rejected.70 I agree that the terms are so spongy and unilluminating and were used so loosely and inconsistently that there is little to be said for retaining them. But in their time, I think, these terms did more than generate confusion.71 I think they provided reassurance—reassurance that only certain kinds of lifesaving measures could be, and would be, terminated; that disconnecting an unconscious patient's respirator in some vague way only constituted a "slight deviation" from our official morality; that if, as some contended and others wondered, we were making quality of life judgments or engaging in passive euthanasia it was "the . . . thing in its mildest . . . form."72

Yes, the time has come to say good riddance to the extraordinary/ordinary means doctrine. But over the years these terms have done their work. Their very vagueness seduced not a few—and, if I may say so, greased the slippery slope.

A. The Respirator vs. the Feeding Tube

As we all know, Karen Ann Quinlan's parents sought, and eventually obtained, permission to remove their comatose daughter from the respirator. But it is worth recalling that, probably be-
cause they viewed feeding as "natural" or "basic" or "ordinary" care, Karen's parents did not request permission to remove the feeding tube that was to keep their daughter alive for another nine years. Indeed, Karen's father voiced surprise when asked when he wanted the feeding tube disconnected, replying, "Oh, no, that is her nourishment." Nor did Karen's parents object when, some months after the case was decided, the director of the nursing home where Karen had been moved told them: "I can't see pulling out a feeding tube . . . because that is not a nice way to die, starving and wasting away over a period of weeks."

If the Quinlans had sought permission to remove Karen's feeding tube, they probably would have been rebuffed—even if they could have shown by clear and convincing evidence that this was their daughter's wish. For as recently as the early 1980s the idea that fluids and nutriment might be withdrawn from a comatose patient was a notion that would have been repudiated, if not condemned, by most health professionals. They would have regarded such an idea as morally and psychologically objectionable, legally problematic, and medically wrong. The notion would have gone "against the stream" of medical standards of care.

But the views of health professionals have changed—and the law has moved—very quickly in the decade and a half since the Quinlan case was decided.

In 1983, a presidential commission found "no particular treatments—including such 'ordinary' hospital interventions as parenteral nutrition or hydration . . . to be universally warranted" and maintained that "[t]he sensitivities of the family and of care giving

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73 P. Ramsey, supra note 70, at 270.
75 Siegler & Weisbard, Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?, 145 Archives of Internal Med. 129 (1985); see also Bleich, Providing Nutrition and Hydration for Terminally Ill Patients, 2 Issues in L. & Med. 117, 127 (1986) ("At least until recent years, there would have been virtual unanimity among ethicists that withdrawal of nutrition and oxygen could not be sanctioned."); Sprung, Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments, 263 J. A.M.A. 2211, 2212-13 (April 25, 1990) ("[T]he removal of such life-sustaining treatments as intravenous fluids and nutrition was considered a gross deviation from legal and ethical standards just 7 years ago.").
76 President's Commission, supra note 69, at 90.
professionals” should determine whether or not permanently unconscious patients should be provided artificial feeding. In 1986, the American Medical Association Council of Ethical and Judicial Affairs took the position that withholding or withdrawing artificially or technologically supplied nutrition or hydration should be evaluated according to the same standards applicable to other kinds of life-sustaining measures.

The following year a Hastings Center taskforce on death and dying reached the same conclusion. The same year, a New York State task force on life and the law also rejected any distinction between artificial nutrition and hydration and other forms of life-support, finding the “symbolic importance” of providing nutrition and hydration outweighed by other considerations.

It is fairly clear that what might be called the “bioethics establishment” no longer sees any need to “draw the line” short of terminating artificial nutrition and hydration. Nevertheless, on the eve of the *Cruzan* case, the issue was still a matter of considerable dispute. A goodly number of respected commentators argued that the distinction should be preserved for various reasons: (1) nutrition and hydration are basic care, not medical treatment; (2) providing such care is an important symbol of our human relatedness and commitment to care; (3) denial of such care poses a serious threat to the doctor-patient relationship; and (4) permitting withdrawal of nutrition and hydration undermines the psychological distinction between “killing” and “letting die.”

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77 Id. at 190.
80 NEW YORK STATE TASK FORCE, supra note 16, at 36-40.
81 Id. at 39.
82 See generally the contributions of Robert Barry, David Bleich, John Connery, Dennis Horan and Gilbert Meilaender to ISSUES IN L. & MED. (Sept. 1987). See also the summary of the arguments that have been made for preserving the distinction in NEW YORK STATE TASK FORCE, supra note 16, at 37-38.

In 1987, ten experts in ethics, law and medicine prepared a statement against the withdrawal of “artificially provided” food and water for people suffering even the severest disabilities. See May, Barry, Griese, Grisez, Johnstone, Marzen, McHugh, Meilaender, Siegler & Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES IN L. & MED. 203, 211 (1987) (“It is not morally right, nor ought it to be legally permissible, to withhold or withdraw nutrition and hydration provided by artificial
Moreover, “nearly half” of the forty states that have adopted living-will statutes (including Missouri) “specifically exclude artificial nutrition and hydration from the category of life-sustaining treatment [that may be] refused.” I realize that some state courts have taken the position that such legislation does not foreclose the development of judicial doctrine allowing cessation of such medical procedures. Nevertheless, if, as the Supreme Court recently informed us, “the pattern of enacted laws” is “the primary and most reliable indication” of national consensus, the reluctance of many state legislatures to permit the termination of artificial feeding, even where the patient has executed a living will, would seem to pose a formidable obstacle to a constitutionally protected “right to die” in cases like Cruzan.

