Thesis and Abstract

# THE RIGHT TO RECEIVE ASSISTANCE IN SUICIDE AND EUTHANASIA, WITH PARTICULAR REFERENCE TO THE LAW OF THE UNITED STATES

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## Abstract

**THE RIGHT TO RECEIVE ASSISTANCE IN SUICIDE AND EUTHANASIA, WITH PARTICULAR REFERENCE TO THE LAW OF THE UNITED STATES**

Neil M. Gorsuch

Whether to legalize assisted suicide and euthanasia is among the most hotly debated legal and public policy issues today in the United States, as it is in many countries. In this Thesis, I first (in Chapters I and II) isolate the critical questions in this debate, the answers to which will likely determine the fate of assisted suicide and euthanasia in America's courts and legislatures: Is there historical precedent for allowing the practices? Do fairness concerns dictate that we must permit assisted suicide and euthanasia because we allow patients to refuse life-sustaining treatment? Do principles of personal autonomy compel legalization? Does legalization represent the "greatest good for the greatest number" on a utilitarian scale?

In the next portion of the Thesis (Chapters III through VIII), I address each of these questions.

I conclude that there is some, but limited, support in the historical record for legalization (Chapter III). I find that many of the proffered distinctions between refusing life-sustaining care, on the one hand, and assisted suicide and euthanasia, on

the other, cannot withstand scrutiny. Nonetheless, I suggest that at least one rational basis does exist for distinguishing between the practices (Chapter IV).

I consider legal doctrine surrounding autonomy and personal privacy, and conclude that it is likely too weak a foundation on which to build a judicially-created right to assisted suicide (Chapter V). Because scholarly and legislative debate will not be confined by judicial doctrine, however, I consider three competing moral-political theories of autonomy. I find that two such theories could afford a right to assisted suicide and euthanasia, though, if so, they would likely require that the right be extended to all competent adults, not just the terminally ill or those suffering untreatable pain (Chapter VI).

I acknowledge that substantial utilitarian arguments exist for normalizing assisted suicide and euthanasia, but I also identify utilitarian arguments against the practices. I suggest that the existence of strong arguments on both sides of the utilitarian calculus raises the further question whether consequentialist reasoning can be usefully employed to arrive at a definitive policy outcome when, as here, incommensurable goods are at stake (Chapter VII). I then consider recent works by Richard Posner and Richard Epstein, using their writings as case studies

for assessing the soundness of my conclusions, suggested in preceding chapters, regarding the autonomy and utilitarian arguments for assisted suicide (Chapter VIII).

In the last portion of the Thesis (Chapters IX and X), I submit that there is a secular moral theory which, to date, has been largely neglected in contemporary American debate over assisted suicide and euthanasia. This theory rests on the notion that the intentional taking of human life by private persons is always wrong. I conclude by developing this theory, considering a number of potential criticisms, and explaining how it might apply to a variety of end-of-life situations.

## Acknowledgments

I wish to thank my supervisor, Professor John Finnis, for his patient and thoughtful guidance throughout the writing of this thesis. I owe a great deal, as well, to Professor John Keown and Dr. Timothy Endicott, for their careful reading of the thesis and their valuable comments. Judge Richard Posner, Professor Richard Epstein, Professor Daniel Klerman, Dr. Christian Mammen, and Todd Zubler all took the time to review and offer helpful suggestions on prior draft portions of this manuscript, and I am very much in their debt. I thank also Bernadette Murphy and Jessica Bartlow for their excellent editorial assistance, and the Marshall Scholarship Commission for its financial support of my studies at Oxford.

Borrowing in part from P.G. Wodehouse, I thank my wife, Louise, and my daughters, Emma and Belinda -- without whose constant love and attention this thesis would've been finished in half the time (and without whom life would've been half as fully lived).

## Dedication

For the memory of my father.

# CHAPTER I

# INTRODUCTION

Whether to permit assistance in suicide and euthanasia is among the most contentious legal and public policy questions in America today. The issue erupted into American public consciousness on June 4, 1990, with the news that Dr. Jack Kevorkian -- a slightly built, greying, retired Michigan pathologist -- had helped Janet Adkins, a 54 year-old Alzheimer's patient, kill herself.[1] Dr. Kevorkian later revealed that he had not taken the medical history of Ms. Atkins, had not conducted a physical or mental examination, and had not consulted Ms. Adkins's primary care physician.[2] Dr. Kevorkian had simply agreed to meet Ms. Adkins in his Volkswagen van, which he had outfitted with a "suicide machine" consisting of three

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[1]See State of Michigan v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994).

[2]Isabel Wilkerson, Prosecutors Seek to Ban Doctor's Suicide Device, N.Y. Times, sec. 1, at 6, col. 5 (Jan. 5, 1991). Dr. Murray Raskind, one of the physicians who cared for Ms. Adkins in the early stages of her disease, testified that she was physically fit at the time of her death. Dr. Raskind added in court testimony that Ms. Adkins was probably not mentally competent at the time of her death. Id.

chemical solutions fed into an intravenous line needle. Dr. Kevorkian tried five times to insert the needle before eventually succeeding.[3] Ms. Adkins then pressed a lever releasing death-inducing drugs into her body.

Since Janet Adkins's death first made national headlines, Dr. Kevorkian claims to have assisted more than 130 suicides.[4] Derek Humphry, founder of The Hemlock Society, a group devoted to promoting the legalization of euthanasia, has praised Dr. Kevorkian for "breaking the medical taboo on euthanasia."[5] The American Civil Liberties Union ("ACLU") has taken up his legal defense.[6]

While the term "assisted suicide" is often used to describe Dr. Kevorkian's practices, it is a misnomer.

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[3]Pamela Warrick, Suicide's Partner, L.A. Times, part E, at 1, col. 2 (Dec. 6, 1992).

[4]Brian Murphy, Kevorkian Silent, Starts Prison Term, Detroit Free Press <http://www.freep.com/news/xtra2/ qkevo14.htm> (site visited Sept. 14, 2001) (hereinafter, "Murphy, Kevorkian Silent").

[5]See Derek Humphry, Law Reform, 20 Ohio N.U. Law Rev. 729, 731 (1993).

[6]Charlie Cain (compiler), Key Events in the History of Michigan's Debate Over Abortion and Assisted Suicide, The Detroit News, at A8 (Mar. 2, 1997).

There is no crime called "assisted suicide," and, as we shall see in Chapter III, no legal penalty for the patient who seeks help in dying. Instead, the crime at issue is assisting suicide, and it is targeted solely to those who help another commit suicide. The legal right sought by proponents is, to be precise, a right to receive assistance in killing oneself without the assistant suffering adverse legal consequences. Recognizing its imprecision, I will nonetheless defer to pervasive usage and employ the term "assisted suicide" in this thesis as a short-hand description for the proffered right.

Using the term "assisted suicide" to describe Dr. Kevorkian's practices is, however, a misnomer in yet another respect. Dr. Kevorkian seeks to establish not only a right to receive assistance in suicide (what we shall call assisted suicide), but also a right to be killed by another person, so long as the act is performed with the consent of the decedent and the killer is motivated by compassion or mercy (what is properly labeled euthanasia). In fact, in 1999 Dr. Kevorkian killed a patient for a nationwide television audience on the program *60 Minutes*, and did so specifically to provoke a public debate on euthanasia. (Dr. Kevorkian was later convicted of second-degree murder, after a trial in which he chose to act as his

own counsel).[7]

While perhaps the most notorious American proponent of assisted suicide and euthanasia, Dr. Kevorkian hardly stands alone. In 1984, the Netherlands became the first country in the world to afford express legal endorsement to some forms of assisting suicide and euthanasia. The Dutch Supreme Court declared that, although euthanasia was punishable as murder under the nation's penal code, physicians could claim an "emergency defense" under certain circumstances.[8] After several failed attempts, in November, 2000, the lower house of the Dutch Parliament voted 104-40 in favor of a physician assisted suicide exception to the nation's homicide laws, codifying -- and liberalizing in some key respects -- the prior judicial "emergency defense"; the Dutch Senate gave its

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[7]Murphy, Kevorkian Silent.

[6]As developed by Dutch courts, the emergency defense applied when (a) a patient requested assistance freely and voluntarily; (b) the request was well-considered, durable, and persistent; (c) the patient was experiencing intolerable suffering with no prospect of improvement; (d) other alternatives to alleviate the patient's suffering had been considered and found wanting; (e) any act of euthanasia was performed (only) by a physician; and (f) the physician had consulted an independent colleague. Report of the Select Committee on Medical Ethics, House of Lords, HL Paper, 21-I of 1993-1994 Session (hereinafter, "House of Lords Report HL Paper, 21-I of 1993-1994 Session"), Appendix 3. These criteria paralleled professional guidelines established by the Royal Dutch Medical Association. See Walter Lagerway, trans., Guidelines for Euthanasia, 3 Issues in Law & Medicine 429 (1988).

assent in April 2001.[9] The Northern Territory of Australia passed a law permitting assisted suicide in 1996, but that legislation was quickly repealed months later by Australia's federal parliament.[10] Belgium has now also followed the Dutch example, adopting a law that took effect in late September 2002.[11]

Within the United States, Dr. Timothy Quill, a University of Rochester professor, provoked early debate on the assisted suicide question in 1991, writing an article in the New England Journal of Medicine discussing and defending his decision to prescribe barbiturates to a cancer patient, even though

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[9]Public Agenda Online <http://www.publicagenda.org/issues/news.cfm?issue_type=right2die#MPPOASAE> (site visited Jan. 15, 2001); CNN.com/WORLD, Dutch Law Stokes Death Debate, <http://www6.cnn.com/2001/WORLD/europe/04/11/euthanasia.debate/> (site visited Sept. 10, 2001). See also Ch. VII.2, infra (discussing legislative changes).

[10]For a thorough account of how the Australian law came about, its procedures, and the seven deaths that took place pursuant to its provisions, see David Kissane, Deadly Days in Darwin in The Case Against Assisted Suicide: For the Right to End-of-Life Care 192 (Kathleen Foley and Herbert Hendin, eds. 2002). Switzerland, too, does not treat assisted suicide as a crime, even when committed by non-doctors; though "no verified statistics" regarding the practice of assisted suicide in Switzerland are presently available, its regime has received attention recently as the number of "death tourists," primarily from Britain, spiked from 3 in 2000 to 55 in 2001. See Death in a Consumer Society (Editor's Choice), 326 British Medical Journal (Feb. 1, 2003).

[11]See Euthanasia.com <http://www.euthanasia.com/belgiumlaw.html> (site visited July 4, 2003).

she admitted that she might use them at some indefinite time in the future to kill herself.[12] A New York grand jury was convened but ultimately declined to bring an indictment for assisted suicide; the state medical board also considered pressing disciplinary charges but eventually relented, reasoning that Dr. Quill had written a prescription for drugs that had a legitimate medical use for his patient (as a sleeping aid for her insomnia), and that he could not have definitely known that the patient would use them to kill herself. Ruling, in essence, that the evidence was too equivocal to conclude that Dr. Quill intended to cause the death of his patient, the board declared the matter closed.[13]

In 1992, a gynecology resident submitted an anonymous article to the Journal of the American Medical Association that was the subject of a long-running debate in the most prominent American medical journals. Entitled It's Over Debbie, the article described how the author administered a lethal injection to a terminal cancer patient (an act of

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[12]Timothy Quill, Death With Dignity, 324 New Eng. J. of Medicine 691 (1991). See also Timothy Quill, The Ambiguity of Clinical Intentions, 329 New Eng. J. of Medicine 1039 (1993).

[13]See The New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context 5 (1994) (hereinafter, "New York Task Force on Life and the Law").

euthanasia, not assisted suicide), whom he had never previously met, after her plea to "get this over with."[14]

After its publication in the early 1990s, The Hemlock Society's book, Final Exit, quickly rocketed to the New York Times' best-seller list. With more than a half million copies sold, it provides step-by-step instructions (in easy-to-read large print) on various methods of "self-deliverance." In August 2003, its sales on Amazon.com still ranked 9,030 among all books on offer (which is very high indeed) and was priced at $11.16 ("you save $2.79; usually ships within 24 hours").[15] Chapter titles range from "Self-Deliverance by Plastic Bag" (a recommended method) to "Bizarre Ways to Die" (discussing the relative merits of guns, ropes, and firecrackers) and "Going Together" (ideas for double suicides). A New England Journal of Medicine

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[14]Anonymous, It's Over Debbie, 259 Journ. of the Amer. Med. Ass'n 272 (1988).

[15]See <http://www.amazon.com/exec/obidos/ASIN/0440507855/qid=1019245097/sr=2-1/ref=sr-2-1/1025330579-6179338> (site visited Aug. 25, 2003).

study found that instances of asphyxiation by plastic bag measurably increased shortly after the book's publication.[16]

The public discussion sparked in the early 1990s by Kevorkian, Quill, Final Exit, and Dutch practices quickly matured into a growing debate in academic circles. By the mid- to late-1990s, respected legal thinkers from a variety of moral and philosophical perspectives began publishing books pressing the case for legalizing assisted suicide and euthanasia -- including Ronald Dworkin in 1994,[17] Judge Richard Posner in 1995,[18] and Richard Epstein in 1999.[19]

The growing academic and public discussion of assisted suicide and euthanasia was accompanied by increasing political and legal activism. In 1988, an early voter referendum campaign in California aimed at

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[16]See P.M. Marzuk et al., Increase in Suicide by Asphyxiation in New York City After the Publication of *Final Exit*, 329 New Eng. J. of Medicine 1508-10 (1993). Though the book was billed as providing "self-deliverance" information for the terminally ill, the New England Journal of Medicine study found that, of the fifteen suicides who used the book during the study period, six suffered from no illness whatsoever. Id.

[17]Ronald Dworkin, Life's Dominion (1994) (hereinafter, "Dworkin, Life's Dominion").

[18]Richard A. Posner, Aging and Old Age (1995) (hereinafter, "Posner, Aging and Old Age").

[19]Richard Epstein, Mortal Peril: Our Inalienable Right to Health Care? (1999) (hereinafter, "Epstein, Mortal Peril").

toppling the State's law banning the assistance of suicide failed to attract the necessary 450,000 verified signatures to secure a spot on the ballot.[20] Another effort just four years later not only secured a spot on the ballot, but garnered 48 percent of the vote. A similar 1991 effort in Washington State obtained 46.4 percent of the vote.[21] By 1994, the referenda campaign bore its first fruit when Oregon voters narrowly voted to legalize assisted suicide, 51 percent to 49 percent, though subsequent legal challenges delayed implementation until 1997.[22]

Since 1992, bills have been introduced to legalize assisted suicide or euthanasia in various state legislatures, including Alaska, Arizona, Colorado, Connecticut, Hawaii, Iowa, Maine, Maryland, Massachusetts, Michigan, Nebraska, New Hampshire, New Mexico, Rhode Island, Vermont, and Washington.[23] All

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[20]See Allan Parachini, Bringing Euthanasia to the Ballot Box, L.A. Times, sec. 5, at 1 (Apr. 10, 1987).

[21]See Sandi Dolbee, Right to Die Measure Rejected by State Voters, San Diego Union-Tribune, at A3 (Nov. 4, 1992); Jay Mathews, Term Limits, Assisted Suicide, Abortion Rights Losing in Washington, Wash. Post, sec. 1, at A28 (Nov. 6, 1992).

[22]See Spencer Heinz, Assisted Suicide: Advocates Weigh In, Oregonian, at A1 (Dec. 9, 1994); Oregon Health Division, Oregon's Death with Dignity Act: The First Year's Experience (1998) (hereinafter, "Oregon, First Year's Experience").

[23]See Julia Pugliese, Don't Ask -- Don't Tell: The Secret Practice of Physician-Assisted Suicide, 44

have failed -- so far. In recent years, some states have actually strengthened or reaffirmed their laws prohibiting assisting suicide. Dr. Kevorkian's home State of Michigan is an example.[24] So is New York, where a government-commissioned blue-ribbon panel rejected any change by a unanimous vote.[25] Maryland passed a statute for the first time codifying that state's common law teachings against assisted suicide.[26] In the last several years, Iowa, Oklahoma, and Virginia also have strengthened their laws against the practice.[27] Congress has entered the fray, too, disavowing Oregon's experiment and banning the use of any federal health care funds in support of assisted suicide or euthanasia.[28] And so has the current

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Hastings L.J. 1291, 1319 (1993); American Medical News, vol. 38, no. 17, at 5 (May 1, 1995); The Providence Journal, at 1C (May 8, 1995); Hemlock Society, Physician Assistance in Dying: Legislation by State <http://www.hemlock.org//common/states _12.html> (site visited Sept. 1, 2002).

[24]See NBC News, Doctor-Assisted Suicide, State by State <http://www.msnbc.com/modules/statebystate/state.asp?state=Michigan&ST=MI&2w=no#marker> (site visited Sept. 1, 2002).

[25]See New York Task Force on Life and the Law.

[26]See Appendix A.

[27]See Appendix A; Hemlock Society, Physician Assistance in Dying: Legislation by State <http://www.hemlock.org/common/states_12.html> (site visited Sept. 1, 2002).

[28]42 U.S.C. § 14401 et seq.

presidential administration, issuing executive regulations in late 2001 seeking to stop Oregon doctors from employing federally regulated medicines (if not other means) to assist suicides. The administration has argued that such conduct does not qualify as a "legitimate medical practice" under the Controlled Substances Act, the federal law which regulates the dispensation and use of pharmacological substances.[29] The federal government's administrative ruling has precipitated an ongoing legal battle (which we shall explore) with the State of Oregon, and the matter is currently pending before a panel of the Ninth Circuit.[30] In the last several years, a number of other countries, including England, Canada, Australia, New Zealand, and Hungary also have considered and rejected proposals to

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[29]21 C.F.R. Part 1306 (Nov. 9, 2001) [AG Order No. 2534-2001] (Attorney General's finding that assisted suicide is not a "legitimate medical purpose" and that prescribing, dispensing, or administering federally controlled substances to assist suicide therefore violates the federal Controlled Substances Act). See also Memorandum for the Attorney General, U.S. Department of Justice, June 27, 2001, reprinted at Whether Physician-Assisted Suicide Serves a "Legitimate Medical Purpose" Under the Drug Enforcement Administration's Regulations Implementing the Controlled Substances Act, 17 Issues L. & Med. 269 (2002) (hereinafter, "Memorandum for the Attorney General") (discussing Attorney General's rationale for ruling).

