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Assisted Suicide and Euthanasia: The Cases Are in the Pipeline

Yale Kamisar
University of Michigan Law School, ykamisar@umich.edu

Civil Rights

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When I first wrote about this subject 36 years ago,[1] the chance that any state would legalize assisted suicide or active voluntary euthanasia seemed minuscule. The possibility that any court would find these activities protected by the Due Process Clause seemed so remote as to be almost inconceivable. Not anymore.

Before this decade ends, at least several states probably will decriminalize assisted suicide and/or active voluntary euthanasia. [Editor's note: In November, Oregon became the first state to legalize physician-assisted suicide, allowing doctors to prescribe lethal medication for competent, terminally ill adults who request it.]

A distinct possibility also exists that the U.S. Supreme Court will announce a constitutional right to assisted suicide. I continue to believe the Court will not discover or recognize such a right, but the possibility that it may do so can no longer be disregarded.

Three cases challenging the constitutionality of the criminal prohibitions against assisted suicide are now in the "judicial pipeline."

The likelihood that this issue will continue to divide the state courts and lower federal courts until the highest court in the land resolves the matter is evidenced by events last May: Within the space of seven days, a federal district court in Seattle and a state appellate court in Michigan reached opposite conclusions as to whether there is a constitutionally protected "right" or "liberty" to assisted suicide.[2]

On May 3, Chief Judge Barbara Rothstein of the U.S. District Court in Seattle, Washington, became the first federal judge to strike down a statute outlawing assisted suicide on Fourteenth Amendment due process grounds. In *Compassion in Dying v. Washington*,[3] Judge Rothstein invalidated a Washington state law prohibiting assisted suicide insofar as it placed an undue burden on competent, terminally ill adults who seek this assistance. According to the court, a terminally ill person's right to choose physician-assisted suicide is no less intimate or personal a decision and no less deserving of constitutional protection than a pregnant woman's right to choose abortion.

Only one other court in this country, a Michigan trial court, had ever held that there is a constitutional right to assisted suicide.[4] But on May 10, the Michigan Court of Appeals reversed that court on this point. A 2-1 majority rejected the argument that the right to suicide or to suicide assistance is a "logical extension of [the] catalog of rights" protected by the "guarantee of personal privacy."[5]

Two months later, the odds that the U.S. Supreme Court soon will grapple with this issue increased. Three terminally ill patients and three physicians who care for such patients (among them Dr. Timothy Quill, probably the nation's most eloquent proponent of physician-assisted suicide) filed suit in federal district court in Manhattan, seeking to invalidate New York's anti-assisted suicide law.[6] The lawsuit is being financed by Compassion in Dying, the same Washington state group that achieved a favorable ruling in the Seattle case.[7]

Assisted Suicide v. Euthanasia

Although all three cases involve the right to assisted suicide, not active voluntary euthanasia, I think this is a distinction without a difference. In physician-assisted suicide, the doctor makes the lethal means available to the patient, who then performs the last act herself. In active voluntary euthanasia, the physician not only provides the means of death but carries out the final death-causing act as well.

Some proponents of assisted suicide say there is an important distinction between this practice and euthanasia. Other proponents tend to lump the two practices together (under the labels "physician-assisted death" or "aid-in-dying"). I agree with the second group.

Assisted suicide and voluntary eu-

Yale Kamisar is the Clarence Darrow Distinguished University Professor at the University of Michigan Law School.

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thanasia are much more alike than they are different. Each involves the active intervention of another to bring about death. If and when the right to assisted suicide is established, it will be extremely difficult to stop short of active voluntary euthanasia.

If a patient's inability to commit suicide for either physiological or psychological reasons entitles her under certain circumstances to the active intervention of another person in order to bring about her death,[8] why shouldn't a patient's inability—*despite* preliminary assistance—to perform the last death-causing act, for either physiological or psychological reasons, entitle her to active voluntary euthanasia?

If assisted suicide is appropriate when patients "need more help from the physician than merely abating treatment, but less help than would be required if they were asking the physician to kill them,"[9] why isn't active voluntary euthanasia appropriate when less help than "killing them" would *not* suffice? When patients are unable to perform the ultimate act and thus nothing less than "killing them" *is* required to "help" them die an "easy" death?