But Chief Justice Rehnquist, who wrote the majority opinion in Cruzan, drew no distinction between the feeding tube and other lifesaving measures. And concurring Justice O’Connor explicitly means to the permanently unconscious or other categories of seriously debilitated but nonterminal persons.”). A hundred prominent persons from various disciplines and different religious traditions signed the statement. See id. at 212-17.


See Cantor, supra note 34, at 389.

See Stanford v. Kentucky, 109 S. Ct. 2969, 2977 (1989). See also id. at 2975 (“[F]irst’ among the objective indicia that reflect the public attitude toward a given sanction’ are statutes passed by society’s elected representatives.”).

In describing post-Quinlan developments in the state courts, the Chief Justice observed—without any expression of approval or disapproval—that the New Jersey Supreme Court had “rejected certain categorical distinctions that had been drawn in prior refusal-of-treatment cases,” such as the distinction “between treatment by artificial feeding versus other forms of life-sustaining medical procedures.” Cruzan v. Director, Missouri Dep’t of Health, 110 S. Ct. 2841, 2849 (1990). He also noted, again without comment, that recently the Illinois Supreme Court had “adopted the ‘consensus opinion [that] treats artificial nutrition and hydration as medical treatment.’” Id. at 2890.

The best reading of the Chief Justice’s opinion, I think, is that with one possible exception, the distinction between artificial feeding and other kinds of lifesaving measures is a distinction without a constitutional difference. The one possible exception may be evidence of the incompetent patient’s wishes. Some people may be willing to remove a respirator or other forms of life support when they are in a certain medical condition, but balk at discontinuing artificial food and water. To put it somewhat differently, some people may have the respirator in mind, but not the feeding tube, when they say they do not want to live “as a vegetable” if and when they become permanently unconscious. Thus, some state courts are likely to require more specific evidence of the patient’s wishes, and the Supreme Court is likely to give them more leeway in this regard when the particular form of life support at
rejected any such distinction. As she saw it, the artificial provision of nutrition and hydration implicated the same liberty interests as did other medical interventions—"the 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."\(^7\) It was almost as if Justice O'Connor were responding to another Justice's argument to the contrary. So far as I can tell, however, no member of the Court argued to the contrary.

### B. "Artificial" Feeding vs. "Natural" Feeding

What next? Not all patients in an "irreversible chronic vegetative state," as the court described Mildred Rasmussen's condition,\(^8\) lose their swallowing reflex.\(^9\) In *Rasmussen*, the public fiduciary sought appointment as guardian for the purpose of removing the patient's nasogastric tube. Before the intermediate appellate court could render its decision, the patient died "from complications following pneumonia."\(^10\) In the course of its discussion of the case, the state supreme court noted, without further comment:

> For some reason, Rasmussen's physician removed the nasogastric tube after the petition for guardianship was filed and was surprised to learn that Rasmussen could

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\(^7\) Id. at 2287 (O'Connor, J., concurring).

\(^8\) Rasmussen v. Fleming, 154 Ariz. 207, 218, 741 P.2d 674, 685 (1987). Rasmussen's physician testified that for two years she had been "in a chronic vegetative state from which she had a zero probability of returning to a higher level of functioning." Id. at 212-13, 741 P.2d at 679-80. According to a court-appointed neurologist, she "existed in a profound vegetative state from which she would never recover." Id. at 213, 741 P.2d at 680.


\(^10\) 154 Ariz. at 213, 741 P.2d at 680. The court nevertheless retained the matter for decision because the issues presented were so important. *Id.*
swallow food on her own. The nursing staff, however, still had to place the food into [her] mouth. The record does not indicate whether the tube was ever reinserted.\textsuperscript{91}

Although the \textit{Rasmussen} courts did not address this issue, in the years ahead cases are bound to arise where the courts will be asked to authorize the discontinuance of "natural" feeding. How will they decide this question?

Although some commentators have forcefully argued to the contrary,\textsuperscript{92} a plausible case—not a few physicians and ethicists would say an overwhelming case—can be made for the proposition that, unlike "manual feeding" or "regular feeding," "the administration of artificial nutrition has a distinctly medical cast."\textsuperscript{93} After all, "[e]ven installation of a simple intravenous tube requires medical expertise"\textsuperscript{94} and "[a] gastrostomy tube (as was used to provide food and water to Nancy Cruzan) or jejunostomy tube must be surgically implanted into the stomach or small intestine."\textsuperscript{95} Thus, it would be no great feat to draw a legally significant line between artificial or technologically supplied nutrition and say, spoon feeding—or, more generally, between life-sustaining measures that are "medical" in character and those that are not.\textsuperscript{96}

\textsuperscript{91} \textit{Id.} at 212 n.1, 741 P.2d at 679 n.1.
\textsuperscript{92} See supra note 82 (citing \textit{Issues in Law and Medicine} and New York State Task Force).
\textsuperscript{93} Cantor, supra note 34, at 384.
\textsuperscript{94} \textit{Id.}
\textsuperscript{95} Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2857 (O'Connor, J., concurring).
\textsuperscript{96} This, it seems, is where many physicians and ethicists would draw the line today. See, e.g., Ellman, Cruzan v. Harmon and the Dangerous Claim that Others Can Exercise an Incapacitated Patient's Right to Die, \textit{29 Jurimetrics J.L. Sci. & Tech.} 389, 391 (1989):

To [most bioethicists], and to the American Medical Association, the key difference is not between medical care on one hand and food and water on the other; it is between anything technologically supplied—nutrition, air or medicine—and the simple provision of food and water. The Missouri Supreme Court effectively treats the gastronomy tube like the dinner tray, while most authorities treat it like a respirator.