[30]The state has won the first round, convincing a federal trial court judge to reject the Bush administration regulations, but the matter is currently pending on appeal. See Ch. IX, infra; Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Ore. 2002).

overturn their laws banning assisted suicide.[31]

With relatively little to show for their early voter referenda and legislative efforts, American euthanasia proponents opened a new front in the mid-1990s, filing law suits in Washington State and New York seeking to have statutes banning assisted suicide declared unconstitutional.[32] Wildly disparate lower court rulings resulted. One federal trial court found a constitutional right to assistance in suicide; another held that no such right exists.[33] Appellate courts reviewing these decisions produced even more fractured opinions.[34] In 1997, the cases culminated in argument before the United States Supreme Court. In 9-

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[31]See House of Lords Report HL Paper, 21-I of 1993-1994 Session (England); Rodriquez v. British Columbia (Attorney General) [1993] 3 S.C.R. 519 (Canada); note 10, supra (Australia); nzoom.com <http://onenews.nzoom.com/onenews_detail/0,1227,173412-1-7,00.html> (site visited July 4, 2003) (noting 1995 effort in New Zealand was defeated in parliament 61-29, and renewed 2003 effort expected to lose); Euthanasia.com <http://www.euthanasia.com/hung.html> (site visited July 4, 2003) (discussing Hungary's highest court rejection of a challenge to laws banning assisted suicide).

[32]Kevorkian also filed a losing state court challenge to the Michigan law banning assisted suicide. See note 1, supra.

[33]See Compassion in Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994)(finding constitutional right); Quill v. Koppell, 870 F. Supp. 78 (S.D.N.Y. 1994) (rejecting constitutional right).

[34]See Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995), vacated en banc, 79 F.3d 790 (9th Cir. 1995); Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996).

0 decisions, the Court upheld the Washington and New York laws banning assisted suicide.[35] At the time, the press hailed the Court's rulings as major victories for opponents of euthanasia and assisted suicide.[36] But few noticed that critical concurring justices addressed only the question whether laws banning assisted suicide are facially unconstitutional -- that is, unconstitutional in all possible applications -- and specifically reserved for a later case the question whether those laws are unconstitutional as applied specifically to terminally ill adults seeking death. Thus, far from definitively resolving the assisted suicide issue, the Court's decisions only assure that the coming decade will witness even more debate over assisted suicide and euthanasia than the last.

In Chapter II, I discuss the Washington and New York cases and seek to ascertain their implications for future cases. I suggest that these cases raise four key questions on which much future debate is likely to focus: whether there is historical precedent for legalization; whether concerns of equal protection or fairness dictate that, if we permit patients to refuse

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[35]Washington v. Glucksberg, 521 U.S. 702 (1997); Vacco v. Quill, 521 U.S. 793 (1997).

[36]See, e.g., Joan Biskupic, Unanimous Decision Points to Tradition of Valuing Life, Wash. Post, at A1 (June 27, 1997) (hereinafter, "Biskupic, Unanimous Decision").

life-sustaining care like food and water, we must also allow assisted suicide and euthanasia; whether respect for personal autonomy and self-determination compels legalization of these other practices; and whether legalization would represent the solution that would provide the greatest good for the greatest number of persons. In Chapters III through VIII, I discuss each of these questions in turn.

In Chapter III, I review the legal history of assisted suicide and euthanasia and conclude that there is some, but only modest, historical support for treating them as "rights."

In Chapter IV, I submit that, while many efforts to distinguish assisted suicide and euthanasia from the refusal of life-sustaining care are unsound, a meaningful moral-legal distinction between the practices does exist, making it doubtful that legalization of assisted suicide and euthanasia is required as a matter of fairness or equal protection.

In Chapter V, I address arguments from the legal doctrine surrounding the concept of personal autonomy, as adduced in the Supreme Court's substantive due process jurisprudence; I conclude that the doctrine, at least as developed to date, is too fragile a foundation on which to erect a right to assisted suicide or euthanasia.

In Chapter VI, I expand beyond the purely legal-doctrinal issue to the question whether fundamental principles of personal autonomy, as developed by leading contemporary moral-legal philosophers, might augur in favor of legalization. I conclude that they may, but that, to the extent they do, they suggest a euthanasia right open not just to the terminally ill, but to all competent adults.

In Chapter VII, I consider utilitarian arguments for assisting suicide and euthanasia and conclude that they are practically and analytically indeterminate. In Chapter VIII, I test my tentative conclusions developed in Chapters V through VII regarding autonomy and utilitarian arguments for assisted suicide against the writings of, among others, two of America's most prominent legal thinkers, Judge Richard Posner and Professor Richard Epstein.

Having examined extant arguments suggested by the case law and various contemporary legal thinkers, in Chapters IX and X, I suggest that contemporary American legal debate over assisted suicide has largely overlooked a basic moral principle -- namely the idea that all human beings are intrinsically valuable and the intentional taking of human life by private persons is always wrong, whatever the claims of fairness or autonomy or utility may be. In Chapter IX, I examine

the roots of this principle in secular moral theory and the common law, consider its application to the assisted suicide and euthanasia debate and the current dispute over the application of the Controlled Substances Act to Oregon's assisted suicide experiment, and address a number of potential criticisms. In Chapter X, I suggest that the principle that all human life is intrinsically valuable may help illuminate and provide guidance in end-of-life disputes beyond assisted suicide and euthanasia, including in the increasingly frequent cases involving the discontinuation of life-sustaining medical care for incompetent persons.

# CHAPTER II

# THE GLUCKSBERG AND QUILL CONTROVERSIES: THE JUDICIARY'S (NON-) RESOLUTION OF THE ASSISTED SUICIDE DEBATE

## II.1 The Washington Due Process Litigation

In 1994, a group of Washington State physicians and patients, along with an assisted suicide advocacy organization, filed suit in federal district court seeking a declaratory judgment that the state statute forbidding the assistance of another person in committing suicide[1] was unconstitutional under "substantive" due process doctrine. The case was assigned to District Judge Barbara Rothstein who heard argument and issued a prompt written decision granting the requested relief.

Under the Fourteenth Amendment, no state may "deprive any person of life, liberty, or property, without due process of law."[2] Despite the procedural tone of the Fourteenth Amendment's language, Judge

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[1]Wash. Rev. Code § 9A.36.060(1) (1994).

[2]U.S. Const. amend. XIV.

Rothstein observed that, "through a long line of cases," the Supreme Court has interpreted the Amendment's liberty component as containing certain "substantive" rights that the states may not abridge except for the most compelling reasons; these "substantive" rights, Judge Rothstein explained, pertain to "marriage, procreation, contraception, family relationships, childrearing, and education."[3]

For guidance on whether assisted suicide might qualify as a new addition to this list, Judge Rothstein turned to the then-most recent major exposition of substantive due process jurisprudence, Planned Parenthood v. Casey,[4] in which the Court reaffirmed the right to abortion. Judge Rothstein observed that, while discussing abortion, the three-justice plurality in Casey suggested that matters

> involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of the liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.[5]

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[3]Compassion in Dying, 850 F. Supp. at 1459.

[4]505 U.S. 833 (1992).

[5]Id. at 851.

Judge Rothstein found this reasoning "highly instructive."[6] "Like the abortion decision," Judge Rothstein reasoned, "the decision of a terminally ill person to end his or her life involves the most intimate and personal choices a person may make in a lifetime and constitutes a choice central to personal dignity and autonomy."[7]

Judge Rothstein also found instructive the Supreme Court's decision in Cruzan v. Director, Missouri Department of Health.[8] There, the Court assumed without deciding that the liberty component of the Fourteenth Amendment embraces the right of a competent adult to refuse life-sustaining medical treatment.[9] Given this apparent right, Judge Rothstein posed the question whether there is "a difference for purposes of finding a Fourteenth Amendment liberty interest between refusal of unwanted treatment which will result in death and committing physician-assisted suicide in the final

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[6]Compassion in Dying, 850 F. Supp. at 1459.

[7]Id. at 1459-60 (internal quotation marks and brackets omitted).

[8]497 U.S. 261 (1990).

[9]Id. at 278 (this right "may be inferred from our prior decisions"); id. at 279 ("the logic of the cases . . . would embrace such a liberty interest").

stages of life?"[10] Judge Rothstein concluded that there is not, because both are "profoundly personal," and at "the heart of personal liberty."[11]

A divided panel of the Ninth Circuit reversed Judge Rothstein's decision. Circuit Judge John Noonan, considered by some a judicial conservative, wrote the majority opinion, itself a stinging rebuke of the district court that stressed three points. Judge Noonan argued, first, that Casey's discussion of autonomy was a mere "gloss" on substantive due process jurisprudence, one that was later "implicitly controverted by Cruzan."[12] Cruzan, Judge Noonan pointed out, relied upon an examination of history and tradition -- not an abstract conception of "personal autonomy" -- in determining whether the asserted constitutional right should be recognized.[13] Turning to the historical record, Judge Noonan concluded that

> in the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction. Unless the federal judiciary

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[10]Compassion in Dying, 850 F. Supp. at 1461.

[11]Id.

[12]49 F.3d at 591.

[13]Id.

> is to be a floating constitutional convention, a federal court should not invent a constitutional right unknown to the past.[14]

Judge Noonan further suggested that taking Casey's personal autonomy "gloss" so seriously leads to "absurd" results. If "personal dignity and autonomy" is the touchstone of constitutional analysis, Judge Noonan reasoned, every man and woman in the country must enjoy it. Accordingly, a right to assisted suicide cannot be limited to the competent, terminally ill, or aged:

> [t]he depressed twenty-one year old, the romantically devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of existence, meaning, the universe, and life.[15]

Finally, Judge Noonan rejected any attempt to analogize seeking assisted suicide to the right to refuse medical care. To Judge Noonan, the latter merely involves an omission or rejection of medical treatment while the former requires an affirmative act to end life: "When you assert a claim that another . . . should help you bring about your death, you ask

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[14]Id.

[15]Id.

for more than being left alone. . . . You seek the right to have a second person collaborate in your death."[16]

Two and a half years after the suit was filed, an en banc panel of the Ninth Circuit vacated Judge Noonan's decision and reinstated the trial court's judgment by a vote of 8 to 3. The majority opinion was written by Judge Reinhardt, as well known for his expansive theories of the Constitution as Judge Noonan is for his more restrictive views.

The en banc court's 50-page opinion tracked Judge Rothstein's analysis. It rejected Judge Noonan's assertion that history is "our sole guide" in substantive due process inquiries; indeed, the court reasoned, if history were the only guide, the Supreme Court never would have declared anti-miscegenation laws unlawful in Loving v. Virginia,[17] since such laws were commonplace at the time the Fourteenth Amendment was adopted.[18] Neither would the Supreme Court have recognized a right to an abortion; more than three-

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[16]Id. at 594.

[17]388 U.S. 1 (1967).

[18]79 F.3d at 805.

quarters of the states restricted abortions when the Fourteenth Amendment was passed.[19] Besides, the en banc court argued, the historical record concerning suicide itself is "more checkered" than Judge Noonan had acknowledged.[20] Judge Reinhardt pointed to the fact that Socrates and Plato permitted suicide under some circumstances, the Stoics glorified it, and Roman law sometimes permitted it.[21] While conceding that assisted suicide was unlawful under English and American common law, Judge Reinhardt stressed that the majority of states has not treated suicide or attempted suicide as criminal matters since at least the beginning of the twentieth century.[22]

Turning to Casey and Cruzan, Judge Reinhardt contended that Judge Rothstein's autonomy analysis had been right all along: Basic life decisions are constitutionally protected, and "[l]ike the decision of whether or not to have an abortion, the decision how

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[19]Id. at 806.

[20]Id.

[21]Id. at 807-08.

[22]Id. at 808-09.

and when to die is one" of them.[23] The en banc court also rejected Judge Noonan's proffered act-omission distinction. Judge Reinhardt saw little difference between the omission of "remov[ing] the tubes through which Cruzan received artificial nutrition and hydration," on the one hand, and the act of a lethal injection, on the other:

> Cruzan, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death.[24]

To Judge Noonan's assertion that a right to assistance in suicide would have to be extended to the desperate or depressed, the en banc court responded that the state has a legitimate interest "in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated."[25] By contrast, the court stressed, "the state's interest in preserving

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[23]Id. at 813.

[24]Id. at 816.

[25]Id. at 820 (emphasis added).

life, is substantially diminished in the case of terminally ill, competent adults who wish to die."[26] Though the court formally restricted its ruling recognizing the right to assisted suicide to competent and terminally ill persons, it deliberately left open the possibility that, at a later date, the right might be extended to persons who are depressed or suffering other psychological ailments that cannot be, in its phrase, "significantly ameliorated."[27]

In one critical respect the en banc court went even further than the trial court. Judge Reinhardt virtually admitted that approving a right to assistance in suicide would necessarily lead to approval of a right to euthanasia, though he strained to point out that the formal recognition of the latter right would, like a right to assisted suicide for depressed persons whose condition cannot be ameliorated, have to await another day:

> We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician.

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[26] Id.

[27] Id.

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The question whether that type of physician conduct may be constitutionally prohibited must be answered directly in future cases, and not in this one. We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life.[28]

Recognizing the logical implications of the court's holding, certain otherwise sympathetic commentators, like libertarian Richard Epstein, have chided Judge Reinhardt for a "certain lack of courage" in not directly admitting that euthanasia is also a matter of constitutional right.[29]

## II.2 The New York Equal Protection Litigation

While the Washington litigation progressed through the trial and appellate stages, another battle was being waged on the other side of the country, this time in New York. The New York litigation, filed June 20, 1994, was led by Dr. Timothy Quill, author of the New England Journal of Medicine article defending his decision to prescribe barbiturates to a terminally ill patient.[30] Like the Washington litigants, Dr. Quill and his fellow physician-plaintiffs challenged New York's

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[28] Id. at 831-32.

[29] Epstein, Mortal Peril 340.

[30] See Ch. I, supra.

law prohibiting the intentional assistance or promotion of suicide,[31] contending that it violated the substantive component of the Fourteenth Amendment's Due Process Clause.

Chief Judge Thomas Griesa of the Southern District of New York disagreed. Judge Griesa rejected any attempt to rely on Casey, dismissing its discussion of personal autonomy as "too broad" to ordain the outcome of this case:

> The Supreme Court has been careful to explain that the abortion cases, and other related decisions on procreation and child rearing, are not intended to lead automatically to the recognition of fundamental rights on different subjects.[32]

Like Judge Noonan, Judge Griesa treated the due process claim as depending upon an examination of history and concluded (with little explanation) that the plaintiffs had failed to prove "that physician assisted suicide, even in the case of terminally ill patients, has any

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[31]Section 125.15(3) of the New York penal code provides in pertinent part that "[A] person is guilty of manslaughter in the second degree when: * * * 3. He intentionally . . . aids another person to commit suicide." Section 120.30 provides that "[a] person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide."

[32]Quill, 870 F. Supp. at 83.

historic recognition as a legal right."[33]

As an alternative ground for relief, Dr. Quill and his fellow physician-plaintiffs argued that, even if no due process right exists, the Equal Protection Clause of the Fourteenth Amendment renders statutes against assisted suicide unlawful. Specifically, they noted that under New York statutory law a competent person may refuse medical treatment -- even if doing so will certainly result in death.[34] To treat like persons alike, they argued, assistance in suicide must also be permitted:

> To certain ways of thinking, there may appear to be little difference between refusing treatment in the case of a terminally ill person and taking a dose of medication which leads to death.[35]

Judge Griesa was unconvinced. He held that New York state needed to present only a "reasonable and rational" basis for the distinction in its law.[36] And

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[33]Id.

[34]See N.Y. Pub. Health Law §§ 2960-2979 (McKinney 1994 & Supp. 1997); id. §§ 2980-2994 (McKinney 1994 & Supp. 1997).

[35]Quill, 870 F. Supp. at 84.

[36]Id. The Court declined to apply strict scrutiny because, it held, New York's distinction between persons refusing care and those seeking assistance in suicide or euthanasia did not infringe upon any fundamental right and was not based on any suspect classification, such as race. See id. at 2297.

he found such a distinction exists because a patient refusing treatment is merely "allowing nature to take its course" while the act of suicide involves "intentionally using an artificial death-producing device."[37]

Adding to the already complex history of lower court litigation on the assisted suicide question, the Second Circuit reversed Judge Griesa. The court of appeals did not address the due process theory advanced by Dr. Quill below and adopted by the en banc Ninth Circuit court. Instead, it adopted the plaintiffs' equal protection theory. Rejecting Chief Judge Griesa's natural-artificial distinction between refusing care and assisting suicide, the court held that

> there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and withdrawal of ventilation brings about respiratory failure. . . . It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or the condition from which the patient suffers.[38]

New York State responded by proffering another

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[37]Id.

[38]Quill v. Vacco, 80 F.3d at 729.

distinction between assisting suicide and refusing treatment, claiming (as Judge Noonan had) that one involves an affirmative act while the other is only an omission. But the Second Circuit rejected this theory too:

> [T]he writing of a prescription to hasten death . . . involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation, and/or dehydration.[39]

Quoting Justice Scalia's concurrence in Cruzan, the court held that the act-omission distinction is "'irrelevan[t]'" because "'the cause of death in both cases is the suicide's conscious decision to pu[t] an end to his own existence.'"[40]

While the Second Circuit rejected the possibility of drawing a rational distinction between the right to refuse and assisted suicide, it, unlike the Ninth Circuit, remained notably mute on whether a law permitting assisted suicide but rejecting euthanasia could survive similar scrutiny, though the gulf between refusing care and assisted suicide appears to many a great deal wider than any remaining distance between

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[39] Id.

[40] Id. (quoting Cruzan, 497 U.S. at 296-97 (Scalia, J., concurring)).

assisted suicide and euthanasia.

Judge Calabresi separately concurred.[41] In his view, New York's ban on assisted suicide was "neither plainly unconstitutional" nor "plainly constitutional."[42] Drawing upon his earlier writings when he served as a full-time professor of law,[43] Judge Calabresi argued for a novel procedure: a "constitutional remand."[44] Under such a procedure, New York's prohibitions on assisted suicide would be vacated on the grounds that they might be unconstitutional. New York's legislature would, however, be free to re-enact those same laws:

> I contend that [the] law is neither plainly unconstitutional (because in derogation of one of the express clauses of our fundamental charter or, for that matter, of the more general clauses, as these have been interpreted in our constitutional history and traditions), nor plainly constitutional.
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> I would hold that, on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due

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[41] Id. at 731.

[42] Id. at 738.

[43] Guido Calabresi, A Common Law for the Age of Statutes (1982), cited at 80 F.3d at 735.

[44] Quill, 80 F.3d at 738.