Suppose a patient is unable to swallow the pills that will bring about her death or is otherwise too weak to perform the last act (for example, push a button or pull a string) that will fulfill a persistent wish to die. If there is or ought to be a right to assisted suicide, how can a right to active voluntary euthanasia be denied simply because a person can't perform the final death-causing act alone?

The distinction between assisted suicide and euthanasia is too thin to endure for very long. Indeed, even now, it is a distinction that the media, the public, and even many commentators are either unable or unwilling to take seriously.

The one formidable distinction is the distinction between the termination of medical treatment (even life-sustaining treatment) and the active intervention of another to promote or to bring about death. This is the distinction that proponents of assisted suicide are attacking. If this bridge falls, the flimsy bridge between assisted suicide and active voluntary euthanasia seems sure to follow.

Task Force Report

Earlier this year, when the New York State Task Force on Life and the Law issued its report on the law and ethics of death and dying, it addressed *both* assisted suicide and voluntary active euthanasia.[10] (Recognizing the important moral and social issues presented by an assisted suicide case involving Dr. Quill and one of his patients,[11] the State Board for Professional Misconduct had asked the task force to provide guidance in this area.[12]) The 24-member body issued a 181-page report unanimously rejecting proposals to legalize either voluntary euthanasia or assisted suicide.

An officer of the Hemlock Society immediately disparaged the report by noting that the task force included representatives of religions that prohibit suicide.[13] But only six task force members were clerics; they were greatly outnumbered by medical school deans, physicians, lawyers, bioethicists, and state health officials. Why did all 24 members vote to keep the total ban against assisted suicide intact?

The issue of assisted suicide will divide the lower courts until the highest court in the land resolves it.

The task force is an influential body whose previous legislative proposals had reflected deep respect for individual autonomy. Seven years earlier this same group had taken the position, at a time when the issue was still hotly disputed, that the right of the individual to terminate life support should include the right to withhold and withdraw artificially provided food and water.[14] But in 1994 the task force balked at crossing the historic divide between the individual's right to the termination of medical treatment and an individual's right to request the active intervention of another to promote or to bring about death:

> In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many people who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.[15]

The task force recognized that one can posit "ideal" cases in which all the recommended safeguards for assisted suicide would be satisfied: Patients would be screened for depression and offered treatment, effective pain medication would be available, and all patients would have a supportive, committed family and doctor.[16] But it concluded that "constructing an ideal or 'good' case is not sufficient for public policy" if, as here, "it bears little relation to prevalent medical practice."[17]

Although Judge Rothstein had read the "right to die" cases as establishing a broad individual right to determine the timing and manner of one's death, the task force maintained that "these cases stand for the more limited proposition that individuals have a right to resist bodily intrusions, and to preserve the possibility of dying a natural death."[18] The report emphasized that "the imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity."[19]

It is *this* right against intrusion—not a general right to control the timing and manner of death—"that forms the basis of the constitutional right to refuse life-sustaining treatment,"[20] the task force maintained. Restrictions on suicide, on the other hand, "entail no such intrusions but simply prevent individuals from intervening in the natural process of dying."[21]

Although the task force's analysis of the "right to die" may influence some members of the Supreme Court, the justices are more likely to be impressed by the tone, quality, depth, and documentation of the task force's public policy arguments. They will likely be affected by

- its thoughtful discussion of the "state of vulnerability" produced by serious illness;
- the uncertainty in estimating a patient's life expectancy and the fallibility of medical practice generally;
- the severe shortcomings of current pain relief practices and palliative care;
- the very small number of people who make an informed, competent choice to die by suicide (particularly if appropriate pain relief and supportive care are provided) and who cannot achieve their goal without another person's assistance;
- the close link between assisted suicide and active voluntary euthanasia;
- the elasticity and instability of the criteria now proposed as safeguards if and when assisted suicide and euthanasia are integrated into medical practice (for example, once euthanasia becomes "an accepted 'therapy'" there is a distinct possibility that patients incapable of

consenting will in certain respects "seem the 'best' candidates for the practice"); and

- the recognition that assisted suicide and euthanasia "will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care."[22]

Dr. Quill said last July that the lawsuit he and his colleagues brought challenging the constitutionality of New York's anti-assisted-suicide law "counters" the New York State Task Force.[23] But if Dr. Quill wants to respond to the task force report he is, I believe, in the wrong forum.