Adds Professor Ellman: "Because presenting food and water to a patient capable of eating and drinking can never be too burdensome, its denial can never be justified." \textit{Id.} at 392. But some will argue that feeding a PVS patient by hand is extremely burdensome. See, e.g., supra note 89 (quoting Ronald Cranford). Moreover, what does it mean to say that a patient is "capable of eating and drinking"? Some are bound to draw a distinction between patients able to \textit{feed themselves} and those able to swallow food on their own, but unable to place the food in their mouths on their own.
I think many courts, perhaps most, will draw such a line—at first. But what of the long run?

I very much doubt that the courts, and physicians’ groups and ethicists, will “hold the line.”97 There is, to be sure, an important psychological and symbolic distinction between discontinuing artificial feeding and terminating what might be called natural feeding. The trouble is that not very long ago the same important distinction was thought to exist between turning off a respirator and removing a feeding tube. Yet the “‘right to die’ movement” was powerful enough to override that once-formidable distinction in the space of a single decade.

“[T]he history of our activities and beliefs concerning the ethics of death and dying,” it has been well said, “is a history of lost distinctions of former significance.”98 What reason is there to think that that history has come to an end? What reason is there to doubt that in the not-too-distant future the distinction between artificial and natural feeding will become still another “lost distinction of former significance”?

Why, it will be asked, should we dwell on “the details” of the method of feeding? People, we will be reminded, have rights and liberties, not spoons or bottles—no more than do respirators or gastrostomy tubes. The focus, we will be told, should be on the patient’s condition, not her particular feeding mechanism.99

As I have already noted, at the time the Quinlan case arose, any attempt to remove Karen’s feeding tube would have met strong resistance. But if Karen could have been fed “naturally,” any attempt to terminate such feeding would have met overwhelming resistance. Indeed, I seriously doubt that anyone at that time would have had the audacity to ask a court to permit cessation of such feeding.

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97 One way to deal with this problem, and others raised by patients in a persistent vegetative state, is to “adjust[] our thinking about death,” to “change[] the focus from biological to psychological processes,” and to expand the definition of “death” to include “permanent loss of sentience.” Wikler, supra note 89, at 44-45. If this change in definition were adopted, “cessation of treatment would not ever require an invocation of the patient’s wishes.” Id. at 44. If this definition were adopted, one might add, cessation of treatment would be permitted even in the face of the PVS patient’s previously expressed wishes to the contrary. See generally infra text accompanying notes 118-20.


However, what we cannot do—perhaps cannot even think about doing—in one step we are often able to do in two or three. Professor Schneider has called this “a psychological aspect of slippery slopes: they work partly by domesticating one idea [say, disconnecting the respirator] and thus making its nearest neighbor down the slope seem less extreme and unthinkable.”

Putting aside psychology, emotion and symbolism, the distinction between artificial and manual feeding does seem rather thin. After all, if one believes that a person suffering the plight of Nancy Cruzan or Mildred Rasmussen is “better off dead” (and it is plain that a great many people do), why keep her alive for many months, or even years, simply because she can be spoon fed?

The trouble (at least the trouble for me) is that putting aside psychology, emotion and symbolism, the distinction between “letting die” and active euthanasia seems quite thin, too. After all, if a person would be “better off dead” and she has a “right to die,” or a “liberty interest” in not being kept alive in a permanently unconscious or barely conscious state, why does she not have the right or the liberty to choose what she regards (or her loved ones are convinced she would regard) as the most “humane” or “dignified” way to die?

V. WHEN IS THERE A “RIGHT TO DIE”? WHEN IS THERE NO “RIGHT TO LIVE”? PROFESSOR ROBERTSON’S VIEWS ON BOTH QUESTIONS

I concur in much that Professor Robertson had to say at this conference about the Supreme Court’s decision in the Cruzan case. I agree that, whether or not one believes Missouri’s vitalist posture toward Nancy Cruzan can be justified as a matter of ethics and policy (and Professor Robertson makes plain his belief that it cannot), “the Supreme Court’s decision upholding this posture was correct as a matter of constitutional law.”


101 Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1156. See also Baron, On Taking Substituted Judgment Seriously, HASTINGS CENTER REP., Sept.-Oct. 1990, at 7 (“I am a long-time advocate of patient’s rights in general and the right to die in particular, but . . . [the Cruzan] Court, in my opinion, did not have legal authority to do what the Cruzans asked of it.”).
As Professor Robertson observes:

If [Nancy Cruzan] had no interest in further living . . . it does not necessarily follow that she also had an interest in dying. If allowing her to die cannot harm her . . . she cannot be harmed by further maintenance either. Nancy Cruzan simply had no further interests in being treated or not being treated. . . .

. . . How valid are the concerns about the indignity and humiliation which result from being sustained artificially which animate the dissenting opinions of Justices Brennan and Stevens? . . .