Process Clauses of the Fourteenth Amendment of the United States Constitution to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness. I would, however, take no position on whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves.[45]

Calabresi's remand theory procedure, if adopted by the federal courts, would represent a non-trivial extension of Chief Justice Marshall's theory of judicial review in Marbury v. Madison,[46] claiming as it does that federal courts have the power under Article III of the Constitution to declare null and void statutory laws enacted by elected legislatures simply because they might violate the supreme law of the land, without ever making any finding, as in Marbury, that they do in fact violate the Constitution.

Even if Calabresi's "constitutional remand" procedure is itself a constitutional device, the justification for employing it in particular cases seems to depend on some degree of confidence that the

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[45]Id.

[46]5 U.S. 137 (1803).

law in question has fallen into desuetude. As Judge Calabresi described it, laws should not be permitted simply to "remain in force through passivity or inertia"; a constitutional remand allows courts to

> tell[] the legislatures and executives of the various states, and of the federal government as well, that if they wish to regulate conduct that, if not protected by our Constitution, is very close to being protected, they must do so clearly and openly.[47]

Passivity and inertia, however, are not labels that can be readily applied to the New York assisted suicide statute. As recently as 1985, Mario Cuomo, then-Governor, convened a task force composed of 24 members representing a wide variety of ethical, philosophical, and religious views and expressly asked the task force to consider whether the State should drop or revise its laws banning assisted suicide; the commission returned with a lengthy report that unanimously favored retaining existing law.[48] Plainly, New York's law does not seem to be an ideal candidate for "remand," even using Judge Calabresi's criteria.

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[47]80 F.3d at 742.

[48]New York Task Force on Life and the Law.

## II.3 The Final Battle? The Supreme Court Does (and Does Not) Decide

By mid-1996, the Ninth and Second Circuit decisions were ripe for review in the U.S. Supreme Court. The Court consolidated the cases and heard argument on January 8, 1997. On June 26, 1997, the Chief Justice delivered two opinions for the Court, overruling both the Ninth and Second Circuits and upholding New York's and Washington's bans on assisted suicide. The Chief Justice was joined by Justices O'Connor, Scalia, Kennedy, and Thomas.

While widely portrayed in the media as a conservative Rehnquist Court victory for enemies of assisted suicide and euthanasia,[49] any such "victory" could prove pyrrhic. Several Justices wrote separately to stress that plaintiffs in Glucksberg and Quill had sought a declaratory judgment that state laws outlawing the assistance of suicide are facially unconstitutional -- that is, unconstitutional in all possible applications. Neither case, they emphasized, presented a situation in which a state was seeking to prosecute specific persons -- a situation in which the affected

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[49]See, e.g., Biskupic, Unanimous Decision.

individuals may raise the narrower question whether laws against assisted suicide are unconstitutional as-applied to them and persons like them.[50] In their various separate opinions, each of these Justices variously hinted, suggested, or at least kept the door open to the possibly that prohibitions against assisting suicide and euthanasia would be unconstitutional if and when applied to competent, terminally ill adults.

The Chief Justice began his opinion for the Court on the substantive due process question by expressing understated skepticism about the Ninth Circuit's en banc court's reliance on Casey and Cruzan's discussions of personal autonomy, rather than on an examination of

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[50]See, e.g. Quill, 521 U.S. at 809 (O'Connor, J., concurring); id. at 809-10 (Stevens, J., concurring in the judgments); id. at 750 (Ginsburg, J., concurring in the judgments). But see Glucksberg, 521 U.S. at 735 n.24 (Souter, J., concurring) (arguing that cases posed as-applied, not facial, challenges). A facial challenge to a legislative act is "the most difficult challenge to mount successfully since the challenger must establish that no set of circumstances exists under which the Act would be valid." United States v. Salerno, 481 U.S. 739 (1987). By contrast, an as-applied challenge requires the challenger to establish only that the Act is unconstitutional as applied to his or her particular set of facts. Id.

legal history: to qualify as a "fundamental liberty interest," the Chief Justice wrote, the asserted right must be both "deeply rooted in this Nation's history and tradition" and also "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [it] were sacrificed."[51] And, the Chief Justice added, "[w]e begin as we do in all due-process cases, by examining our Nation's history, legal traditions, and practices."[52]

Unlike Judge Reinhardt's historical analysis, the Chief Justice did not consult ancient philosophers or Roman law. Instead, he began with English common law experience; even there, the Chief Justice began and ended his analysis in a single paragraph, summarily concluding that suicide and its assistance were never permitted in English common law.[53] The Chief Justice devoted somewhat more attention (a few pages) to American legal history. While conceding Judge Reinhardt's point that the penalties associated with suicide were eventually repealed by all American

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[51]Glucksberg, 521 U.S. at 721.

[52]Id. at 709.

[53]Id. at 710-11.

jurisdictions, the Chief Justice declined the Ninth Circuit's invitation to read much into that fact: "[T]hough States moved away from Blackstone's treatment of suicide [as a crime], courts continued to condemn it as a grave public wrong."[54] Of even more direct significance, the Chief Justice held, is the fact that American jurisdictions have always treated assisting a suicide as a felony.[55] Having found that "[t]he history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it," the Chief Justice "conclude[d] that the asserted 'right' to assisted suicide is not a fundamental liberty interest protected by the Due Process Clause."[56]

Turning to Cruzan and Casey, the Chief Justice rejected the notion that the Due Process Clause creates a constitutional guarantee of "self-sovereignty" embracing all "basic and intimate exercises of personal

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[54]Id. at 714.

[55]Id. at 713-16.

[56]Id. at 728 (discussing Thomas Marzen, et al., Suicide: A Constitutional Right?, 24 Duquesne L. Rev. 1 (1985)).

autonomy."[57] Cruzan, he wrote, "was not simply deduced from abstract concepts of personal autonomy."[58] Rather, the Chief Justice saw its result as dictated by a purely historical analysis:

> [G]iven the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions.[59]

The Chief Justice brushed aside, too, reliance on supposedly "highly instructive" or "prescriptive" passages in Casey:

> That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, and Casey did not suggest otherwise.[60]

The Chief Justice's equal protection analysis was even more succinct than his due process discussion. New York's distinction between refusing life-sustaining medical treatment and assisted suicide, he wrote, survives rational basis review because it "comports

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[57] Id. at 724.

[58] Id. at 725.

[59] Id.

[60] Id. at 727-28 (citations omitted).

with fundamental legal principles of causation."[61] Specifically, when a patient refuses treatment, "he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication."[62] While essentially adopting Judge Griesa's natural-unnatural distinction, the Chief Justice nowhere addressed the Second Circuit's criticism that inducing death by withdrawing life-sustaining medical treatment (e.g., respirators and feeding tubes) is no more "natural" than inducing death by active means (e.g., lethal injection).

Instead, the Chief Justice simply carried on, arguing that the distinction between refusing care and assisting suicide is further justified on grounds of intent. "The law has long used actors' intent or purposes to distinguish between two acts that may have the same result."[63] For example, the common law of homicide distinguishes "between a person who knows that another person will be killed as the result of his

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[61]Quill, 521 U.S. at 801.

[62]Id.

[63]Id. at 802.

conduct and a person who acts with the specific purpose of taking another's life."[64] And, in this case, a physician who withdraws care pursuant to an express patient demand "purposefully intends, or may so intend, only to respect his patient's wishes."[65] By contrast, the Chief Justice wrote, a doctor assisting a suicide "must necessarily and indubitably, intend primarily that the patient be made dead."[66]

The Chief Justice's due process and equal protection opinions spoke for the Court only by virtue of Justice O'Connor's fifth vote. Justice O'Connor, however, filed a separate statement joined by Justices Ginsberg and Breyer that substantially limited the precedential effect of the Chief Justice's opinions.[67]

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[64] Id. (quotation marks omitted).

[65] Id. at 801.

[66] Id. at 802 (internal quotation marks omitted).

[67] Justice Ginsburg added separately, and somewhat cryptically, that she "concurr[ed] in the Court's judgment substantially for the reasons stated in" Justice O'Connor's separate opinion, yet nowhere explained where exactly she differed (or agreed) with Justice O'Connor's (or the Court's) reasoning. Id. at 789. Justice Breyer joined Justice O'Connor's opinion "except insofar as it joins the opinion of the Court." Id.

Justice O'Connor stressed that the only question presented in the cases before the Court was whether the New York and Washington laws outlawing assisted suicide are facially unconstitutional, or invalid in all possible applications. On that question, Justice O'Connor conceded that laws banning assisted suicide have at least some constitutional applications. For example, Justice O'Connor wrote, the fear "that a dying patient's request for assistance in ending his or her life might not be truly voluntary justifies" at least some restrictions on access to assistance in suicide.[68] But Justice O'Connor expressly left open the possibility that laws against assisting suicide also have unconstitutional applications. Indeed, she hinted that a dying patient whose request is "truly voluntary" might present just such a case.[69]

Justices Souter and Stevens also filed separate concurrences. Justice Souter disagreed with the Chief Justice's contention that substantive due process analysis requires an examination of history or tradition. To him, substantive due process analysis is

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[68] Id.

[69] Id.

incapable of "any general formula," except to say perhaps that it should be "like any other instance of judgment dependent on common-law method," with arguments "being more or less persuasive according to the usual canons of critical discourse."[70] In the end, however, Justice Souter concluded that, even using his mode of analysis, states have rational reasons for refusing to permit at least some forms of assisted suicide. But he also noted that states are in the process of reconsidering their laws against assisted suicide, added his view that such reconsideration is a good idea, and strongly suggested that legalization of assisted suicide (at least in some circumstances) should be its result. Justice Souter pointedly commented that he did not want to see "legislative foot-dragging" on the assisted suicide question and that, if such foot-dragging occurs, "[s]ometimes a court may be bound to act regardless of the institutional preferability of the political branches as forums for addressing constitutional claims."[71]

Justice Stevens likewise heavily hinted how he

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[70] Id. at 769.

[71] Id. at 788.

would rule in an as-applied challenge limited to terminally ill adult patients, analogizing to the Court's decades-long battle over capital punishment in individualized, fact-bound case after case:

> [J]ust as our conclusion that capital punishment is not always unconstitutional did not preclude later decisions holding that it is sometimes impermissibly cruel, so is it equally clear that a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid.[72]

Justice Stevens went on to argue that, while Cruzan and Casey are not prescriptive of a right to assistance in suicide, as Judge Reinhardt had suggested, they

> give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death.[73]

Lest any doubt remain about how he would rule in an as-applied challenge brought by a competent, terminally ill patient, Justice Stevens offered his view that "[t]he liberty interest at stake in a case like this

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[72] Id. at 741.

[73] Id. at 745.

differs from, and is stronger than, . . . the common-law right to refuse medical treatment" underlying the Cruzan decision.[74]

On the equal protection question, Justice Stevens argued that the Court's distinction between refusing care and assisting suicide based on intent is "illusory" because a doctor discontinuing treatment can

> do[] so with an intent to harm or kill that patient. Conversely, a doctor who prescribes lethal medication does not necessarily intend the patient's death -- rather that doctor may seek simply to ease the patient's suffering and to comply with her wishes.[75]

The "illusory" nature of the distinction is further demonstrated, Justice Stevens suggested, by the fact that the American Medical Association endorses administering pain-killing medication to terminally ill patients suffering pain, even when it results in death. "The purpose of terminal sedation is to ease the suffering of the patient and comply with her wishes."[76] This same intent, Justice Stevens argued, "may exist

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[74]Id. (emphasis added).

[75]Id. at 751.

[76]Id.

when a doctor complies with a patient's request for lethal medication."[77]

While rejecting a distinction based on intent, Justice Stevens concurred in the Court's equal protection decision overruling the Second Circuit and agreed with the Court's reasoning, insofar as it held that death in assisted suicide cases is "caused" by unnatural human intervention, while death in refusal of treatment cases is "caused" by nature taking its course.[78] Like the Court, however, Justice Stevens declined to address the Second Circuit's provocative criticisms of this causation-based distinction.

## II.4 The Aftermath of Glucksberg and Quill

The immediate consequence of the Supreme Court's rulings was to return the assisted suicide question to the states and the political process. A less immediate and obvious, but perhaps even more important, consequence is the fact that many justices appear to be leaning in favor of recognizing a constitutional right

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[77]Id.

[78]Id. at 750.

to assistance in suicide for competent, terminally ill persons.

Whether the assisted suicide and euthanasia question is ultimately resolved in the legislative or judicial arena, Glucksberg and Quill make clear that only the opening salvo has been fired in what is likely to be a lengthy case-by-case "litigation war" similar, as Justice Stevens suggested, to the fight over capital punishment. Glucksberg and Quill also help expose the sort of moral-legal arguments we can expect to hear on both sides of the debate in any legislative chamber or judicial proceeding. Four central issues emerge:

First, there is a division between those who see no historical precedent for permitting assisted suicide and euthanasia (Chief Justice Rehnquist and Judge Noonan) and those who question whether the weight of history is so definitively against the practices (Judge Reinhardt).

Second, there is a difference of opinion over whether principles of fairness (equal protection) require us to permit assisted suicide and euthanasia if we allow patients to refuse life-sustaining medical

care. The Second Circuit thought principles of fairness so required. Justice Stevens came close to agreeing with the Second Circuit, disputing any distinction based on intent. But the New York trial court disagreed, and so did a majority of the Supreme Court.

Third, there are those, like Judges Rothstein and Reinhardt and Justice Stevens, who are convinced that the themes of self-determination, personal choice and autonomy underlying Casey and Cruzan provide grounds for a right to assistance in suicide and euthanasia. Meanwhile, others, such as Chief Justice Rehnquist, find such "abstract" notions of personal autonomy completely unavailing.

Finally, there are some who are curious whether society as a whole would be improved or worsened by legalization. Justices O'Connor and Souter expressed open interest in what "experimentation" in the states might "prove" about the utility of legalizing assisted suicide and euthanasia.

While these four issues represent axes around which litigation has so far evolved, definitive answers

have yet to emerge. Is euthanasia antithetical to our Nation's tradition? Is it only fair to legalize assisting suicide and euthanasia, given that we allow patients to refuse life-sustaining care? Are rights to assistance in suicide and euthanasia essential to personal choice and identity? Would legalizing assisted suicide and euthanasia bring with it consequences that, on the whole, would do more good or harm? These are questions that principled legislators and judges will continue to ask. The following several chapters seek to outline the competing arguments on each of these issues and attempt more complete answers.

# CHAPTER III

## ASSISTED SUICIDE, EUTHANASIA, AND THE HISTORICAL RECORD

### III.1 Introduction

The relevance of history to the constitutional debate over assisted suicide and euthanasia is the subject of much dispute. Some contemporary jurists (notably Chief Justice Rehnquist) see an analysis of historical legal rules and rights as critical to any substantive due process analysis. Others (such as Justice Souter) think it bears little or no relevance. And at least some inside and outside the judiciary have questioned the practice of relying upon the preferences of past majorities to interpret the Fourteenth Amendment, which was added to the Constitution in the aftermath of the Civil War with special concern for

promoting the advancement of minority rights.[1] But the history test has proven powerfully attractive to federal courts faced with substantive due process disputes for at least the last 60 years. In contrast to the competing test focused on the demands of "personal autonomy" and dependent on "reasoned judgment" (which we shall explore in greater detail later), the history test is perceived by its advocates as offering a more objective approach to due process adjudication. As Justice Powell once put it, "an approach grounded in history imposes limits on the judiciary that are more meaningful than any based on the abstract formula . . . suggested as an alternative."[2]

One of the earliest cases to synthesize the history test into a coherent means for deciding substantive due process fundamental liberty questions was Snyder v. Massachusetts. There, Justice Cardozo, speaking for the Court, faced an appeal from a murder

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[1]Perhaps most notably, see John Hart Ely, Democracy and Distrust 62 (1981) (hereinafter, "Ely, Democracy and Distrust").

[2]Moore v. East Cleveland, 413 U.S. 494, 503 n.12 (1977).

conviction. The victim was shot to death at a gasoline station in Somerville, Massachusetts and the jury found "abundant evidence" of the defendants' guilt.[3] One defendant claimed, however, that the trial judge's refusal to permit him to be present at a jury view of the gas station constituted a denial of due process. Justice Cardozo rejected the notion that judges should resolve such due process questions by reference to their unbounded "reasoned judgment," and held that government policy "does not run foul of the Fourteenth Amendment because another method may seem to our thinking to be fairer or wiser or to give a surer promise of protection to" the individual right-claimaint.[4] Instead, Justice Cardozo held, states are

> free to regulate the procedure of [their] courts in accordance with [their] own conception of policy and fairness, unless in so doing [they] offend[] some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental.[5]

The right proffered by the defendant-appellant in Snyder did not qualify under this standard, Justice

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[3]291 U.S. 97, 103 (1934).

[4]Id. at 105.

[5]Id.

Cardozo continued, because the common law of England and America (which Justice Cardozo analyzed at length) did not suggest that the right to be present at a view was critical to the administration of justice.[6]

Snyder's history test -- focused on whether a proffered right qualifies as a "principle of justice" "rooted in the traditions . . . of our people" -- is now commonly used means for resolving substantive due process disputes. For example, in a 1972 decision the Supreme Court decided that compulsory school attendance laws violated the First and Fourteenth Amendments and did so, in part, because a "strong tradition" in "the history and culture of Western civilization" suggested that parents have the right to guide the education of their children; indeed, the Court held, this right was "established beyond debate as an enduring American

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[6]Id. at 114-16. Earlier cases which Justice Cardozo cited as antecedents for his history test did use history to guide their analysis, but they did not seem to afford it an especially favored role in resolving due process disputes. See, e.g., Twining v. New Jersey, 211 U.S. 78, 106-07 (1908) (noting absence of historical support for the proposed right, but proceeding to consider whether it should be recognized anyway because reason alone suggests that it is "a fundamental principle of liberty and justice which inheres in the very idea of a free government and is the inalienable right of a citizen of such a government").

tradition."[114]

In 1977, Justice Powell employed the history test in Moore v. City of East Cleveland to strike down a local zoning ordinance that had the effect of forbidding a grandmother from living with her grandchildren, holding that such a law interfered with a long-standing tradition of respect for extended families in our legal system:

> the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition. . . . Ours is by no means a tradition limited to respect for the bonds uniting the members of the nuclear family. The tradition of uncles, aunts, cousins, and especially grandparents sharing a household along with parents and children has roots equally venerable and equally deserving of constitutional recognition.[115]

And, of course, the Chief Justice relied on the absence of historical support to turn back the facial challenge to laws banning assisted suicide.

### III.2 Which History?

Even among those who agree that history should govern substantive due process analysis, methodological disputes abound. Supreme Court justices cannot agree,

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[114]Wisconsin v. Yoder, 406 U.S. 205, 232 (1972).