The report is not a monograph on due process, equal protection, or the right of privacy. It is addressed to the legislature, not the courts. Although the report does contain a brief discussion of whether there is a constitutional right to assisted suicide or euthanasia, its principal theme is that legalizing assisted suicide would be unwise and dangerous public policy and that the risks would be the greatest for the powerless and the socially disadvantaged.

The report underscores this nation's failure to treat pain adequately or to diagnose and treat depression properly. It also takes cognizance of the social inequality and prejudice that characterize the delivery of American health care.

The way to "counter" this report, it seems to me, is to try to refute its findings, assumptions, and public policy arguments—not to claim that prohibiting assisted suicide is beyond the power of the legislature.

Over the years, many proponents of assisted suicide and active voluntary euthanasia have tried hard to convince the public that the only substantial objections to their proposals are based on religious doctrine.[24] The New York State Task Force report is a graphic demonstration that this is not so.

It is hard to believe that a majority of the U.S. Supreme Court will rule that a legislature that was troubled by the same nonreligious concerns that led the task force to oppose the legislation of assisted suicide—and reached the same basic conclusions the task force did—acted unconstitutionally. ☐

Notes

1 Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

2 *See* notes 3 and 5 *infra* and accompanying text.

3 850 F. Supp. 1454 (W.D. Wash. 1994). For

trenchant criticism of Judge Rothstein's opinion, *see* Alexander Morgan Capron, *At Law—Easing the Passing*, HASTINGS CENTER REP., July-Aug. 1994, at 2.

4 People v. Kevorkian, No. 93-11482, 1993 WL 603212 (Mich., Wayne County Cir. Ct., Dec. 13, 1993).

5 The court made its ruling in Hobbins v. Attorney General, 518 N.W.2d 487 (Mich. Ct. App. 1994), which had been consolidated on appeal with *Kevorkian*. *See* discussion in 518 N.W.2d 487, 492-94. Despite its refusal to recognize a constitutional right to assisted suicide, the court did agree with Ms. Hobbins and Dr. Kevorkian that the anti-assisted suicide law violated a state constitutional procedural requirement: By both establishing a commission to study certain issues relating to death and dying and amending the penal code to create the crime of assisted suicide, the law had run afoul of a state constitutional provision that no law shall embrace more than one object. *See* discussion in 518 N.W.2d 487, 489-92.

6 *See* Timothy E. Quill, *The Care of Last Resort*, N.Y. TIMES, July 23, 1994, at 19.

7 *See Lawsuit Challenges New York's Law Banning Assisted Suicide*, N.Y. TIMES, July 22, 1994, at B3.

8 *See* Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 LAW, MED. & HEALTH CARE 116, 118 (1992).

9 *Id.*

10 THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT (1994) [hereafter 1994 TASK FORCE REPORT].

11 *See generally* TIMOTHY E. QUILL, DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE (1993).

12 *See* 1994 TASK FORCE REPORT, *supra* note 10, at 4-5.

13 *See* Elisabeth Rosenthal, *Panel Tells Albany to Resist Legalizing Assisted Suicide*, N.Y. TIMES, May 26, 1994, at 1 (reporting the response to the report by Sidney Rosoff, president of the Hemlock Society).

14 THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT, V (1987) (Executive Summary).

15 1994 TASK FORCE REPORT, *supra* note 10, at ix (Executive Summary).

16 *Id.* at 120.

17 *Id.*

18 *Id.* at 68. Although the task force report was published three weeks after the decision in the *Compassion in Dying* case, the report was written before Judge Rothstein issued her ruling in that case.

19 *Id.* at 71.

20 *Id.*

21 *Id.*

22 *See id.* at 72, 121, 125, 131-33, 145, 147.

23 *See* Quill, *supra* note 6.

24 The primary reason I wrote *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation, supra* note 1, in 1958 is that I disagreed strongly with the view of Glanville Williams, the leading proponent of active voluntary euthanasia at the time, that "euthanasia can be condemned only according to a religious opinion." GLANVILLE WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 312 (1957).