. . . [B]ecause [a permanently unconscious patient like Nancy Cruzan is] not capable of feeling the indignity or humiliation which may result from artificial treatment, these concerns do not show that gastrostomy feeding harmed Nancy Cruzan.\textsuperscript{102}

Moreover,

[A] state requirement for treatment of an incompetent patient would violate a right to refuse treatment by advance directive only if the person, when competent, had in fact directed that treatment not occur. Inferences or guesses that the patient would have issued such a directive if she had thought of it are not equivalent to making a directive.

. . . .

The majority's conclusion that the state may legitimately require a high degree of certainty that a prior directive against treatment has been made is neither irrational nor unjustifiably obstructive of such choices. If there is a right to refuse medical care in advance, state requirements to ensure that the right has in fact been exercised serve legitimate state interests in protecting life and in preventing erroneous determinations about what the patient had chosen when she was competent.\textsuperscript{103}

I also share Professor Robertson’s view that the Court properly

\textsuperscript{102} Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1158-59.

\textsuperscript{103} Id. at 1163-64.
rejected the Cruzans’ back-up argument that, even in the absence of substantial proof that their decision reflected the wishes of their daughter, they had an independent right to decide Nancy’s fate as part of a fundamental right of “family autonomy” or “family privacy.” As a matter of constitutional law, family autonomy has never embraced the right to terminate a close family member’s life support and its sphere should not be expanded to include it.\textsuperscript{104} As Professor Ira Mark Ellman put it on the eve of \textit{Cruzan}:

\begin{quote}
\textit{[A]ny constitutional rule protecting each individual’s right to make her own medical decisions emerges from a principle of self-determination—or autonomy—and can therefore protect only an individual’s right to make decisions about her own treatment. A guardian’s or family member’s judgment is not entitled to the special deference arising from the autonomy principle, for it is a judgment that one person makes about another, not a judgment that the patient makes about herself.}
\end{quote}

\ldots Since the autonomy principle is foundational to any constitutional claim that individuals may decide for themselves whether to accept or refuse life-sustaining treatment, the constitutional claim fails in [the \textit{Cruzan}] case. The family’s claim to decide cannot be piggybacked on Nancy’s autonomy.\textsuperscript{105}

I agree too, that the \textit{Cruzan} majority’s use of the term “liberty interest” rather than a “constitutional right of privacy”\textsuperscript{106} is “a significant move in the Court’s ongoing debate about the derivation of unwritten rights from the open-textured clauses of the Constitution”\textsuperscript{107} and that this move is not merely “symbolic” but one that “could substantially affect the standard of scrutiny that state restrictions on treatment refusals must meet.”\textsuperscript{108}

\textsuperscript{104} See id. at 1170-71.
\textsuperscript{106} “Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy,” noted the Court, “we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest.” 110 S. Ct. at 2852 n.7.
\textsuperscript{107} Robertson, \textit{Cruzan and Nontreatment Decisions}, \textit{supra} note 27, at 1174.
\textsuperscript{108} Id. Continues Robertson:

By avoiding “fundamental right” language, the Court may implicitly allow
Finally, I agree that "Cruzan is hardly a decisive defeat for a constitutional 'right to die.'" Indeed, as pointed out earlier, I believe that, although they did not achieve the result they desired in Cruzan, "right to die" proponents secured two significant victories: The Court seems to have rejected, or at least indicated that it would reject, any distinction (a) between the feeding tube and other forms of life support and (b) between "dying" or "terminally ill" patients and those whose conditions have stabilized and could be kept alive for many years.

I part company with Professor Robertson, however, when he leaves the Cruzan case, when his focus shifts from the constitutional limitations on states, such as Missouri, which take a "vitalist" position to the constitutional restraints, if any, on those jurisdictions which adopt "nonvitalist" policies.

A. Constitutional Restraints, If Any, on "Nonvitalist" State Policies

What about the incompetent but conscious patient—one who has "some interest in treatment" because that treatment is not harmful and provides "some additional, conscious life"? According to Robertson, if the additional life "is of very marginal quality," a state is free to conclude that "human life in such a diminished state need not be maintained if there are significant costs involved" (for example, if the burdens to "family, taxpayers or others" are great). Indeed, Robertson goes so far as to say that "[o]nly where the interests in further living are very clear and substantial should the state be prevented from withholding states to restrict this "liberty interest" upon a lesser showing of need than it would require if that interest were characterized as a fundamental right, thereby requiring the state to meet the rigorous standard of scrutiny traditionally applied to violations of fundamental rights.

Id. at 1145 n.19.

Id. See supra text accompanying notes 41-49 & 86-87.

"From the vitalist perspective, all human life is viewed as worthy of protection regardless of its quality or functional ability." Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1140. Nonvitalists "accept quality of life judgments"; they regard human life as worth protecting "only if that life meets certain minimal standards of functional ability." Id. at 1141.

Id. at 1195.
treatment.”

The state has even more leeway to adopt nonvitalist policies, Professor Robertson tells us, when dealing with permanently unconscious patients. “Such policies could take the form of allowing family or proxy to decide about treatment on any basis, including their own interest; in having state or private insurers withhold payment for maintenance of such patients; or adopting a cognitive death definition of brain death.”

Robertson asks, but does not directly answer, whether permanently unconscious patients are “persons” under the Constitution. A reasonable approach, he tells us, is to say that “they are legal persons but lack interests that need protection from state nonvitalist positions.” Then, as I see it, they are not “legal persons” after all or might as well not be called legal persons.

I do not think Professor Robertson would disagree. At one point he observes that if a state wanted to define PVS patients or other permanently unconscious persons as “dead” it is “difficult to see” what would prevent it from doing so.