[115]431 U.S. 494, 504 (1977) (plurality opinion).

for example, on what "level" of historical abstraction they should operate. The Court's recent decision in Lawrence v. Texas,[116] overturning Texas's laws banning homosexual sodomy, illustrates the point. There, the Court, rejecting its own prior decision in Bowers v. Hardwick,[117] held that private consensual homosexual sodomy is a right guaranteed by the substantive component of the due process clause.[118] In doing so, Justice Kennedy, speaking for the majority, focused (in part) on the question whether there was a history of laws, such as Texas's, banning homosexual sodomy while permitting heterosexual sodomy, and the Court found highly persuasive the fact that "[i]t was not until the 1970's that any State singled out same-sex relations

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[116]123 S. Ct. 2472 (2003).

[117]478 U.S. 186 (1986).

[118]Id. The Court, however, stopped short of actually holding homosexual sodomy to be a fundamental right -- a point Justice Scalia emphasized in dissent. Id. at 2488. Instead, the Court described the Texas statute as "further[ing] no legitimate state interest which can justify its intrusion into the personal and private life of the individual." Id. at 2484. It is, thus, unclear whether a fundamental right, triggering strict judicial scrutiny, is implicated by the practice of homosexual sodomy, or whether the Court simply believes the Texas law fails the rational basis test -- a point that will, no doubt, engender future litigation. See Bernard James, Lawrence, Bollinger, The National Law Journal, S8 (Aug. 4, 2003).

for criminal prosecution, and only nine States have done so."[119] Meanwhile, Justice Scalia, in dissent, chided the majority for focusing solely on the (relatively new) laws singling out homosexual sodomy such as Texas's and disregarding entirely the "longstanding history" of equally applicable laws from other states that have prohibited sodomy regardless of whether it is performed by same-sex or opposite-sex couples.[120]

A 1989 decision, Michael H. v. Gerald D.,[121] provides another illustration. There, Justice Scalia, joined by Chief Justice Rehnquist, included a controversial footnote arguing that courts conducting substantive due process inquiries ordinarily should "refer to the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified."[122] In Glucksberg, the Court appeared to follow this dictum, focusing only on the narrow question whether history supports a right to

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[119]123 S. Ct. at 2479.

[120]Id. at 2493 (Scalia, J., dissent).

[121]491 U.S. 110 (1989).

[122]Id. at 127 n.6.

assistance in suicide, and eschewing more general historical discussions about autonomy and "self definition."[123]

Justices O'Connor and Kennedy, however, filed a separate opinion in Michael H. to register their view that the Court had not always examined -- and need not always rely on -- the most specific level of tradition available.[124] Sometimes, they argued, the Court has legitimately examined history at a more "general" level. Justice Souter seemed to take this tack in the assisted suicide cases, pointing to the fact that individuals have settled rights to refuse unwanted medical care and procure abortions as evidence of a more general tradition permitting "[e]very human being of adult years and sound mind . . . to determine what shall be done with his own body."[125] Judge Reinhardt similarly placed stress on the legal history of suicide

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[123]Glucksberg, 521 U.S. at 710-19.

[124]See Michael H., 491 U.S. at 132.

[125]Glucksberg, 521 U.S. at 777 (internal quotation marks omitted).

rather than the specific history of assisted suicide and euthanasia.[126]

It is unclear, however, whether Justices O'Connor and Kennedy meant to suggest in Michael H. that a court actually may disregard an on-point "specific" tradition (e.g., the history of the law about assisting suicide) in favor of a generally analogous, but less directly applicable one (e.g., the history of the law about suicide). The primary case they cited for support, Eisenstadt v. Baird,[127] certainly does not suggest such license. There, the Court declared that laws prohibiting the sale of contraceptives to unmarried persons violate the Due Process Clause on the ground that prior cases (all dealing with married couples) suggested a general right to "reproductive privacy." In Michael H., Justices O'Connor and Kennedy pointed to the fact that, at the time Eisenstadt was decided, a long-standing and more specific tradition existed in many states outlawing the sale of contraceptives to unmarried persons. But Justices O'Connor and Kennedy neglected to mention the fact that the Court in

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[126]See Compassion in Dying, 79 F.3d at 806-10.

[127]405 U.S. 438 (1972).

Eisenstadt did not consider or even identify this more specific tradition, and the Court never offered reasons why it should be rejected in favor of a more general tradition. That Eisenstadt overlooked a "specific" tradition without comment does not offer much of a reasoned basis for rejecting specific traditions in future substantive due process cases. Besides, Eisenstadt's result can be defended fully, without contortions over historical "levels" and even without reference to due process doctrine, as an equal protection decision simply requiring the same access to contraceptives for married and unmarried persons alike.

Just as there exists dispute among history test adherents over what "level" of historical abstraction should be applied, there is also disagreement over what history is relevant. In due process cases, the Supreme Court has frequently looked not only to this Nation's history, but also to English common law. But why stop there? Why not examine Roman or Greek or some other ancient precedent as, say, Justice Blackman did in his opinion for the Court in Roe v. Wade.[128] And what about

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[128]410 U.S. 113 (1973).

contemporary experience in other western countries? The majority in Lawrence relied heavily on recent European legal development,[129] while the dissent argued vociferously that the only relevant history is America's history.[130] In Glucksberg, the Supreme Court also focused primarily on U.S. history, though it briefly examined the history of the English common law, while Judge Reinhardt devoted pages of the federal reports to describing ancient suicide practices.

Of course, even if agreement can be reached on what history is relevant, there remains the question how far forward to go. When interpreting the Fourteenth Amendment, should we limit ourselves to pre-ratification history, as originalists like Judge Robert Bork might suggest,[131] or should we look to more recent history as well? In Lawrence, the majority placed great stress on an "emerging recognition" that "liberty gives substantial protection to adult persons in deciding how to conduct their private lives in matters

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[129]123 S. Ct. at 2481.

[130]Id. at 2494-95.

[131]See, e.g., Robert H. Bork, The Tempting of America: The Political Seduction of the Law (1989) (hereinafter, "Bork, The Tempting of America").

pertaining to sex."[132] The dissent, meanwhile, argued that fundamental rights depend on "deeply rooted" traditions, not "emerging awareness[es]."[133]

### III.3 The Project

So far, we have raised questions about whether and how the history test should be applied in substantive due process disputes. We have questioned whether past majorities should be used to give meaning to a constitutional provision that was designed to protect minority rights. We have examined the problems posed by different "levels" of historical abstraction. And we have seen that how far back we look and whose history we choose to consult can influence the result we reach.

To this list of questions about whether and how the history test is to operate, we might add others: Are practicing lawyers and judges well-equipped to serve as historians? And can the history test, with its competing levels of abstraction and unresolved methodological issues, really supply the sort of

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[132]123 S. Ct. at 2480.

[133]Id. at 2493.

objective means for resolving due process disputes that the Supreme Court seems to want? To be sure, history imposes some constraint on discretion, but consider the widely divergent conclusions drawn by Judge Reinhardt and the Chief Justice in the assisted suicide cases (or by Justices Kennedy and Scalia in the homosexual sodomy case) from the same historical record.

The fact that the history test does not provide entirely objective guidance may suggest, to some, the need to refine its operation (answering definitively, for example, the critical methodological questions: what level? whose history? how far back?); others, as we shall see in Chapter V, see the shortcomings of the history test as reason to eschew the notion that the due process guarantee contains any unwritten substantive component that can be adduced through judicial exposition. For now, however, the question arises, given the history test as we know it today, methodological warts and all: what can we say about assisted suicide and euthanasia from the historical record? To answer this question, we must examine as broad a historical record as we can, consulting the ancients as well as more directly relevant English,

colonial, and American history, and examining both the specific history of assisted suicide and euthanasia as well as the more generally relevant history of suicide. It is to these tasks that we now turn.

### III.4 The Ancients

While Judge Reinhardt is correct that suicide was sometimes tolerated by ancient Greeks and Romans, often it was not and, when suicide was tolerated, there is little evidence that such toleration was linked in any way to concern for the terminally ill.

Athenian law treated suicide as a crime, "punishing" the "guilty" by amputating the corpse's right hand and denying traditional burial rituals.[134] Plato similarly condemned suicide on multiple occasions. For example, in Phaedo, Plato (through Socrates) argued that a philosopher should embrace natural death when it comes because it will free him from the shadowy cave of human existence and bring him into contact with truth.[135] But, Plato added, it is wrong to seek out death, and choosing suicide is akin

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[134]A.W. Mair, Suicide, 12 Encylopedia of Religion and Ethics 26-30 (J. Hastings, ed. 1992).

[135]Plato, Phaedo § 61c (Benjamin Jowett, ed. 2000).

to a soldier "run[ning] away" from his or her assigned post and duties.[136] In Laws, Plato condemned suicide on the grounds that it "imposes [an] unjust judgment [of death] on [oneself] in a spirit of slothful and abject cowardice."[137]

To his general support of Athenian law, Plato did add three exceptions: suicide might be permissible when compelled by (1) judicial order; (2) excruciating misfortune; or (3) moral disgrace.[138] The first category, however, is not properly a category of suicide at all. Here, Plato acknowledged merely that the victim of state execution coerced to be the agent of his own death (e.g., Socrates accepting the hemlock as his sentence after trial) is morally blameless. Likewise, in the second category, Plato did not endorse (or even appear to contemplate) rationally chosen suicide, but instead expressed compassion for deaths compelled (*anankastheis*) by misfortune -- the result perhaps of what we would today label depression or mental illness. Only in his third category did Plato

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[136]Id. § 62b-6.

[137]Plato, Laws § 873c7 (David Gallup, ed. 1999).

[138]Id. § 854c4-5.

provide any form of approval for rational, intentional acts of self-killing, but even this was limited to persons killing themselves as the result of intense moral disgrace.

In The Republic, Plato also argued that individuals should be permitted to refuse intrusive medical treatments that may lengthen their lives at the expense of making them very unpleasant:

> But with bodies diseased through and through, [Asclepius] made no attempt by regimes . . . to make a lengthy and bad life for a human being and have him produce offspring likely to be such as he; he didn't think he should care for the man who's not able to live in his established round, on the grounds that he's of no profit to himself or the city.
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> And, as for those with a naturally sickly and licentious body, they thought that living is of no profit either to themselves or others, that the art shouldn't be applied to them, and that they musn't be treated -- not even if they were richer than Midas.
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> * * *
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> Will you set down a law in the city providing . . . for an art of medicine . . . which will care for those of your citizens who have good natures in body and soul; while as for those who haven't, they'll let die the ones whose bodies are such . . . .[139]

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[139]Plato, The Republic §§ 407(d), 408(a), 409e-410a (Allan Bloom, ed. 1991).

This, however, is not so much an argument directed at a right to commit (or assist) suicide as it is an argument for what we would today call the right to refuse unwanted medical treatment.[140] Further, Plato's claim was less that a person has a right to choose whether to discontinue intrusive medical treatment and more the distinctly illiberal claim that persons dependent on such care are objectively better off dead than alive, and so should not be kept alive.

Aristotle used suicide to raise the larger question whether self-regarding acts that impose no harms on third parties can ever be considered "unjust."[141] Acts of injustice, Aristotle contended, depend in large measure on the degree of the actor's intent: Involuntary acts can be "neither unjust[] nor just";[142] similarly, acts "done in ignorance" or as a result of negligence ("e.g. he threw not with intent to wound but only to prick"), and those done with

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[140]Of course, whether these practices can be distinguished rationally is another matter, one we will take up in Chapter IV.

[141]Aristotle, Nicomachean Ethics § 1138(a)-(b) (J.A.K. Thomson, trans. 1953) (hereinafter, "Aristotle, Ethics").

[142]Id. § 1135(a).

knowledge but not after deliberation ("e.g. the acts due to anger or other passions"), do not mitigate the consequence of the act but are also sometimes "excusable."[143] By contrast, acts done "from choice" are premeditated and conscious and, thus, matters for which we are always responsible:

> [I]f a man harms another by choice, he acts unjustly; and <u>these</u> are the acts of injustice which imply that the doer is an unjust man.[144]

Having focused on the question of intentional acts, as opposed to merely accidental, negligent, or foreseen ones, Aristotle turned to the suicide question and remarked that:

> there are some just acts enjoined by law as consistent with virtue in general -- e.g. the law does not allow a man to kill himself. Again, when a man voluntarily -- that is, knowing who the victim and what the instrument is -- injures another . . . contrary to the law, he is acting unjustly. But a man who cuts his throat in a fit of anger is voluntarily doing, contrary to the right principle, what the law does not allow; therefore he is acting unjustly. But towards whom? Surely not himself, but the state; because he suffers voluntarily, and nobody is voluntarily treated unjustly. It is for this reason that the state imposes a penalty, and a kind of dishonour is attached to a man has taken his own life, on the ground that he is guilty of an offence against the state.[145]

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[143] <u>Id.</u>

[144] <u>Id.</u>

[145] <u>Id.</u> § 1138.

In this passage, Aristotle concedes that a suicide imposes no injustice on third persons -- "because he suffers voluntarily, and nobody is voluntarily treated unjustly." Nonetheless, Aristotle suggests that suicide is properly proscribed because "there are some just acts enjoined by law as consistent with virtue in general" in order to ensure "the right principle" of life.[146] Though the passage is highly ambiguous, Aristotle perhaps can be fairly read to give vent here to the view that the state has a legitimate interest in preventing the destruction of all human lives, and that this is a basic feature of justice, or what he calls the "right principle" of life.[147]

Other Greek (and Roman) thinkers were more varied in their thinking. Stoics -- recalled as champions of enduring adversity without complaint -- considered suicide an acceptable response to physical adversity. Cicero, for example, argued that "when a man's circumstances contain a preponderance of things in accordance with nature, it is appropriate for him to remain alive; when he possesses or sees in prospect a

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[146]Id.

[147]Id.

majority of the contrary things, it is appropriate for him to depart from life."[148] Pythagoras, meanwhile, strongly opposed suicide.[149] Epicurus, often cited as an advocate of comfort in life and death, was less concerned with the liberty to commit suicide than he was skeptical that suicide could ever be the product of rational choice: "he is of little account who finds many good reasons for departing from life."[150]

Under Roman law, criminals committing suicide to avoid punishment (e.g., the death penalty) or their worldly obligations (e.g., deserting soldiers and runaway slaves) were regularly punished.[151] Their corpses were abused and their fortunes were forfeited to the state, sometimes leaving wives and children penniless.[152] Meanwhile, other forms of suicide were

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[148]See, e.g., Cicero, De Finibus 60-61 (Rackham, trans. 1914).

[149]See Cicero, De Senectute xx (J.W. Allebn & J. Greenough trans. & ed. 1866) (stating Pythagoras's view that people should not "depart from their guard or station in life without the order of their commander, that is, of God").

[150]Letters, Principal Doctrines, and Vatican Sayings 68, Vatican Saying 38 (Russell Geer, trans. 1997).

[151]11 The Civil Law 129 (S. Scott. trans. 1932) (Justinian Digest, bk. 48, tit. 21, para. 3).

[152]Id.

generally allowed:

> Where persons who have not yet been accused of crime, lay violent hands on themselves, their property shall not be confiscated by the Treasury; for it is not the wickedness of the deed that renders it punishable, but it is held that the consciousness of guilt entertained by the defendant is considered to take the place of a confession.[153]

Roman law offered no basis for limiting access to suicide to the terminally ill, or even the rational and voluntary; the physically healthy and mentally ill were as free to kill themselves as the sick or competent. Antony, Brutus, Cornelia, and Cleopatra are a few examples of Roman suicides motivated not by illness but in response to simple fear of moral disgrace and dishonor (arguably just the sort of practice Plato meant to endorse in Laws).

Suicide was also treated as a form of circus entertainment. After publicly promising to do so and amid much fanfare, Peregrinus threw himself into a pyre at the Olympic Games to achieve fame. After losing a battle, Sardanapalus, King of Nineveh and Assyria, apparently gathered his wife and concubines, set himself on a luxurious couch, and ordered slaves to set

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[153] Id.

them all on fire.[154] During the Punic Wars, it was also apparently easy to recruit individuals to volunteer for execution in exchange for money paid to their heirs; others could be found, for a higher price, to be slowly beaten and mangled to death for popular entertainment.[155]

### III.5 Early Christian History

Though the Bible nowhere explicitly forbids suicide, from its earliest days Christianity taught against the practice. Addressing the question in the fifth century, Augustine argued that intentional self-destruction generally constitutes a violation of the Sixth Commandment:

> It is not without significance, that in the holy canonical books, no divine precept or permission can be discovered which allows us to bring about our own death, either to obtain immortality or to avert some evil. On the contrary, we must understand the Law of God as forbidding us to do this, where it says, "Thou shalt not kill."[156]

Augustine, however, emphasized the distinction

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[154]E. Cobham Brewer, The Dictionary of Phrase and Fable (1894).

[155]Robert Barry, The Development of the Roman Catholic Teachings on Suicide, 9 Notre Dame J.L. Ethics & Pub. Pol'y 449, 464 (1995).

[156]Augustine, The City of God Bk. I, ch. 20 (R.W. Dyson, ed. 1998) (hereinafter, "Augustine, The City of God").

between intentional and unintentional self-destruction. At the time of his writing, powerful schismatic forces threatened the unity of the Catholic Church, including the Donatists, a sect of particularly rigorous North Africans who had even attempted to murder Augustine. Donatists believed, among other things, that Christians who had caved in to persecution before Constantine formally legalized Christianity were unfit to serve the Church, and that Church teachings suggesting that the Holy Spirit imbued every clerical office were wrong, the presence of the Holy Spirit depending instead on individual priests being in a state of grace.