What does it mean to say that defining a permanently unconscious patient as “dead” is “within state power”? It means, I take it, that a hospital could require the termination of a PVS patient’s life support over the objection of every close family member and could do so even though, when still a vibrant person, the patient explicitly and emphatically stated in writing that if she ever

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113 Id. at 1196 (emphasis added).

114 In describing PVS patients and others who are permanently unconscious, Professor Robertson, as do many commentators, uses the terms “irreversibly comatose,” “permanently comatose” or, sometimes, simply “comatose.” See id. at 1196-99. However, according to Ronald Cranford, a leading authority on the PVS patient and a neurologist who was a consultant to the Cruzan family, PVS patients are unconscious, but not comatose, as many believe; “permanent unconsciousness” is the best term to describe them. See Cranford, supra note 89, at 28. Therefore, except when quoting Professor Robertson directly, I shall refer to PVS patients as “permanently unconscious” patients.

115 Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1197 (emphasis added).

116 Id.

117 Id.

118 See id. at 1199 (“Whatever the policy arguments against [taking the] position [that cortical death is death for all purposes], it is difficult to see that it would be unconstitutional.”).

119 “[A] definitional approach to the irreversibly comatose,” observes Robertson, “would be within state power despite strong policy reasons against adopting such a position.” Id. (footnote omitted).
became permanently unconscious she wanted to be kept alive. Dead is dead. Moreover, why bother about turning off respirators or removing feeding tubes? Why not simply administer a lethal injection? Dead is dead.

Nor is that all. Professor Robertson himself notes that if a state expands the definition of “brain death” to include the PVS patient, as he is fairly confident a state could do, “[as] a corollary,” such a patient “could be used as a source of organs or as a subject of experimentation.” Again, dead is dead.

Does anyone really believe that if a number of states expanded their definition of “death” to include permanently unconscious patients, that would be the end of it? Does anybody really doubt that ten or twenty years down the road the definition would be expanded again? The next time around, the definition of “death” would, at the least, embrace elderly, incompetent patients who, though in extreme states of disability, are conscious—people such as Claire Conroy or Mary O'Connor, people who could be described as “minimally responsive” or “barely conscious.”

Unless and until the definition of “death” is expanded, a state may adopt what Robertson calls a “loose substituted judgment” test or it may utilize what he variously calls a “best interests” or “patient’s current interests” or “current best interests” test. The latter test is not based, as is the substituted judgment test, on “what the patient would have chosen if she were competent.” Rather, Robertson tells us (some of the time), it focuses on “what

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120 Id. at 1199 n.203.
123 In an article Professor Robertson wrote recently with Professor Dresser, the authors take the position that conscious patients “cannot reasonably be said to have any continued interest in living” when their “level of awareness is so minimal” that they are “unable to appreciate being alive” and state further that “incompetent patients with minimal ‘relational capacity,’ such as Nancy Cruzan, Claire Conroy or Mary O'Connor, lack significant interests in having their lives maintained.” Dresser & Robertson, Quality of Life and Nontreatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach, 17 Law, Med. & Health Care 234, 240 (1989).
124 See Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1190-94. Robertson calls the test the loose substituted judgment approach because “[n]o requirement of actual evidence of past wishes is needed.” Id. at 1192.
125 See id. at 1194-95.
126 See id. at 1192.
serves this patient’s interests in her current situation of illness and permanent incompetency.”

As I hope to show in the next segment of this Paper, the “patient’s current interests” test, an approach that Robertson favors, is misnamed, or at least misleading. In practice, I venture to say, it will not consider the patient’s present circumstances as much as it will take into account the totality of the circumstances (especially the family’s). In practice, I think, it will not turn on the “best interests” of the patient as often as it will turn on the “best interests” of the family—or of society generally. As Robertson recognizes elsewhere, one applying the “best interests” test, as he explains that test, will inevitably grapple with “quality of life assessments and the conflicts they pose with other interests.”

In the paper he presented at this conference, one might say, Professor Robertson only addressed the question whether a state is constitutionally free to adopt the “best interests” approach he describes. But Robertson leaves no doubt that he considers this test a better one than the more traditional substituted judgment approach. And in a recent article he co-authored with Professor Rebecca Dresser, one that treats the best interests test more extensively than he did at this conference, Robertson makes it even clearer that he considers such an approach not merely constitutionally permissible, but good public policy.

B. Robertson’s “Best Interests” Test vs. A “Loose Substituted Judgment” Approach. How would Robertson’s “Best Interests” Test Work?

As already indicated, I have considerable difficulty understanding what Professor Robertson means by a “best interests” test or

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127 Id. at 1194.
128 See Dresser & Robertson, supra note 123, at 242: “The comparative advantage of the current interests test is that quality of life assessments and the conflicts they pose with other interests are faced openly, rather than in the guise of family or proxy decision of what the patient would choose if competent.” If Robertson deems it desirable to face quality of life assessments and the conflicts they pose with other interests openly and honestly, he might consider changing the name of the test.
129 See Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1194-96, 1201-02. Indeed, at two points Professor Robertson suggests that the “best interests” test is not only constitutionally permissible, but may be constitutionally required. See id. at 1195, 1201.
130 See Dresser & Robertson, supra note 123, passim.
just how it would work. Sometimes he tells us that the test will focus only on the patient’s present condition and will serve only her interests from her perspective. At other times, however, he seems to say something quite different.

Putting aside these inconsistencies for the moment, I cannot help wondering why, considering the other things he has to say about permanently unconscious and minimally conscious patients, Robertson would be attracted to a best interests of the patient test.

He emphasizes repeatedly that permanently unconscious patients “ha[ve] no further interests in being treated or not being treated.” Indeed, “they lack the mental substrate essential to the possession of interests.” Moreover, he has indicated elsewhere that conscious patients “cannot reasonably be said to have any continued interest in living”—and presumably no interest in dying either—if their “level of awareness is so minimal that [they are] unable to appreciate being alive.”

One might argue that maintaining the life of a permanently unconscious or minimally conscious patient is, or may be, a violation of that person’s bodily integrity or dignity. But Robertson would disagree. Concerns about indignity and humiliation “cannot matter” to such a patient, he tells us, because she “lacks awareness of her situation and its impact on her family.” “The real offense” is not to the patient, who is incapable of feeling the indignity or humiliation that may result from medical intervention, but “to competent observers, whose own concepts of what constitutes dignified and respectful medical treatment for seriously compromised human beings have been violated.”

One might also argue that maintaining the existence of a permanently unconscious or minimally conscious person violates that person’s previous values and interests. Again, however, Robertson would disagree. As he sees it, with the possible exception of the

123 Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1158.
124 Id. at 1157. See also id. at 1161-62 (“When the patient is irreversibly comatose . . . neither treatment nor its absence serves her interests because the patient lacks the mental capacity to have any interests whatsoever.”).
125 See supra note 123 (quoting Dresser & Robertson article).
126 Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1159 (footnote omitted). See also id. at 1189.
127 Dresser & Robertson, supra note 123, at 238 (emphasis added).
relatively rare case where a person has issued an explicit advance directive concerning medical conditions that have come to exist, "the patient's previous values and interests are no longer relevant to her because her situation has changed so drastically." Indeed, a "key point" of his paper is that "respect for incompetent persons requires focusing on their present interests and welfare, not on the interests and values they had when they were competent."

Where does this take us? If (a) only in the unusual case will the incompetent, severely debilitated patient have made an advance directive concerning future medical conditions; (b) in the usual case, where an explicit advance directive is lacking, the patient's previous values and interests are "no longer relevant" and thus not to be considered; (c) permanently unconscious or minimally conscious patients have no interest in living or in dying; and (d) such patients are incapable of feeling any of the indignity or humiliation that others may feel when they view them, in many cases what, if anything, will be accomplished by focusing on the patient's interests from her perspective?

The "best interests of the patient" test, unlike the substituted judgment approach, asserts Robertson, "has the great virtue of asking the right question because it recognizes that the decision affects the incompetent patient as she now is, not as she previously was." It strikes me, however, that in many cases (at least if the test is taken seriously and applied strictly) Robertson's approach will have a great shortcoming—it will ask an unanswerable question.

Robertson tells us (some of the time) that his "best interests" test focuses on "the present interests of the incompetent patient, viewed from her current perspective" and that it addresses "what serves this patient's interests in her current situation of illness and permanent incompetency." But won't many incompetent, severely debilitated patients lack any interests? Won't many be unable to view anything from their perspective?

Robertson also tells us that his test "aims to protect the inter-
ests of the present incompetent patient, rather than to serve other interests" and that if this test is applied the decision "will be driven by respect for the patient, rather than for other interests." But if, as Robertson tells us, many incompetent, debilitated persons have no interests to speak of, or no significant ones, won't a decisionmaker who rigorously applies this test often hit a blank wall? Isn't the decisionmaker likely to—indeed, bound to—look beyond the best interests of the patient from the patient's perspective? Isn't it almost inevitable that the decisionmaker will take into account other interests?

As Robertson's discussion proceeds, it becomes clear, I think, that this is so. "The most difficult policy questions will arise," he points out,

in situations involving conscious, incompetent patients who have some slight interest in further treatment but where treatment would be burdensome for the patient's family, taxpayers or others. The advantage of loose substituted judgment is that it permits non-treatment to occur without confronting this conflict. On the other hand, if a best interests test is followed, the conflict will inevitably arise.\textsuperscript{143}

Why, if we apply a best interests of the patient test strictly, will a conflict arise? Why should there be a "conflict"? If further treatment does serve this patient's interest, albeit slightly—and Robertson tells us that it does—why should it matter that maintaining her existence would burden "family, taxpayers or others"? Why shouldn't the only thing that matters be that the patient does have "some slight interest in further treatment"?

After all, there is always the possibility, however remote, that (a) a misdiagnosis has occurred or (b) a remarkable recovery may take place or (c) a miracle "cure" will be discovered.\textsuperscript{144} From the per-

\textsuperscript{141} Id. at 1195 (emphasis added).
\textsuperscript{142} Id. (emphasis added).
\textsuperscript{143} Id. at 1195-96 (emphasis added, footnote omitted).
\textsuperscript{144} Cf. Cantor, supra note 34, at 413. Professor Cantor notes that, if a permanently unconscious patient "senses no detriment in an indefinite limbo, it is not so clear that his or her material best interests dictate removal of life-support." Id. Moreover, the best interests of the permanently unconscious patient, "as customarily measured in terms of physical and emotional benefits and burdens to the patient, are not determinable." Id. at 436.
spective of the patient, from the vantage point of her own net best interests, this is not a difficult case, let alone the most difficult one. It is, or ought to be, an easy case. If it is not, then we are not applying a best interests of the patient test.