Donatists were regularly persecuted by church and state authorities, and eventually the death penalty was authorized. Though Augustine opposed killing the Donatists, he also opposed the Donatists' tactic of deliberately provoking their own arrests and executions. Augustine accused some Donatists of going

> so far as to offer themselves for slaughter to any travelers whom they met with arms, using violent threats that they would murder them if they failed to meet with death at their hands. Sometimes, too, they extorted with violence from any passing judge that they should be put to death by executioners . . . it was their daily sport to kill themselves by throwing themselves over

precipices, or into the water, or into the fire.[157]

While the Donatists claimed that they were martyrs, Augustine argued that true Christian martyrs are willing to accept execution rather than forsake God, but are never deliberate volunteers for death:

> I have heard that you say that the Apostle Paul intimated the lawfulness of suicide when he said, "though I give my body to be burned," [1 Cor. 13:3] supposing that because he was there enumerating all the good things which are of no avail without charity, such as the tongues of men and of angels, and all mysteries, and all knowledge, and all prophecy, and the destruction of one's goods to the poor, he intended to include among these good things the act of bringing death upon oneself. But observe carefully and learn in what sense Scripture says that any man may give his body to be burned. Certainly not that any man may throw himself into the fire when he is harassed by a pursuing enemy, but that, when he is compelled to choose between doing wrong and suffering wrong, he should refuse to do wrong rather than to suffer wrong, and so give his body into the power of the executioner, as those three men did who are being compelled to worship in the golden image, while he who was compelled threatened them with the burning fiery furnace if they did not obey. They refused to worship the image: they did not cast themselves into the fire, and yet of them it is written that they "yielded their bodies, that they might not serve nor worship any god except their God." This is the sense in which the apostle said, "If I give my body to be burned."[158]

Permitting intentional self-destruction would, Augustine feared, lead down a slippery slope. If

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[157]Select Library of Nicene and Post-Nicene Fathers of the Christian Church § 185.3.12 (various dates and translators, Eerdmans, rpt. 1976-79).

[158]Id. § 173.5.

seeking death to avoid temporal troubles were acceptable, then why not allow suicide to avoid any risk of future sin or other degradation? "If there could be any just reason at all for [suicide], surely there could be none more just than this."[159] In fact, during the sacking of Rome, Christian virgin women committed suicide in order to avoid rape and, they thought, mortal sin. Early Christians revered these women. But Augustine disagreed: "Why, then, should a [person] who has done no harm do harm to [herself], and, in slaying [herself] slay an innocent [person] so as not to suffer the crime of another? Why should [she] perpetrate on [herself] a sin of [her] own so that another's sin might not be perpetrated upon [her]?"[160]

Aquinas echoed and built upon foundations laid by Augustine (and Aristotle), submitting that suicide is

> altogether wrong for three reasons. Firstly, it runs counter to the natural inclinations of nature and charity to love and cherish oneself. Secondly, it does injury to the community to which each man belongs as a part of the whole. And thirdly, it wrongs God whose gift life is and who alone has power over life and death. What gives

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[159]Augustine, The City of God Bk. I, ch. 27.

[160]Id. Bk. I, ch. 17.

> man mastery over himself is free will. So he may licitly manage his own life in respect of everything that contributes to it; but his passage out of this life to a happier one is not subject to his own free will but to the authority of God.[161]

Aquinas's third argument involves an expressly religious appeal, and he never fully developed his second argument. But his first argument he did develop as part of a larger moral theory.

According to Aquinas, there are certain irreducible, basic human goods knowable to all persons by practical reasoning; human life is among them.[162] To do damage intentionally to the basic good of human life (whether one's own life or another's) is contrary to "nature and charity." This is not to say that killing can never be justified. Aquinas, like Aristotle and Augustine, asserted that acts performed to carry out deliberate, rational choice are different in kind from those unintended or involuntary. Intentional choices are ones we embrace, rationally accept, and are within our control; while not devoid of moral character, unintended and involuntary actions are not always

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[161]Thomas Aquinas, Summa Theologiae (hereinafter, "Aquinas, ST") Part II of the Second Part, Q.64, a.3.

[162]Id. Part I of the Second Part, Q.94, a.1-2; Part I of the Second Part, Q.10, a.1.

within our control, and thus speak less to who we are, a point to which we shall return in Chapter IV.

In a passage directly following his discussion of suicide, Aquinas argued that self-defense undertaken with the intent, not to kill the aggressor, but to stop the aggression can be a morally upright action. The victim may know that the aggressor will die as the (unintended) result of his gunshot or blow, but he or she commits no categorical wrong in acting solely with the intent of stopping an act of aggression:

> Nothing keeps one act from having two effects, one of which is in the scope of the agent's intention while the other falls outside that scope. Now moral actions are characterized by what is intended, not by what falls outside the scope of intention, for that is only incidental, as I explained previously.
>
> Thus, from the act of defending himself there can be two effects: self-preservation and the killing of the attacker. Therefore, this kind of act does not have the aspect of "wrong" on the basis that one intends to save his own life, because it is only natural to everything to preserve itself in existence as best as it can. . . .
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> [I]f he repels the attack with measured force, the defense will not be wrong. The law permits force to be repelled with measured force by one who is attacked without offering provocation. It is not necessary to salvation that a man forgo this act of measured self-defense in order to avoid the killing of another . . . .
>
> [But] it is wrong for a man to intend to kill

another man in order to defend himself.[163]

So, too, Aquinas seems to suggest in the suicide context: the act is harmful to the basic good of human life insofar as it is undertaken rationally and deliberately. But unintended self-homicides resulting, for example, from mental illness, depression, duress, fear, grief, or anger, might fall into a different moral category, and they cannot be declared absolute moral wrongs.

Augustine's (and Aquinas's) teachings on suicide influenced subsequent Christian law and practice. By 562, the Council of Braga denied funeral rites to suicides; in 693, the Council of Toledo held that anyone attempting suicide should be excommunicated. In England, the Council of Hertford in 672 denied suicides normal Christian burials; a canon dating from King Edgar's time (c. 1000) reaffirmed this position. Christianity continues to teach against suicide to this day. In 1980, the Vatican issued a Declaration on Euthanasia; Pope John Paul II has taught against suicide, including in his encyclicals, "Veritatis Splendor" and "Evangelium Vitae."[164] The American

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[163]Id. Part II of the Second Part, Q.64, a.7.

[164]Paragraph 65 of the latter condemns euthanasia as "a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person." Euthanasia is defined in sections 64

Lutheran Church, the Episcopal Church, and all branches of Judaism consider suicide an ethical wrong.[165]

### III.6 English Common Law

Early Christian history is of particular relevance to our analysis because of its influence on the common law's initial view of suicide. Writing in the mid-thirteenth century, Bracton, one of the common law's earliest authorities,[166] endorsed the Roman statute that held that a felon intentionally taking his life to escape punishment by the state was subject to having both his movable goods and real property confiscated.[167] In defiance of Roman statutes, however, Bracton added that one who deliberately kills himself "in weariness of life or because he is unwilling to endure further bodily pain" should also suffer confiscation of his

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and 65 in terms that apply to assisted suicide as well. See also National Conference of Catholic Bishops Committee for Pro-Life Activities, Nutrition and Hydration: Moral and Pastoral Reflections, 15 J. Contemp. H.L. 2 Pol's 455 (1999).

[165]See New York Task Force on Life and the Law 91 (reporting views of American Lutheran Church, the Episcopal church, and branches of Judaism). Cf. Damien Keown, Buddhism and Bioethics 44-45 (1995) (discussing respect for human life in Eastern thought).

[166]"The crown and flower of English medieval jurisprudence." 1 Frederick Pollock and Frederic Maitland, The History of English Law Before the Time of Edward I 206 (2d ed. 1952).

[167]Bracton, On the Laws and Customs of England 424 (Samuel E. Thorne, ed. 1968) (hereinafter, "Bracton").

"movable goods," though not his real property.[168] Only suicides induced by insanity -- undertaken by persons incapable of appreciating the significance of their actions (and, thus, incapable of forming an intent to kill) -- escaped punishment: "that a madman is not liable is true."[169]

Historians Michael MacDonald, of the University of Michigan, and Terence Murphy, of American University, assert that Bracton included "sheer weariness with life along with the mental defects that excused self-slaying."[170] This, however, is a questionable claim. Under Bracton's formulation, "sheer weariness" with life reduced the penalty for suicide to the confiscation of movable goods rather than all real and personal property, but, unlike suicides induced by mental illness, acts of self-destruction by those tired of life were not excused.[171]

Though Bracton stated a lesser penalty for suicides undertaken out of weariness with life or abhorrence of pain, all acts of intentional self-

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[168]Id.

[169]Id.

[170]Michael MacDonald and Terence Murphy, Sleepless Souls: Suicide in Early Modern England 22 (1990) (hereinafter, "MacDonald & Murphy, Sleepless Souls").

[171]See Bracton 424.

destruction were condemned. This is particularly notable given that Bracton otherwise permitted Roman statutes to guide his views of English suicide law. Whether Bracton abandoned Roman guidance in this single respect out of deference to intervening Christian teaching against suicide, or perhaps because forfeiture of goods had become a secular custom by the Middle Ages, is a "matter for speculation."[172]

What is not a matter for speculation is that in this one instance where he forsook Roman guidance, Bracton set the course for the common law. Five centuries later, the penalty associated with suicide had changed slightly (suicides of any kind forfeited only their movable goods), but the principle remained the same: all intentional acts of suicide were treated as wrongful. Hale so held.[173] So did Coke.[174] Blackstone likewise condemned intentional suicides -- even going so far as to decry "the pretended heroism, but real cowardice of the Stoic philosophers, who destroyed themselves to avoid those ills which they had

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[172]William Meskill, Is Suicide Murder? 3 Colum. L. Rev. 379, 380 (1903).

[173]1 Matthew Hale, Pleas of the Crown 411 (1736) (hereinafter, "Hale, Pleas").

[174]Edward Coke, Third Institute 54 (1644) (hereinafter, "Coke, Third Institute").

not the fortitude to endure."[175] Meanwhile, five hundred years after Bracton, unintentional acts of self-killing remained no crime. Suicide compelled by mental illness was often cited as the classic example.[176] But Coke also provided an illustration of an unintentional (and therefore excusable) act of self-homicide by a rational and competent person: if one were to "cut off a limb to prevent the spread of gangrene," but bleed to death as an accidental result, that would not, Coke emphasized, constitute suicide at common law.[177]

### III.7 Colonial American Experience

Pre-revolutionary American suicide law generally followed contemporary English common law and norms. Forfeiture was known in the American colonies in the seventeenth and eighteenth centuries. So was the ancient pagan practice, never formally endorsed in English common law, of dishonoring the suicide's corpse, often by burying it at a crossroads where some speculated the dead person's spirit would be lost and

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[175]4 William Blackstone, Commentaries on the Laws of England 189 (1769) (hereinafter, "Blackstone, Commentaries").

[176]E.g., 1 Hale Pleas 411; Coke Third Institute 54.

[177]Coke, Third Institute 54.

unable to find its way home to haunt others.[178]

Virginia recorded cases of ignominious burial in 1660 and 1661; in the latter instance, the coroner's jury explicitly held that the suicide was "to be buried at the next cross as the Law Requires with a stake driven through the middle of him in his grave."[179] Forfeiture was practiced in the colony as late as 1706 and 1707, though it appears that the colony's Governor sometimes interceded to protect the heirs' inheritance.[180]

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[178]Glanville Williams has hypothesized about the origin of this ancient practice: "An obvious explanation of the choice of the crossroads is that they also helped to lay the ghost by making the sign of the cross; but though this may have contributed to the survival of the custom into the Christian era, it has a much earlier ancestry. In early times and among primitive peoples even honorable burial was frequently performed at cross-roads, but this spot was specifically chosen for murderers and suicides. Among the reasons that have been suggested for the practice are that the constant traffic over the grave would help to keep the ghost down; or that the number of roads would confuse it and so prevent it from finding its way home." Glanville Williams, The Sanctity of Life and the Criminal Law 233 (1958) (hereinafter, "Williams, Sanctity of Life").

[179]W. and M. Quart., XVI, 181 (Aug. 26, 1661).

[180]Arthur P. Scott, Criminal Law in Colonial Virginia 108 n.193 (1930).

In Massachusetts, forfeiture was abandoned as early as 1641,[181] though maltreating the suicide's body apparently retained its appeal for some time. The 1672 compilation of the "General Laws and Liberties" of the Massachusetts colony, for example, intones that "considering how far Satan doth prevail," it is

> therefore order[ed], that from henceforth if any person . . . shall at any time be found by any Jury to . . . be willfully guilty of their own Death . . . [he] shall be Buried in some Common High-way where . . . a Cart-load of Stones [shall be] laid upon the Grave as a Brand of Infamy and as a warning to others to beware of the like Damnable practices.[182]

In 1647, what was to become Rhode Island also passed a statute condemning all intentional suicide and applying traditional common law penalties:

> Self-murder is by all agreed to be the most unnatural . . . wherein that he doth it, kills himself out of a premeditated hatred against his own life or other humor . . . his goods and chattel are the kind's custom, but not his debts nor land; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing.[183]

South Carolina appears to have proscribed suicide as early as 1706, instructing coroner juries to return

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[181]See Commonwealth v. Mink, 123 Mass. 422, 425-26 (1877).

[182]The Colonial Laws of Massachusetts of 1672 (William H. Whitmore, ed. 1887).

[183]The Earliest Acts and Laws of the Colony of Rhode Island and the Providence Plantations, 1647-1719 19 (J. Cushing, ed. 1977).

a felony verdict "against the Peace of our Sovereign Lady the Q[u]een, her Crown and Dignity" in cases where the decedent "voluntarily and feloniously . . . of himself did kill and murder himself."[184] In 1715, North Carolina adopted English common law ("the Laws of England are the Laws of this Government") and, with it, the traditional suicide proscription.[185]

### III.8 The Modern Consensus: Suicide

By the late 1700s and early 1800s, enforcement of the common law's forfeiture penalty began to fade in England, though formal abolition of the forfeiture penalty did not occur until 1870.[186] The ancient pagan practice of dishonoring the corpse also faded, though it, too, was not formally outlawed until much later. The 1823 burial of a suicide at the crossroads of Eaton Street, Grosvenor Place, and King's Road in central London apparently finally galvanized Parliament into action.[187]

Like England, eighteenth-century America witnessed a change in attitude regarding the criminal penalties associated with suicide. Pennsylvania led the way in

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[184]1 The Earliest Printed Laws of South Carolina, 1692-1734, 192 (J. Cushing, ed. 1978).

[185]Id. at 322.

[186]MacDonald & Murphy, Sleepless Souls 233.

[187]Id. at 236.

1701 when it rejected criminal penalties for suicide in its new "Charter of Privileges to the Province and Counties."[188] By the opening of the nineteenth century, New Hampshire, Maryland, Delaware, New Jersey, North Carolina, and Rhode Island followed suit, passing statutory or constitutional provisions repealing criminal laws against suicide.[189]

In Britian, Lord Hoffmann has suggested that the eventual decriminalization of suicide amounted to recognition of a de facto right to commit the act: "[I]ts decriminalization was a recognition that the principle of self-determination should in that case prevail over the sanctity of life."[190] American ethicist Dan Brock has offered a similar reading of the historical record:

> [t]hat suicide or attempted suicide is no longer a criminal offense in virtually all states indicates an acceptance of individual self-determination in

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[188]The Earliest Printed Laws of Pennsylvania, 1681-1713 209 (J. Cushing, ed. 1978) ("If any person, through Temptation or melancholly, shall Destroy himself, his Estate, Real & Personal, shall, notwithstanding, Descend to his wife and Children or Relations as if he had Died a natural death").

[189]See N.H. Const. pt. 2, art. 89 (1783); Md. Const. of 1776, decl. of rts. § 24; Del. Const. of 1792, art. 1, § 15; N.J. Const. of 1776, art. 17; N.C. Const. of 1778; R.I. Pub. Laws § 53, at 604 (1798).

[190]Airedale N.H.S. Trust v. Bland, [1993] A.C. 789, 827.

the taking of one's own life.[191]

Judge Reinhardt expressed much the same view in Compassion in Dying.[192]

The reading of the historical record offered by Hoffmann, Brock, and Reinhardt is open to question. To be sure, dragging the suicide's body around town, driving stakes through it, and leaving grieving families penniless had lost whatever appeal they once held in the human imagination, but it is a large leap from that fact to the conclusion that suicide had become normalized at law, let alone a matter of legal right. Indeed, even after repeating penalties for suicide, many states continued to describe it in their case law and statute books as "unlawful and criminal" and "malum in se."[193]

Rather than the result of some new social approval of suicide, the elimination of criminal penalties was more likely the result of an enlightened realization that they did no good and hurt complete innocents. With the "wrong-doer" dead and gone, seizure of his

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[191]Dan Brock, Voluntary Active Euthanasia, Hastings Center Report 22, no. 2 at 19 (1992).

[192]850 F. Supp. at 1465.

[193]See e.g., Commonwealth v. Mink, 123 Mass. 422, 429 (1877). See also Wayne LaFave & Austin Scott, Criminal Law § 7.8, at 649 (1986); New York Task Force on Life and the Law 55.

worldly goods often worked terrible hardships on the surviving spouse and orphans. Zephaniah Swift, an early American treatise writer and later Chief Justice of the Connecticut Supreme Court, explained that "[t]here can be no greater cruelty, than the inflicting a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender."[194] Thomas Jefferson, drafting a bill to reform Virginia laws, wrote that the law should "not add to the miseries of the party by punishments or forfeiture."[195] Writing with the perspective and agenda of a revolutionary against the British crown, Jefferson argued that, while penalties for suicide had been enforced in "barbarous times," with forfeiture the product of a greedy crown acting out of a "spirit of rapine and hostility . . . toward [its] subjects," such penalties were "inconsistent with the principles of moderation and justice which principally endear a republican government to its citizens."[196] The Massachusetts Supreme Judicial Court similarly, though without the same revolutionary agenda as Jefferson,

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[194]2 Zephaniah Swift, A System of the Laws of the State of Connecticut 304 (1796).

[195]2 Thomas Jefferson, The Papers of Thomas Jefferson 275 (J.P. Boyle ed. 1952) (hereinafter, "Boyle, Jefferson Papers").

[196]6 Boyle, Jefferson Papers 255.

explained the decision of that state's legislature to repeal suicide's criminal penalties "as one which may well have had its origin in consideration for the feeling of innocent surviving relatives."[197]

The change in attitude toward criminal penalties was also the result of a growing consensus that suicide is an essentially medical problem. Jefferson recognized suicide early on "as a disease."[198] Study after study in our own time by physicians and psychiatrists suggests that perhaps as many as 90 percent of all suicides may suffer from a diagnosable medical disorder.[199] In its commentary to the Model

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[197]Mink, 123 Mass. at 429.

[198]6 Boyle, Jefferson Papers 492-507.

[199]See Yeates Conwell & Eric Caine, Rational Suicide and the Right to Die: Reality and Myth, 325 New Eng. J. of Medicine 1100 (1991) ("90 to 100 percent of [suicides] die while they have a diagnosable psychiatric illness"); E.S. Schneidman, Rational Suicide and Psychiatric Disorders, 326 New Eng. J. of Medicine 889 (1992) (a "majority" of those committing suicide suffer from mental illness); Herbert Hendin and Gerald Klerman, Physician-Assisted Suicide: The Dangers of Legalization, 150 Am. J. of Psychiatry 143 (1993) (expressing similar opinion); E. Stengel, Suicide and Attempted Suicide 52 (1964) (arguing one third of people committing suicide suffer from "a neurosis or psychosis or severe personality disorder"); E. Robins, The Final Months 10, 12 (1981) (94 percent of suicides studied had a mental disorder); Brian Barraclough, et al., A Hundred Cases of Suicide: Clinical Aspects, 125 Brit. J. Psychiatry 355, 356 (1974) (93 percent of suicides studied suffered from a mental disorder).