Further evidence that we are not doing so when we apply Professor Robertson's test is provided, I think, by the 1989 article he co-authored with Professor Dresser. In that article the authors leave little doubt that what they call "the incompetent patient's current interests" test is not strictly a patient's current interests test:

An alternative approach [to the substituted judgment test] that is more likely ... to give factors external to patient welfare their proper role is to ask whether treatment actually serves the incompetent patient's existing interests. If treatment cannot succeed in supplying patients with an acceptable quality of life, then external considerations should be permitted to affect the decision. If treatment would serve patient interests but would impose heavy burdens on family or society, the conflict can be faced openly.\(^{146}\)

I do not deny that it is better to face a conflict openly rather than to deal with it covertly. Again, however, once it is stipulated, as it is, that "treatment would serve patient interests," why—under an "incompetent patient's current interests" test—should there be any "conflict" between the patient's interests and the "heavy burdens" her existence imposes "on family or society"? Why should "factors external to patient welfare" play any role—why should these "external considerations" be permitted to influence the life-or-death decision—if treatment does not assure an "acceptable quality of life"? Acceptable to whom? If the patient

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Although he would favor termination of life support in many, or all, of the same cases that Professor Robertson would, Professor Cantor "prefers to call the applicable legal standard 'preservation of human dignity,' rather than 'best interests' of the patient." Id. However, Professor Robertson would not agree. See supra text accompanying notes 134-35. According to him, concerns about the indignity and humiliation which may result from medical treatment "cannot matter to the comatose patient, who lacks awareness of her situation and its impact on her family." Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1159.

\(^{146}\) See Dresser & Robertson, supra note 123, at 240.

\(^{146}\) Id. (emphasis added).
“obtains negligible benefits from life”\textsuperscript{147} and experiences no pain and suffering, why would her continued existence be unacceptable to her?

Although I have serious problems with Professor Robertson’s “best interests” approach, I have no affection for the “loose substituted judgment” test—one that he subjects to much-deserved criticism.\textsuperscript{148} As other commentators have pointed out, ascertaining what a person would have decided if she miraculously became competent and aware of her present plight “is a quixotic enterprise in the absence of clearcut prior expressions by the patient,”\textsuperscript{149} an enterprise that often “serves to mask the extent to which the decision is being made by another.”\textsuperscript{150}

The trouble is that much of Professor Robertson’s criticism of this approach applies to his “best interests” test as well. Robertson complains that the substituted judgment test “ignores the patient’s current interests,”\textsuperscript{151} but according to him many severely debilitated patients have no interests or no significant ones to consider. Moreover, as the Dresser and Robertson article makes plain, even under Robertson’s “best interests” test, “external considerations” may override a patient’s net best interests. In practice, I fear, these “external considerations” will often play a decisive role.

A “substituted judgment” approach, observes Robertson and his co-author, “has a strong allure.”\textsuperscript{152} But so does a “best interests of the patient” test. Who can be against such a test? Each test carries a cosmetic label. Robertson’s “best interests of the patient” test may mask the extent to which the decision serves interests other than the patient’s every bit as much as the substituted judg-

\textsuperscript{147} In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) permits the termination of life-sustaining treatment, absent any explicit treatment directive or other clear evidence of an incompetent patient’s past preferences, if the patient experiences pain so great that continued treatment would be “inhumane.” Elsewhere in their article, Professors Dresser and Robertson criticize Conroy for articulating the benefit-burden analysis too narrowly, for the case “fails to include such factors as lack of awareness and relational capacity. Thus, it does not authorize nontreatment [the death] of permanently unconscious or barely conscious patients who obtain negligible benefits from life, but experience no pain and suffering.” Dresser & Robertson, supra note 123, at 241 (emphasis added).

\textsuperscript{148} See Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1142-44, 1190-94.

\textsuperscript{149} Cantor, supra note 34, at 412.

\textsuperscript{150} Beschle, supra note 12, at 364.

\textsuperscript{151} Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1191.

\textsuperscript{152} Dresser & Robertson, supra note 123, at 235.
ment approach may mask the extent to which the decisionmaker is exercising his own judgment, not trying to ascertain the patient's.

One reason the substituted judgment test is so attractive, we are told, is that "it recognizes a central role for family discretion in treatment decisions for incompetent patients." The same can be said, however, for the "best interests of the patient" approach. "Close scrutiny of the family's assessment" of what the patient would choose if competent or what the patient in fact once said, Professors Dresser and Robertson point out, "is frequently omitted, thus giving [family members] ultimate discretion to decide the matter." I agree. But I fail to see why the family's assessment of the patient's best interests will receive any closer scrutiny if, as will often be the case, physicians and family members will agree that the patient's quality of life is not "acceptable" or that the patient's state of existence is not "a sufficient good to justify further treatment."

Under either test, I think, the likelihood is the same: In almost all cases in which the attending physician concurs in the family decision, neither family members nor physicians will have to justify their choice, nor will the decision be reviewed by a disinterested party.

Under the "loose substituted judgment" test, protests Robertson, the family "is asked to decide what the patient would have chosen if she were competent but is given no guidance in choosing among the several meanings that that capacious phrase might have." But under his "best interests" test "external considerations" come into play whenever treatment cannot provide patients with "an acceptable quality of life"—and that is a capacious phrase if I ever saw one. Moreover, assessing best interests "requires observers to evaluate from the incompetent patient's perspective indications of [her] subjective state, and ultimately, to judge whether this state of existence is a sufficient good to justify further treatment of the patient."