Penal Code, the American Law Institute has summed up the contemporary view that

> [t]here is scant reason to believe the threat of punishment will have deterrent impact upon one who sets out to take his own life. . . . Moreover, it is clear that the intrusion of the criminal law into such tragedies is an abuse. There is a certain moral extravagance in imposing criminal penalties on a person who has sought his own self-destruction, who has not attempted direct injury to anyone else, and who more properly requires medical or psychiatric attention.[200]

Reinforcing the conclusion that the law had come to recognize suicide not as an accepted human right, but as a medical or social problem ill-suited to remedy through the imposition of criminal penalties, an exception to traditional battery doctrine evolved, providing both the state and private individuals with a legal privilege to forcibly detain persons attempting suicide.[201] Most American states have now codified such an exception to common law battery doctrine; New York's statute is typical, allowing the civil detention of one "who appears to be mentally ill and is conducting himself in a manner which poses substantial risk of physical harm to himself as manifested by threats or

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[200]Model Penal Code § 210.5, cmt. 94.

[201]See, e.g., 2 G.C Addison, Law of Torts § 819, at 708 (3d ed. 1870) ("[A] person disordered in his mind who seems disposed to do mischief to himself or another person, the restraint being both necessary for the safety of the lunatic and the preservation of the public peace.").

attempts at suicide."[202] Similarly, in California "any person [who], as a result of a mental disorder, is a danger . . . to himself or herself" can be committed involuntarily to a mental health facility for a period of time.[203]

### III.9 The Modern Consensus, Continued: Assisting Suicide and Euthanasia

The Hoffmann-Brock-Reinhardt hypothesis that elimination of suicide's criminal penalties signaled an endorsement or acceptance of the practice is further called into doubt by specific developments in the law of assisted suicide and euthanasia. Originally, the common law drew a distinction between different sorts of suicide assistants: Assistants present at the suicide's death could be held guilty of murder or manslaughter, but those clever enough to slip out while the suicide drank the poison they supplied or used the gun they provided were held innocent of any crime. Under ancient common law doctrine, assistants before the fact to <u>any</u> crime could not be tried until the principal criminal actor was convicted; since the

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[202]N.Y. Mental Hyg. Law § 9.41 (McKinney Supp. 1983-84).

[203]Cal. Welf. & Inst. Code § 5250 (West 1984). <u>See also</u> Kate E. Bloch, <u>The Role of Law in Suicide Prevention: Beyond Civil Commitment -- A Bystander Duty to Report Suicide Threats</u>, 39 Stan. L. Rev. 929, 934 n.36 (1987) (compiling citations to similar statutes in most states).

suicide was unavailable for prosecution, courts (syllogistically) reasoned that they could not try any accessory before the fact to that particular "crime."[204]

So went the common law in England and most American jurisdictions until 1861 when statutes were enacted abolishing the practical effect of the distinction between accessories before and after the fact.[205] Although this change in the general criminal law doctrine was made without any specific reference to assisted suicide, courts on both sides of the Atlantic soon came to conclude that accessories before the fact to suicide could be held liable for murder or manslaughter.[206] Thus, almost 100 years after the

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[204]See, e.g., Rex v. Russell, [1832] 1 Moody C.C. 356; Regina v. Ledington, [1839] 9 Car. & P. 79; 2 Francis Wharton, Criminal Law 31-32 (1874). There is a curious tension between this rule and the common law's decision to punish suicide. On the one hand, the common law deemed the deceased beyond the reach of legal process for the purposes of inquiring whether he was a principal in his own murder so that his accessory might be tried. On the other hand, the common law considered the deceased within legal process for the purpose of investing a coroner's jury to inquire into whether the deceased was competent and an adult when he took his own life (and to determine that he did, in fact, kill himself), as well as for the purposes of "punishing" him by forfeiture of his assets to the crown or state.

[205]See 24 & 25 Vict. ch. 23, sec. 94; Francis Wharton, Criminal Law 33 (1874) (noting that by 1874 the "old technical rule" that an accessory before the fact could not be convicted before the principal had been "corrected by statute" in many American states).

[206]See, e.g., Rex v. Croft, [1944] K.B. 296 (C.C.A.) (upholding conviction of the survivor of a suicide pact); Commonwealth v. Hicks, 82 S.W. 265, 266

abolition of penalties for suicide itself, common law courts were in the process of expanding criminal liability for its assistance.

Glanville Williams has charged that this new development in liability for accessories before the fact is a "good example[] of the purely mechanical manufacture of criminal law, with no reference to penal policy."[207] But applying the same rule to the canny suicide assistant who exited the room at a propitious moment and the unsophisticated assistant who remained brought the common law into harmony -- eliminating (rather than creating) a mechanical distinction; indeed, it was hailed at the time as an equitable and enlightened change in penal policy.[208] Williams's complaint thus seems, at bottom, less an attack on the logic of the law's progression than the policy direction it took.

As statutes came to supplant the common law as the

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(Ky. App. 1904) ("In this case, it would be impossible to punish the principal; but it is not believed that under any sound reasoning the accessory [before the fact] would thereby go scot free."); Burnett v. People, 68 N.E. 505 (1903) ("it becomes immaterial what was the character of the crime committed by the principal or whether there was any crime"); Regina v. Gaylor, [1857] D. & B. 228, 169 Eng. Rep. 1011 (C.C.R.) (upholding conviction).

[207]Williams, The Sanctity of Life 265.

[208]See, e.g., Richard Wolfrom, The Criminal Aspect of Suicide, 39 Dick. L. Rev. 47 (1934-1935).

primary vehicle for regulating many human affairs, assisted suicide was codified as a crime in most American jurisdictions. By the time the Fourteenth Amendment was ratified in 1868, nine of the then 37 states had adopted statutes making assisted suicide a crime.[209] The Field Code, a reformist codification project that influenced legislative efforts in state after state during the nineteenth century, included a specific prohibition against assisted suicide.[210] I have undertaken a survey of contemporary state statutory laws concerning assisted suicide, the results of which can be found at Appendix A. Currently, thirty-seven jurisdictions have statutes clearly banning the practice of assisted suicide, while two more states (Michigan and Montana) also appear to have statutory provisions that outlaw the practice.[211] Of the remaining eleven states, six treat assisted suicide as a common

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[209]Kevorkian, 447 Mich. at 777-78, 527 N.W.2d at 731.

[210]The Field Code § 231 ("Aiding Suicide. Every person, who willfully, in any manner, advises, encourages, abets or assists another person in taking his own life, is guilty of aiding suicide."). The influence of the Field Code can be readily seen by comparing its language to current assisted suicide laws in several states. See Appendix A.

[211]See Appendix A. Whether Michigan's statute remains in effect may be immaterial, because the state also treats assisted suicide as a common law crime. See Kevorkian, 447 Mich. 436, 527 N.W.2d 714.

law crime,[212] while four (Utah, Ohio, Wyoming, and North Carolina) have no statute dealing with the issue and have apparently yet to decide a reported case testing the common law status of assisted suicide. However, two of those four states (Utah and Ohio) have medical directive laws that express the legislature's disapproval of mercy killing, and one (North Carolina) has a bill pending in the legislature to make assisted suicide a statutory crime.[213] Only one state in the country (Oregon) has a law approving the practice of assisted suicide, which itself is currently under legal challenge.[214] On the federal level, a Republican Congress and Democratic President in 1997 adopted a law denying the use of federal funds in connection with any act of assisted suicide.[215]

The law of euthanasia runs an even straighter course than the law of assisted suicide. Consensual euthanasia is, again, a form of intentional homicide -- albeit motivated by a sense of mercy and sometimes performed with the consent of the deceased. At common

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[212]Id.

[213]Id.

[214]See Ch. I, supra.

[215]See 42 U.S.C. § 14401, et seq.

law and by statute, it is treated as murder.[216] Courts have refused to treat the victim's consent or the killer's motive as a defense or a reason to accede to defendants' requests for a jury instruction on assisted suicide as a lesser included offense,[217] though they have sometimes treated both the victim's consent and the killer's motives as reasons to mitigate the defendant's punishment.[218]

While the proscription of assisted suicide and euthanasia has been virtually absolute in America, a notable exception existed for a short time. In 1902, the Texas Court of Criminal Appeals in Grace v. State reasoned, much along the same lines as Hoffmann, Brock, and Reinhard, that, because suicide and its attempt were no longer crimes, assisting a suicide should not be illegal either: "So far as the law is concerned, the

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[216]See, e.g., State v. Fuller, 203 Neb. 233, 241, 278 N.W.2d 756, 761 (1979) ("Murder is no less murder because the homicide is committed at the desire of the victim.") (citation omitted); Turner v. State, 119 Tenn. 663, 108 S.W. 1139, 1141 (1908); Martin v. Commonwealth, 184 Va. 1009, 37 S.E. 2d 43 (1946); N.Y. Penal Law § 125.25 (McKinney 1987) (euthanasia falls under definition of second degree murder).

[217]See, e.g., State v. Cobb, 229 Kan. 522, 525-26, 625 P.2d 1133, 1136 (1981) (rejecting defendant's claim that the court should have instructed the jury on assisted suicide rather than homicide where the defendant "was a direct participant in the overt act of shooting [the victim], which caused his death").

[218]See, e.g., Model Penal Code, § 210.5, cmt. at 106; N.Y. Penal Law §§ 125.20(2), 125.25(1)(a) (McKinney 1987).

suicide is innocent; therefore the party who furnishes the means to the suicide must also be innocent of violating the law."[219]

Grace is logically unsound. The rationales for decriminalizing suicide -- fairness to the suicide's innocent family and recognition of the medical causes of suicide -- do not apply to assisted suicide: the penalty for assisted suicide falls on the actor himself, not on his or her family, and there is no reason to presume the suicide assistant to be suffering from any form of mental illness. Moreover, if Grace were right, euthanasia and consensual homicide would have to be decriminalized as well -- if one who hands a gun to the suicide commits no crime, surely one who pulls the trigger at the suicide's request must not either. Texas courts, however, were unwilling to follow Grace to that logical conclusion, and instead continued to hold euthanasia illegal.[220] The Texas state legislature subsequently removed any question by adopting a statute criminalizing the assistance of suicide, thus effectively overruling Grace.[221]

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[219]69 S.W. 529 (Tex. Crim. App. 1902).

[220]Aven v. State, 277 S.W. 1080 (Tex. Crim. App. 1925).

[221]See Tex. Penal Code § 22.08 (1999). The statute has been in place for at least three decades in its current formulation. See id.

While state laws against assisted suicide and euthanasia date back a century or more, in recent years many jurisdictions have reconsidered and reaffirmed them. In 1980, the American Law Institute conducted a thorough review of state laws on assisted suicide, acknowledged the continuing widespread support for criminalization,[222] and endorsed two criminal provisions of its own.[223] In the 1990s, both New York and Michigan convened commissions to reconsider assisted suicide and euthanasia. The New York commission issued a report recommending that existing laws against the practices be retained. While the Michigan panel was unable to achieve unanimity, the state legislature subsequently chose to enact a statute strengthening that state's existing common law ban on assisted suicide. Other states have followed with new statutes banning the practice.[224]

In recent years, virtually every state in the

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[222]Model Penal Code § 210.5, cmt. 5, at 101 n.23 (discussing state statutes).

[223]Id. § 210.5(1) and (2): "(1) Causing Suicide as Criminal Homicide. A person may be convicted of criminal homicide for causing another to commit suicide only if he purposely causes such suicide by force, duress, or deception. (2) Aiding or Soliciting Suicide as an Independent Offense. A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor."

[224]See Ch. I, supra.

country has also passed statutes establishing living wills or durable powers of attorney in health-care situations, and many of these laws contain language making plain that the state does not intend to encourage or permit suicide or its assistance.[225]

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[225]See Ala. Code §22-8A-10 (1990); Alaska Stat. Ann. §§ 18.12.080(a), (f) (1996); Ariz. Rev. Stat. Ann. § 36-3210 (Supp. 1996); Ark. Code Ann. §§ 20-13-905(a), (f), 20-17-210(a), (g) (1991 and Supp. 1995); Cal. Heath & Safety Code Ann. §§ 7191.5(a), (g) (West Supp. 1997); Cal. Prob. Code Ann. § 4723 (West Supp. 1997); Colo. Rev. Stat. §§ 15-14-504(4), 15-18-112(1), 15-18.5-101(3), 15-18.6-108 (1987 and Supp. 1996); Conn. Gen. Stat. § 19a-575 (Supp. 1996); Del. Code Ann., Tit. 16, § 2512 (Supp. 1996); D.C. Code Ann. §§ 6-2430, 21-2212 (1995 and Supp. 1996); Fla. Stat. §§ 765.309(1), (2) (Supp. 1997); Ga. Code Ann. §§ 31-32-11(b), 31-36-2(b) (1996); Haw. Rev. Stat. § 327D-13 (1996); Idaho Code § 39-152 (Supp. 1996); Ill. Comp. Stat., ch. 755, §§ 35/9(f), 40/5, 40/50, 45/2-1 (1992); Ind. Code §§ 16-36-1-13, 16-36-4-19,30-5-5-17 (1994 and Supp. 1996); Iowa Code §§ 144A.11.1-144A.11.6, 144B.12.2 (1989 and West Supp. 1997); Kan. Stat. Ann. § 65-28, 109 (1985); Ky. Rev. Stat. Ann. § 311.638 (Baldwin Supp. 1992); La. Rev. Stat. Ann. 40: §§ 1299.58.10(A), (B) (West 1992); Me. Rev. Stat. Ann. Tit. 18-A, §§ 5-813(b), (c) (West Supp. 1996); Mass. Gen. Laws 201D, § 12 (Supp. 1997); Md. Health Code Ann. § 5-611(c) (1994); Mich. Comp. Laws Ann. § 700.496(20) (West 1995); Minn. Stat. §§ 145B.14, 145C.14, (Supp. 1997); Miss. Code Ann. §§ 41-41-117(2), 41-41-119(1) (Supp. 1992); Mo. Rev. Stat. §§ 459.015.3, 459.055(5) (1992); Mont. Code Ann. §§ 50-9-205(1), (7), 50-10-104(1), (6) (1995); Neb. Rev. Stat. §§ 20-412(1), (7), 30-3401(3) (1995); N.H. Rev. Stat. Ann. §§ 137-H:10, 137-H:13, 137-J:1 (1996); N.J. Stat. Ann. §§ 26:2H-54(d) (e), 26:2H-77 (West 1996); N.M. Stat. Ann §§ 24-7A-13(B)(1), (C) (Supp. 1995); N.Y. Pub. Health Law § 2989(3) (1993); Nev. Rev. Stat. § 449.670(2) (1996); N.C. Gen. Stat. §§ 90-320(b), 90-321(f) (1993); N.D. Cent. Code §§ 23-06.4-01, 23-06.5-01 (1991); Ohio Cent. Code Ann. § 2133.12(A), (D) (Supp. 1996); Okla. Stat. Ann. Tit. 63, §§ 3101.2 (C), 3101.12(A), (G) (1996), 20 Pa. Cons. Stat. § 5402(b) (Supp. 1996); R.I. Gen. Laws §§ 23-4.10-9(a), (f), 23-4.11-10(a), (f) (1996); S.C. Code Ann. §§ 44-77-130, 44-78-50(A), (C), 62-5-504(O) (Supp. 1996); S.D.

Meanwhile, repeated efforts to legalize assisted suicide and euthanasia in at least 15 states have resulted in failure after failure.[226]

Recent British experience parallels the American experience. In 1993-1994, the House of Lords commissioned a select committee to review provisions of Britain's 1961 Suicide Act concerning assisted suicide;[227] after lengthy hearings where ethicists, physicians, and legal philosophers were heard, the panel opted in favor of retaining existing law.[228] In 1999, the Council of Europe likewise issued a report on the terminally ill and dying and recommended the

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Codified Laws §§ 34-12D-14, 34-12D-20 (1994) Tenn. Code Ann. §§ 32-11-110(a), 39-13-216 (Supp. 1996); Tex. Health & Safety Code Ann. §§ 672.017, 672.020, 672.021 (1992); Utah Code Ann. §§ 75-2-1116, 75-2-1118 (1993); Va. Code Ann. § 54.1-2990 (1994); Vt. Stat. Ann. Tit. 18 § 5260 (1987); V.I. Code Ann., Tit. 19, §§ 198(a), (g) (1995); Wash. Rev. Code §§ 70,122.070 (1), 70.122.100 (Supp. 1997); W. Va. Code §§ 16-30-10, 16-30A-16(a), 16-30B-2(b), 16-30B-13, 16-30C-14 (1995); Wis. Stat. §§ 154.11 (1) (6) 154.25(7), 155.70(7) (Supp. 1996); Wyo. Stat. §§ 3-5-211, 35-22-109, 35-22-208 (1994 Supp. 1996). See also 42 U.S.C. § 14402(b)(1)(2), (4) ("Assisted Suicide Funding Restriction Act of 1997").

[226]See Ch. I, supra.

[227]In 1961 the British Parliament enacted a statute holding that "[a] person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction to imprisonment for a term not exceeding fourteen years." Suicide Act, 1961, Ch. 60.

[228]See House of Lords Report HL Paper, 21-I of 1993-1994 Session.

retention of laws "upholding the prohibition against intentionally taking the life of terminally ill or dying persons," concluding "that terminally ill or dying persons' wish to die never constitutes any legal claim to die at the hand of another person."[229]

In November 2001, a panel of the House of Lords, sitting as England's final court of appeal, heard the case of Regina (Pretty) v. Director of Public Prosecutions. The Lords there rejected, by a vote of 5-0, the notion that the European Convention for the Protection of Human Rights and Fundamental Freedoms trumps Britain's 1961 statute and ensconces a right to assisted suicide in European law.[230] The petitioner argued, among other things, that the putative right to assisted suicide stems from Article 2 of the Convention, which (perhaps somewhat ironically) protects the right to life. While the Lords acknowledged that this provision was enacted in order to preserve the full dignity of human life, they held that "an article with that effect cannot be interpreted as conferring a right to die or to enlist the aid of another in bringing about one's own death."[231]

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[229]Council of Europe's Recommendation 1418 2-4 (1999).