When it comes to capacious questions, it is hard to top whether

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163 Id.
164 Id.
165 See infra text accompanying note 158.
166 Cf. Robertson, Involuntary Euthanasia, supra note 38, at 268.
167 Robertson, Cruzan and Nontreatment Decisions, supra note 27, at 1192.
168 Dresser & Robertson, supra note 123, at 240 (emphasis added).
one's state of existence is "a sufficient good." That strikes me as the ultimate capacious phrase. If it has a rival, it is whether a patient has an "acceptable quality of life."

VI. SOME FINAL THOUGHTS

Now that I have come to the end of my remarks, I realize that I have given the Cruzan case rather short shrift. One reason is that Professor Robertson's analysis of Cruzan was so thoughtful, careful and thorough (I like to believe I would have said that even if I did not agree with him so much) that it left me very little to say about the case.

Another reason is that Professor Robertson took a long, hard look at the other side of the coin: When does a person have a constitutional "right to live"? A great deal of attention has been paid to the constitutional limitations on states, such as Missouri, that take a "vitalist" position. Robertson, though, addresses a question that has rarely been asked: What constitutional restraints, if any, are there on states that want to adopt "nonvitalist" policies? I must confess that I had not thought about this issue very much until I read Robertson's paper. The more I think about it, however, the more I realize how difficult this issue is and the more I wonder why, until now, it has been so neglected.

This conference has been billed as "Cruzan and the 'Right to Die.'" But Professor Robertson gave all of us who attended the conference a big bonus. He made some very trenchant and provocative remarks (they certainly provoked me) about the constitutional "right to live" and when people have no such constitutional right, a topic I think few of us thought much about until today.

I have little doubt that Professor Robertson's comments will stimulate others in the field and generate a good deal of literature on the subject. And when others do take pen in hand they will have to read and reread Professor Robertson's paper. That will be the place to begin.

Because so little has been written or said about when one has no constitutional "right to live," it is easy to criticize anyone who is brave enough to wrestle with it. If I had taken the lead in discuss-

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ing this issue rather than merely commenting on Robertson’s views, I am not sure what I would have done. I do know that if I had given the Sibley Lecture and Professor Robertson had followed me to the podium, I would have caught heavy fire.

I do have one tentative view on the “right to live.” I am uncomfortable with a best interests test as well as a substantial judgment approach. I am also uneasy about reexamining, revising and gradually expanding the definition of “death.” But if I had to choose, if I had to make a “choice of evils,” I think I would select the “definitional” approach toward “death,” however discomfiting that approach would be. Redefining and expanding the definition of “death” would, as I suggested earlier, pose “slippery slope” problems and it would be a disagreeable task, indeed an abhorrent one. Abhorrence, however, may be a virtue in this case. The very wrenchingness of the enterprise and the very awesomeness of the assignment (it would be hard to escape responsibility this time) would increase the likelihood that the process would move slowly and cautiously.

If a life-or-death judgment must be made, there is something to be said for “a collective social judgment, rather than idiosyncratic choices of parents and committees, as to when social costs outweigh individual benefits.”

Robertson said that a decade and a half ago when he wrote a much-acclaimed article on the involuntary euthanasia of defective newborns. (He was not reticent about using the “E” word in those days).

If a life-or-death judgment must be made, “it is essential that the circumstances in which nontreatment may be said to be in a patient’s best interests be specified beforehand by an authoritative body, and that procedures which assure that a particular case falls within such criteria be followed.”

Robertson said that, too.

As for granting parents and physicians ultimate discretion to decide these matters, “a central element of procedural justice is impartial decisionmaking after full consideration of relevant information. Yet, neither parents nor physicians are impartial or disinterested; both have a strong personal interest in the outcome of their decision.” Once again, Professor Robertson said that fif-

160 Robertson, Involuntary Euthanasia, supra note 39, at 266.
161 Id. at 255 n.221.
162 Id. at 263 (footnote omitted).
teen years ago.

As for designating a committee to decide whether to terminate treatment, such an approach "risks losing society’s pervasive symbolic commitment to the value of individual life, as well as embarking on the slippery path of rational-utility assessments of public worth."163 "[E]mbarking on the slippery path"? This time those are Robertson’s words, not mine.

I think one who reads Robertson’s 1975 article in its entirety will conclude that in those days he balked at adopting any test for terminating life-sustaining treatment. “Comparisons of relative worth among persons, or between persons and other interests,” he said then, “raise moral and methodological issues that make any argument that relies on such comparisons extremely vulnerable.”164 “Unless the quality of a [defective newborn’s] life affects its value, a judgment for which there is no legal precedent,” he also said then, “the likelihood that treatment means life should justify [the medical] procedure.”165

It appears that in the last decade and a half Professor Robertson, along with quite a few others, has (if I may use that term one last time) moved a considerable distance down the slippery slope.

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163 Id. at 265 (footnote omitted).
164 Id. at 252.
165 Id. at 237 (footnote omitted). One may argue that different considerations govern the termination of treatment for newborns and for the elderly, but Robertson only drew a distinction between defective newborns and “terminally ill” elderly patients, those who “will soon die with or without the [medical] procedure.” Id. As discussed at length earlier, neither Karen Quinlan nor Nancy Cruzan were “terminally ill” as that term is usually defined and as Robertson defined it. See supra Section II.D.