[230]See [2001] UKHL 61, 1 AC 800.

[231]Id. Judgment of Lord Bingham of Cornhill § 5.

Turning to the petitioner's argument under Article 8 of the European Convention, which protects a right to privacy, the Lords agreed that a non-trivial privacy/autonomy interest was at stake in the proffered right to assisted suicide, but held that it is "for member states" of the European Convention to balance that interest against "the risk and likely incidence of abuse if the prohibition on assisted suicide were relaxed."[232] The Lords noted that a select committee had considered the assisted suicide question in 1993-1994 and concluded that a blanket prohibition against the practice was justified precisely because of the perceived possibility that "vulnerable people -- the elderly, lonely, sick or distressed -- would feel pressure, real or imagined, to request early death . . . [and] the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."[233]

Finally, the Lords considered the argument that it is discriminatory, and thus a violation of Article 14's guarantee of equal treatment under law, to permit the able-bodied the "right" to commit suicide while denying those stricken with physical maladies the right to seek

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[232] Id. § 29.

[233] Id. (internal quotation marks omitted).

needed assistance in their self-destruction. The Lords rejected this argument, too, holding, as I have suggested in the foregoing, that this argument is "based on a misconception"; suicide was decriminalized not because it was ever deemed a legal right, but "because it cast an unwarranted stigma on innocent members of the suicide's family."[234] The European Court of Human Rights affirmed the Lords' result on April 29, 2002.[235]

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[234] Id. § 35. Petitioner also raised arguments under other articles of the Human Rights Convention, including those forbidding inhuman torture (Article 3) and guaranteeing freedom of thought (Article 9). These arguments were also rejected.

[235] Pretty v. United Kingdom, [2002] 2 FCR 97 (European Court of Human Rights, Fourth Section). The European Court's handling of the Article 8 issue was, however, softer than the Lords'. The European Court began by explaining that, "[w]ithout in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. . . . The Court is not prepared to exclude that [precluding Ms. Pretty from obtaining assistance in dying] constitutes an interference with her right to respect for private life." Id. ¶ 65. While suggesting that respect for the sanctity of life and permitting assisted suicide based on quality of life considerations might be reconcilable, the Court did no more to explore or explain that supposition. Instead, the Court proceeded to hold that, even though Ms. Pretty had a valid claim to privacy, states have a right to interfere with such claims to the extent necessary to address "pressing social need" with rules "proportionate to the legitimate aim pursued." Id. ¶ 70. Here, the European Court held, the British government had done enough to establish that a blanket ban on assisted suicide is a proportionate (though, the Court heavily hinted, not the only possible) response to the concern that vulnerable persons might be induced or coerced to accept assisted suicide under any other

Other countries, including Canada, Australia, New Zealand, and Hungary have in recent years likewise actively reconsidered and reaffirmed their laws banning assisted suicide.[236]

## III.10 Conclusion

We have seen that the history test, originally designed as a means of providing objective guidance in substantive due process disputes, somewhat ironically relies on the views of legislative majorities (past ones, at that) to interpret a provision designed to promote the advancement of minority rights. And, rather than securing an absolutely objective means of resolving substantive due process disputes, the history test is the subject of considerable methodological disputes.

Mindful of such difficulties, but seeking to apply the history test faithfully, we examined the historical

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regime: "States are entitled to regulate through the operation of the general criminal law activities which are detrimental to the life and safety of other individuals. . . . The more serious the harm involved the more heavily will weigh in the balance considerations of public health and safety against the countervailing principle of personal autonomy. . . . . It is primarily for States to assess the risk and likely incidence of abuse if the general prohibition on assisted suicides were relaxed or if exceptions were to be created. Clear risks of abuse do exist, notwithstanding arguments as to the possibility of safeguards and protective procedures." Id. ¶ 74.

[236] See Ch. I, supra (citing developments).

record broadly in terms of time and at different levels of abstraction. We found that ancient suicide practices do lend some support for the normalization of assisted suicide and euthanasia. But such support is both limited and suggestive of a right not to seek out death in response to illness or pain, but of a right far broader than that, perhaps extending to some arguably bizarre practices.

As we have seen, some have fastened on the eventual abandonment of criminal penalties for suicide in American and English common law as suggestive of a right to assisted suicide and euthanasia. But, we found that this reading of the historical record of suicide is questionable; it appears that the abandonment of criminal penalties for suicide betokened less any social or legal endorsement of the practice than it did a growing consensus that suicide is essentially a medical problem. This reading of the record is confirmed by the advent of a legal privilege to detain those who attempt suicide; the fact that many states continued to describe suicide itself as a "wrong"; recently enacted living will statutes which disapprove of suicide and its assistance; and by an examination of the more specific practices of assisted suicide and euthanasia, both of which have remained unlawful throughout the history of Anglo-American law.

# CHAPTER IV

## ARGUMENTS FROM FAIRNESS: *IF* A RIGHT TO REFUSE, *THEN* A RIGHT TO ASSISTED SUICIDE?

### IV.1 Introduction

While there is only modest support in the historical record for the creation of a right to assisted suicide or euthanasia, over the last 20 years virtually every American jurisdiction has come to recognize a right to refuse medical treatment grounded in common law principles that bar nonconsensual touchings and require informed consent before the administration of medical treatment.[1]

Debate persists over many aspects of this new right, however, including, for example, whether and how to extend the right to incompetent persons. Increasingly, "living wills" and "advance directives" are used to instruct family members and physicians on a patient's wishes in the event he or she becomes

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[1]See, e.g., Cruzan, 497 U.S. 261; Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); In re Conroy, 486 A.2d 1209 (N.J. 1985).

incompetent. But what of infants or adults who have never been competent, or persons who become incompetent but leave behind no instructions? Some states have tried to extend the right to refuse treatment to these persons by "substituting the judgment" of a competent, court-designated, person for the judgment of the incompetent patient.[2] Others have developed a "best interest test," whereby courts themselves purport to decide what is in the incompetent's best interests.[3] Both of these doctrines seek to give meaning to a right ordinarily dependent on choice to patients incapable of choosing -- and to do so through an agent never selected by the patient.

I will return to some of the central questions raised by patient "refusals" of care later, in Chapter X. For now, the essential point is that, since the first right to refuse case was decided by the New Jersey State Supreme Court in 1976,[4] virtually every state in the nation has recognized a right, belonging at least to competent adults, to refuse basic, life-sustaining medical care, including tubes supplying food and water. Given the widespread acceptance of such a

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[2]See Cruzan, 497 U.S. at 269-71; Alan Meisel, The Right to Die § 9.7 (1988) and 181-87 (Supp. 1992) (hereinafter, "Meisel, The Right to Die").

[3]Id.

[4]In re Quinlan, 355 A.2d 647 (N.J. 1976).

right, the question follows whether a right to assistance in suicide and euthanasia must also be accepted. If patients have a right to tell their doctors to remove respirators or feeding tubes, in fairness should they also have a right to tell their physicians to administer lethal injections?

The Second Circuit answered this fairness or equal protection question in the affirmative. The federal district court in the Washington State litigation did too. The Supreme Court disagreed, but only in the face of serious questions raised by Justice Stevens and only in the context of a facial challenge. Therefore, no definitive majority ruling on whether a right to euthanasia and assistance in suicide exists <u>as applied</u> to rational, terminally ill patients. And Justice O'Connor left ample room for us to speculate that she (and several other concurring Justices) might find equal protection arguments more availing in such a case.

In what follows, I identify three potential bases for distinguishing between the right to refuse, on the one hand, and the proffered right to assistance in suicide or euthanasia, on the other. Various courts have found two of these potential distinctions -- based on causation and the act/omission distinction -- persuasive grounds for distinguishing between the

practices and, thus, upholding laws banning assisted suicide and euthanasia. Upon further examination, however, I suggest that these courts have overstated the strength of these distinctions.

I then turn to consider the third potential distinction suggested by the case law -- based on intent. Unlike the causation and act/omission distinctions, I suggest that an intent-based distinction may work sufficiently well to withstand a constitutional equal protection challenge. Assisting suicide and euthanasia differ from the right to refuse in that they necessarily entail an intent to kill (and, with it, the judgment that a patient's life is no longer worth living). Such an intention may be present in a decision to refuse treatment but, I suggest, it need not be; though this distinction is obviously a limited one, I suggest that it cannot be dismissed as irrational or devoid of moral force.

### IV.2 A Causation-Based Distinction?

The Supreme Court (like the New York trial court before it) concluded that refusing life-sustaining care and suicide are distinguishable because the one merely "allow[s] nature to take its course," while the other involves an "unnatural" act. This "natural-unnatural" distinction ultimately boils down to an argument over causation: According to this view, rejecting treatment

allows "nature" to cause death, but accepting a lethal injection is "unnatural" because it introduces a new, human causal agent into the picture.

Causation, however, is a legal chameleon.[5] To illustrate the problem, suppose that a driver operates a car over miles of highway at an excessive speed and arrives at a street corner just as a child darts from the curb. Do we say that the driver's excessive speed "caused" the death?[6] Suppose we change the hypothetical: the driver knows in advance that the child will dash into the street and drives the car at a calculated speed in order to arrive at the precise moment the child enters the street. Doesn't that change or strengthen our view about the "cause" of the child's death? In fact, what we perceive as a responsible or causal force may be determined less by a strictly mechanical review of the physical evidence than by an assessment of someone's mental state, our sense of justice, or common sense.

Consider, too, the case of Shirley Egan. On March

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[5]"There is perhaps nothing in the entire field of law which has called forth more disagreement, or upon which the opinions are in such a welter of opinion," as causation doctrine. W. Page Keeton (ed.), Prosser and Keeton on the Law of Torts 263 (5th ed. 1984) (hereinafter, "Prosser and Keeton").

[6]The example is taken from Prosser and Keeton 263-64 & n.6.

8, 1999, Egan's 42-year-old daughter ~~raised~~ the prospect of putting the 68-year-old Egan into a nursing home. Egan responded by shooting her daughter, paralyzing her from the neck down. When Egan's daughter declined life support and died, prosecutors were left to puzzle over whether to charge Egan with murder, as the causal agent of her daughter's death, or with attempted murder, in effect conceding that the daughter's death was "caused" by her refusal of extraordinary life-sustaining measures.[7] Quill, too, reflects the difficulty often associated with causation arguments. There, the U.S. Supreme Court argued that "nature" is the "cause" of death when patients refuse or discontinue unwanted treatment. Meanwhile, three judges of the Second Circuit came to just the opposite view in the same case, explaining that there

> is nothing 'natural' about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and withdrawal of ventilation brings about respiratory failure. . . . It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or the condition from which the patient suffers.[8]

Though causation may be a slippery basis on which

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[7]See Deborah Sharp, Web-Wired Courtroom Lets World Attend Fla. Trial, USA Today, at 3A (Aug. 17, 1999).

[8]Quill, 80 F.3d at 729.

to distinguish between the right to refuse and assisted suicide or euthanasia, it must be acknowledged that the Second Circuit's criticisms are not themselves free from question. Consider, for example, patients who refuse life-sustaining care before its introduction. At least these patients appear to "let nature take its course," even according to the Second Circuit's reasoning; there is no "intervening" artificial care whose withdrawal can be identified as a cause of death. And even for patients who withdraw previously accepted life-sustaining care, one might reasonably question whether it is more accurate to say that the action of withdrawal allows "nature" to resume its course after a temporary detour rather than to label the withdrawal of care as an "intervening" causal agent.

Incomplete though its causation analysis is, the Second Circuit nonetheless has a point. When patients decide to forgo or withdraw basic care like food and water it is hard to say that such human choice didn't have any causal role in their death. Saying "nature" is responsible for deaths in many right-to-refuse cases is thus something like saying that "speed" is responsible for the death of the child crossing the street when the driver set off knowing the child would dart in front of his car and die: it is a causal factor, but perhaps not the only one, or even the most

proximate one.

### IV.3 An Act-Omission Distinction?

The New York trial court proffered another distinction between assisting suicide and refusing treatment, arguing that the former involves an affirmative act while the latter amounts only to an omission. The Second Circuit rejected this distinction, reasoning that "[t]he writing of a prescription to hasten death . . . involves a far less active role for the physician than is required to bring about death through asphyxiation, starvation, or dehydration."[9] The Supreme Court never addressed the act-omission distinction, leaving us to speculate on the reason for its silence: Did it agree with the Second Circuit? Or did the Court simply conclude that there was no reason to reach the issue, having drawn causation- and intent-based distinctions between assisted suicide and refusing care?

The act-omission distinction is deeply entrenched in American doctrinal law. But here, as with causation, the distinction is readily manipulable. Refusing to eat can be cast as "omitting" food or "actively" starving onself. Removing tubes that supply life sustaining food and water can be painted as

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[9]Id.

"actively" pulling the plug or "omitting" the provision of medical care. As Justice Scalia has asked, why would we

> say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide; or that one may not intentionally lock onself into a cold storage locker, but may refrain from coming indoors when the temperature drops below freezing?[10]

Consider in this regard Airedale N.H.S. Trust v. Bland, a decision to which we will return in greater detail in Chapter X. Tony Bland, a British teenager, was crushed while standing in the spectators' pen at an English soccer match. His injuries left him in a so-called "vegetative" state. That is, he was not dying of his underlying maladies, but depended upon tubes to supply him with food and water so that he could live in a comatose condition. His doctors eventually sought to discontinue this care. The case worked its way to the House of Lords, for the first time raising the right to refuse issue in Britain's highest court. The Official Solicitor charged with representing Bland argued against removing his feeding tubes on the ground that to remove them would amount to the intentional taking of human life, and therefore constitute an unlawful act of homicide. A majority of the Lords accepted the submission that the doctors intended to kill Bland; as

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[10]Cruzan, 497 U.S. at 296 (Scalia, J., concurring).

Lord Browne-Wilkinson put it, "[a]s to the element of intention . . . in my judgment there can be no real doubt that it is present in this case: the whole purpose of stopping artificial feeding is to bring about the death of Anthony Bland."[11]

Seeking nonetheless to avoid the unwelcome conclusion that Bland's death would be unlawful, the Lords sought to cast the cessation of care as an omission rather than an active step. Declining treatment would, the Lords reasoned, merely be permitting nature to take its course and, thus, not an act of murder. As Lord Goff put it,

> the law draws a crucial distinction between cases in which a doctor decides not . . . to prolong life, and those in which he decides . . . actively to bring his patient's life to an end. . . . As I have already indicated, the former may be lawful. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering . . . . So to act is to cross the Rubicon which runs between on the one hand the care of the living and on the other hand euthanasia -- actively causing his death to avoid or end his suffering. Euthanasia is not lawful at common law.[12]

The Lords, thus, placed enormous weight on the act-omission distinction, seemingly going so far as to suggest that represents a moral/legal "Rubicon," whereby acts taking life amount to unlawful homicide

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[11]Bland, [1993] A.C. 789.

[12]Id.

while omissions do not. But the Lords did little to explain why omissions of care cannot, at least where an intention to kill is present (as they acknowledged it was in the case before them), also qualify as acts of murder. Nor did the Lords offer any convincing reason for choosing to classify the removal of Bland's tubes as an "omission" of care, rather than an "active" step. In fact, the Lords themselves repeatedly questioned the very distinction they drew. Lord Browne-Wilkinson, for example, candidly admitted that "the positive act of removing the nasogastric tube presents more difficulty. It is undoubtedly a positive act."[13] Lord Goff conceded that "it may be difficult to describe what the doctor actually does as an omission, for example where he takes some positive step to bring the life support to an end."[14] And Lord Mustill expressed "acute unease" about resting the Lords' decision on the "morally and intellectually dubious distinction between acts and omissions," given, as he put it, that "however much the terminologies may differ[,] the ethical status of the two courses of action is for all relevant purposes indistinguishable."[15]

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[13]Id.

[14]Id.

[15]Id.

## IV.4 Toward an Intent-Based Distinction: The Insight of the Double Effect Principle

In 1999, Richard Epstein wrote a book in which he argued for a right to assisted suicide in part on the basis of what he called the "autonomy flip-flop."[16] It is, Epstein argued, an inexplicable "paradox" that, under the rule laid down by Glucksberg and Quill, patients are allowed to make their own decisions when to cease medical treatment, but are not allowed to make the decision when to seek out death: "The distinction between the two cases is, ultimately, not principled but pragmatic."[17] Oddly, however, in reaching this conclusion Epstein did not first consider the Supreme Court's alternative holding that refusing care and assisted suicide rationally differ because of the intentions behind them. A physician who withdraws care pursuant to a patient's request, the Court held, "purposefully intends, or may so intend, only to respect his patient's wishes."[18] By contrast, the Court concluded, a doctor assisting a suicide "must necessarily and indubitably, intend primarily that the patient be made dead."[19] The Court's distinction, to be

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[16]Epstein, Mortal Peril 285.

[17]Id. at 292.

[18]Quill, 521 U.S. at 801.

[19]Id. at 802 (quotation marks omitted).

sure, was quickly drawn and briefly defended, and it is also open to many criticisms, only some of which were suggested by Justice Stevens in his concurrence. But before one can reach the conclusion that Epstein suggested, some consideration of an intent-based distinction between refusing care and assisting suicide is warranted.

To ascertain whether a meaningful moral line can be drawn between assisted suicide and the right to refuse on the basis of intent, we must first ascertain whether a meaningful moral line can ever be drawn between intended and unintended consequences. The notion that intended consequences do possess a special moral character, tacitly endorsed by the U.S. Supreme Court in Quill, is often called the principle of "double effect," and sometimes associated with Thomistic moral philosophy. The principle is commonly interpreted as setting forth certain conditions for assessing whether a person may morally perform an action from which two effects will follow, one bad, and the other good: The agent may not positively will the bad effect, but may merely permit it; if the agent can attain the good effect without the bad effect, he should do so; and the good effect flowing from the action must be at least as immediate (in the order of causality, though not necessarily in the order of time)

as the bad effect. In other words, the good effect must be produced directly by the action, not by the bad effect. Otherwise, the agent would be using a bad means to a good end, which is never allowed. Finally, the good effect must be at least as important as the bad effect to compensate for the allowing of the bad effect to occur.[20] As suggested by these conditions, the principle of double effect categorically rules out any action that is intended to bring about a morally "evil" effect. Yet actions that bring about such effects unintentionally, even if fully foreseen, are not categorically prohibited, but are instead analyzed to determine whether the intended (good) effect is proportional to the unintended (bad) consequence.

The double effect doctrine's association with Christian moral teaching is often cited as reason enough for disregarding it. Timothy Quill has argued, for example, that

> [t]he rule of double effect has many shortcomings as an ethical guide for either clinical practice or public policy. . . . [T]he rule originated in the context of a particular religious tradition. American society incorporates multiple religious, ethical, and professional traditions, so medicine must accommodate various approaches to assessing the morality of end-of-life practices.[21]

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[20]4 New Catholic Encyclopedia, Double Effect, Principle of, 1021 (1967).

[21]Timothy Quill, et al., The Rule of Double Effect -- A Critique of Its Role in End-of-Life Decision

While the double effect doctrine's link to Christian moral teaching is undeniable, that connection may obscure the doctrine's roots in Aristotlean moral theory, which placed strong emphasis on the measure and nature of the actor's intentions in any assessment of the justice or injustice of his or her action.[22] It may also obscure the fact that the doctrine has been recognized to one degree or another by an array of secular moral theorists. Even consequentialist Jeremy Bentham took trouble to distinguish between three different kinds of consequences: those that we intend as our ends or goals; those that we intend as means to our further ends; and those that occur, even if foreseen, as unwanted side-effects of what we do intentionally.[23] Indeed, the insight of the double effect doctrine is not remotely theologic. As Justice Oliver Wendell Holmes, a frequent utilitarian critic of relying on intent, observed, "even a dog distinguishes

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Making, 337 New England Journal of Medicine 1768 (1997) (hereinafter, "Quill, The Rule of Double Effect").

[22]See Ch. III.4, supra.

[23]Jeremy Bentham, Principles of Morals and Legislation ch. 8. After parsing out intended from unintended consequences and admitting that the "goodness and badness of a man's intentions" is "of no small importance," Bentham (characteristically) argued that a preferable way of determining whether an action is good or bad depends on whether its results bring "pain or pleasure: or on account of its effects." Id. We shall take up Benthamite consequentialist arguments for assisted suicide in Chapters VII and VIII.

between being stumbled over and being kicked."[24]

Of course, the question remains why should we, as a secular matter, care more about consequences that are intended versus those that are not? What wisdom lies behind this distinction? Justice Holmes's homespun illustration suggests the beginnings of an explanation. To kick a dog intentionally -- to choose to hurt an animal -- says something about the kicker, his way of interacting with animals and, perhaps, human beings -- in short, it tells us at least something about his character and beliefs, about who he is. By contrast, as Holmes seemed to recognize, watching a person trip over the dog tells us far less about who that person is, his character and beliefs.

The self-defining nature of intended actions can be illustrated by the case, developed earlier in this Chapter, of the drivers who hit the child in the street. In one instance, we considered the driver who comes upon a child darting into the street. The driver hits and kills the child by accident. In doing so, the driver indubitably effects an awful result -- the consequences he brings about are terrible and, as a result, we may censure and punish the driver. But we may very well treat him differently from another driver

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[24]Oliver Wendell Holmes, Jr., The Common Law 3 (1881).

who intentionally hunts down the child with his car. For this latter driver, we may say that no punishment is harsh enough. What undergirds the difference in our reaction to the two drivers? It is the difference in their self-definition, volition, choice. The hunting driver expresses himself to the world through his actions, defines who he is and what he believes, in a very different way than the accidental driver.

The defining nature of intended actions can be further illustrated by any number of choices we make in daily living. Most of us might be said, for example, to "allow" the poor in our cities and towns to go hungry because we fail to do enough to help them -- spending our time and our money in other pursuits, such as family and friends. We may even foresee or know that our failure to do more will mean that some persons will go hungry. While our choices in such cases indubitably say something about who we are, they do not say the same thing about us as would plotting intentionally to starve others. To seek out to starve another person is to endorse that objective, intelligently choose it, and freely will it. By contrast, the occurrence or nonoccurrence of unintended side-effects, even ones we foresee as absolutely inevitable (as with the hungry person left unfed), necessarily say less about our success or failure in

effecting our free will and intelligence in the world.

Simply put, we live as human beings in a world where we must make choices and take actions that, even when entirely legitimate and good, necessarily harm or damage or impinge upon other goods. In choosing to spend a weekend with family, it may unavoidably mean that some persons at the soup kitchen will go hungry. In choosing to spend additional money on a prescription drug care program that primarily benefits the elderly, we as a society may know with crystalline clarity that we will not be able to increase spending on education for the young. In choosing to take a family holiday this year, I will know it will mean that co-workers will have to work overtime. With so many varied and diverse goods to pursue in this life, we cannot help but make choices in pursuit of legitimate and upright aims that also entail inevitable, if unwanted, negative consequences for other instances of human goods.[25]

In contrast to unintended consequences, intended acts are always within our control and always subject to choice. We can always choose to refrain from doing intentional harm to others and, because our purposeful actions are within our control, they reveal more about our character and individuality that any unintended

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[25]Cf. John Finnis, Intention and Side-Effects in Liability and Responsibility: Essays in Law and Morals 61-63 (R.G. Frey and Christopher W. Morris, eds. 1991).

side-effect ever can. To disregard whether or not an act is intended would be in a very real way to disregard the role of free will in the world -- leaving, for example, those who fail to assist charities that feed the hungry open to the same censure and penalties as those who would starve such persons.

Precisely to avoid such acts of injustice, American criminal law often calibrates different levels of responsibility and punishment based on different levels of mens rea. The purposeful killer is considered for lethal injection while the individual who kills in self-defense, foreseeing death as a consequence but intending only to stop the aggression, may receive no punishment at all. The driver who speeds with reckless disregard for the consequences to others but without any intent to harm the darting child may receive jail time, but is often treated far differently than the depraved killer who sets out with a purposeful plan to murder the child. The one who disregards the hungry and homeless likewise may not command respect and admiration, but he is not subjected to the same penalties as one who deliberately harms such persons.

The underlying link between double effect, individualism, and free will I have sought to identify has been voiced by Charles Fried along these lines:

> It is natural that the most stringent moral judgment should relate to intentional acts . . . . Morality is about the good and the right way of our being in the world as human beings. And the way we relate to the world is as we pursue our purposes in the world, i.e., as we act intentionally. . . . The primacy of intention explains why in law and morals a sharp line is drawn between the result, which is intended[,] . . . and the certain concomitant [result], which [is not] intended.[26]

The U.S. Supreme Court, too, has identified the critical nexus between respect for intention, individualism, and human free will, explaining that the distinction between intended from unintended consequences "is no provincial or transient notion. It is as universal and persistent in mature systems of law as belief in freedom of the human will and duty of the normal individual to choose between good and evil."[27] In the Court's view, focus on the role of intention, and thus free will, is especially "congenial to an intense individualism [that] took deep and early root in American soil."[28] Roscoe Pound has gone so far as to

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[26]Charles Fried, Right and Wrong 27 (1978). See also, e.g., Alan Donagan, The Theory of Morality (1977); John Finnis, Allocating Risks and Suffering: Some Hidden Traps, 38 Clev. St. L. Rev. 193 (1990).

[27]Morrisette v. United States, 342 U.S. 246, 250 (1952) (Jackson, J.).

[28]Id. In a case illustrating this point, the United States Supreme Court has held that it violates the Eighth Amendment to preclude a felony murder defendant facing potential execution from presenting evidence to the jury that he did not intend the death as a mitigating factor that might help him avoid the ultimate punishment, "[t]his is not to question, of

suggest that "historically, [American] substantive criminal law is based upon a theory of punishing the vicious will. It postulates a free agent confronted with a choice between doing right and doing wrong and choosing freely to do wrong."[29]

### IV.5 Some (Initial) Arguments Against Double Effect: Conflating Intent and Foresight

Some concede that there is a conceptual distinction can be drawn between intended and foreseen consequences but still question whether, as a practical matter, the line is worth respecting. For example, Glanville Williams, in his texts on English criminal law, discusses what he calls the "doctrine of oblique intent," or what one might call treating knowledge (or foresight) as interchangeable with intent (or purpose). "To reject the doctrine of oblique intent," and thus draw distinctions between intended and merely foreseen

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course, that those who engage in serious criminal conduct which poses a substantial risk of violence, as did the present petitioners, deserve serious punishment regardless of whether or not they possess a purpose to take life. And the fact that death results, even unintentionally, from a criminal venture need not and frequently is not regarded by society as irrelevant to the appropriate degree of punishment. But society has made a judgment, which has deep roots in the history of the criminal law, distinguishing at least for purpose of the imposition of the death penalty between the culpability of those who acted with and those who acted without a purpose to destroy human life." Lockett v. Ohio, 438 U.S. 586, 625-26 (1978) (opinion of White, J.).

[29]Roscoe Pound, Introduction to Francis Sayre, Cases on Criminal Law xxxvi-vii (1927).

consequences, Williams argues, "would involve the law in fine distinctions, and would make it unduly lenient."[30] Williams uses, as an example, terrorists who blow up a plane full of passengers to obtain the insurance payment on the aircraft: while they may not have "intended" the deaths of the passengers, Williams argues, they are "villains" whose reckless indifference to human life deserves no less punishment than intentional killers and, thus, their crimes should be said to be practically equivalent.[31]

Addressing Williams' terrorist example, Andrew Ashworth, in Principles of Criminal Law, appears to agree:

> To establish a philosophical distinction between [intent and foresight] is not to conclude the case in favour of a legal distinction. . . . Fundamentally, it is a question of social judgment whether [the aircraft hijacker] should be bracketed with the purposeful killer or regarded as merely reckless. The draft [English] Criminal Code has it right, surely, in defining intention so as to cover the person who acts "being aware [i.e., knowing] that [the prohibited consequence] will occur in the ordinary course of events."[32]

Similarly, H.L.A. Hart argued that "a foreseen outcome is enough . . . the law does [and should] not require

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[30]Glanville Williams, Oblique Intention [1987] C.L.J. 417, 425. See also Glanville Williams, Textbook of the Criminal Law 84-85 (2d ed. 1983) (hereinafter, "Williams, Criminal Law").

[31]Williams, Criminal Law 85.

[32]Andrew Ashworth, Principles of Criminal Law 149 (1991) (hereinafter, "Ashworth, Criminal Law").

in such cases that the outcome should have been something intended in the sense that the accused set out to achieve it, either as a means or an end."[33] And Justice Holmes, despite his colorful comment about the underfoot dog, would have gone even further; he advocated abandoning most mens rea requirements in favor of "external" or "objective" standards of conduct -- such as his famous (hypothetical) "reasonable person" test.[34]

The "practical" argument for disregarding the intent/foresight distinction articulated by Williams and endorsed by others tends to prove too much. We can surely concede that some criminals who kill with reckless disregard for human life, like the terrorists Williams posits, engage in gravely heinous acts that merit sentences commensurate with their crimes. But doing so does not mean that the intent/foresight line is practically meaningless in all cases, as Williams seems to suggest. The recklessly speeding driver who (foreseeably) hits the darting child is not obviously

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[33]H.L.A. Hart, Punishment and Responsibility 119-20 (1968). See also A.P. Simester and W. Chan, Intention Thus Far [1997] Crim. L. R. 704, 715 (arguing that the deaths caused by Williams's hypothetical terrorist are "so intimately bound up with the villain's intended actions as to be inseparable, and it would be wrong to call them mere side effects.").

[34]See Oliver Wendell Holmes, The Common Law ch. 1. (1881).

the moral equivalent of the driver who purposefully hunts down the child. As we shall discuss in greater detail later, the doctor who administers pain killers to his patients in order to relieve grave suffering, even when death is likely or even inevitable to result, is not clearly the equivalent of, say, a murderer like Dr. Shipman who intentionally kills patients.[35] And the President who orders the shooting down of a plane full of civilian passengers to prevent hijackers from crashing it into a skyscraper is not obviously the equivalent of Williams's terrorist hijackers who perform the same act in an effort to obtain the insurance money.[36] Yet, under Williams's view, in each of the above cases the defendant -- the driver, the doctor, and the President -- would be considered no less culpable for having foreseeably killed than a defendant who intentionally killed. The supposition that intended and merely foreseen homicides are practically equivalent thus fails, at least insofar as it purports to be a rule covering all cases.

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[35]See Department of Health, Harold Shipman's Clinical Practice 1974-1998: A Clinical Audit Commissioned by the Chief Medical Officer (2000) (finding that Shipman, convicted of murdering 15 of his patients, had 297 "excess deaths" compared to other similarly situated physicians).

[36]This example is drawn from M. Cathleen Kaveny, Inferring Intention from Foresight, 120 L.Q.R. 81, 86 (forthcoming, January 2004).

Other commentators have suggested that any distinction between intent and foresight (knowledge) should be ignored, because, at least in the law, the two concepts "overlap."[37] As David Orentlicher has put the point:

> In the law, there is considerable overlap between these two notions [intent and foresight]. The rule of double effect is founded upon the traditional definition of intent in which action X is done to bring about consequence Y. Legal authority, however, also recognizes that a jury may infer intent if death or serious injury is a virtually certain or foreseeable consequence of the defendant's actions an the defendant realized this at the time the action was taken.[38]

Orentlicher's argument, however, simply points out the fact that juries are free, on the same set of facts, to decide whether the an action was intentional or merely knowing or reckless or negligent. That observation -- that juries may infer that a particular effect was intended or perhaps merely foreseen from the same circumstantial evidence -- is unremarkable. It concerns only how we go about finding different degrees of mens rea (intent or knowledge or recklessness or negligence) -- that is, by observing the same physical

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[37]David Orentlicher, The Legalization of Physician Assisted Suicide: A Very Modest Revolution, 38 B.C. L. Rev. 443, 456 (1997) (hereinafter, "Orentlicher, Legalization"). See also Brendan Thompson, Final Exit: Should the Double Effect Rule Regarding the Legality of Euthanasia in the United Kingdom Be Laid to Rest? 33 Vand. J. Transnat'l. L. 1035 (2000) (hereinafter, "Thompson, Double Effect").

[38]Thompson, Double Effect 1057.

evidence and testimony. It does not begin to demonstrate that intent and foresight are the same or should be treated as such. And to the extent Orentlicher seeks to make an empirical claim about the state of American law, I believe he overlooks much contrary evidence.

In fact, as alluded to by the U.S. Supreme Court and Roscoe Pound, many American jurisdictions find the distinction between intent and foresight to be a valuable component of their criminal law. The Model Penal Code, which has been followed in this respect by "most recent [state] legislative revisions" of criminal law,[39] takes pains to distinguish intended (or what it calls purposeful) consequences from those that are merely foreseen (or what it calls known). To intend an act or result, it must be one's "conscious object to engage in conduct of that nature or to cause such a result."[40] Meanwhile, a person who acts with knowledge or foresight of resulting consequences when "he is aware that it is practically certain that his conduct will cause" a certain result.[41] The Model Penal Code explains the distinction between the concepts of intent

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[39]Model Penal Code § 2.02, cmt. 2 (collecting citations to state statutes).

[40]Id. § 2.02(2)(a)(i).

[41]Id. § 2.02(2)(b)(ii)

(purpose) and knowledge (foresight) as follows:

> Knowledge that the requisite external circumstances exist is a common element in both conceptions. But action is not purposive with respect to the nature or result of the actor's conduct unless it was his conscious object to perform an action of that nature or to cause such a result. It is meaningful to think of the actor's attitude as different if he is simply aware that his conduct is of the required nature or that the prohibited result is practically certain to follow from his conduct.
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> . . .
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> [T]here are areas where the discrimination is required and made under traditional law . . . . This is true in treason, for example, insofar as a purpose to aid the enemy is an ingredient of the offense, and in attempts, complicity, and conspiracy, where a true purpose to effect the criminal result is the requisite for liability.[42]

The distinction here is, as the National Commission on Reform of Federal Law explained, "between a man who wills that a particular act or result takes place and another who is merely willing that it should take place.[43]

Wayne LaFave and Austin Scott, leading American treatise writers on criminal law, observe that the meaning of the word "intent" in the criminal law in the United States was for a very long time "rather obscure," and acknowledge that it in some cases has been "defined to include knowledge, and thus it is usually said that one intends certain consequences when

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[42] Id. § 2.02, cmt. 2.

[43] 1 National Commission on Reform of Federal Law Working Papers 124 (1971).

he desires that his acts cause those consequences or knows that those consequences are substantially certain to result from his acts."[44] Still, LaFave and Scott explain, the evolution of the law has been toward greater, not lesser, attention to mens rea distinctions: "the modern view . . . is that it is better to draw a distinction between intent (or purpose) on the one hand and knowledge on the other."[45] While acknowledging, as Glanville Williams and David Orentlicher suggest, that the distinction is "probably of little consequence in many areas of the law [because] often there is good reason for imposing [the same degree of] liability whether the defendant desired or merely knew of the practical certainty of the results," LaFave and Scott note, it nonetheless does matter in "several areas of the criminal law."[46] And, indeed, though many crimes are defined to include an act undertaken either with intent or mere knowledge, the distinction between intent and knowledge does play a central role in many areas of criminal law -- just a sampling of which are noted in the margin.[47]

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[44]Wayne LaFave and Austin Scott, Criminal Law 216 (1986).

[45]Id.

[46]Id.

[47]For examples where the distinction matters in federal (let alone state) criminal law, see, e.g.,

Of course, the modern understanding of intent followed by many American jurisdictions in their criminal laws is not the only one in currency. The distinction between intent and foresight is, for example, sometimes conflated in the law of tort. The Second Restatement of Torts, which holds significant influence in the development of American tort law, defines intent to "denote that the actor desires to cause the consequences of his act, or that he believes that the consequences are substantially certain to result from it,"[48] while the Model Penal Code expressly treats a consequence foreseen as "practical certainty" (a formulation that seems not materially different from the Restatement's "substantially certain" wording) to

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Haupt v. United States, 330 U.S. 631 (1947) and Dennis v. United States, 341 U.S. 494 (1947) (treason); Hartzel v. United States, 322 U.S. 680 (1944) (espionage); 18 U.S.C. § 81 (arson requires "willful[]" and "malicious[]" conduct); 18 U.S.C. § 113 (assault: "(a) . . . with intent to commit murder or rape . . . (b) with intent to commit any felony, except murder or rape"); 18 U.S.C. § 201 (bribery and graft "with intent to influence"); 18 U.S.C. § 373 (solicitation of another to commit a crime of violence "with intent" that the other person commit such a crime); 18 U.S.C. § 471 (counterfeiting and forgery "with intent to defraud"); 18 U.S.C. § 521 ("intend[ing] to promote or further the felonious activities of the criminal street gang"); 18 U.S.C. § 594 (intimidation of voters "for the purpose of"); 18 U.S.C. § 1072 ("willfully" concealing escaped prisoners); 18 U.S.C. § 2101 ("intent" to aid and abet riots).

[48]Restatement (Second) of Torts § 8A (emphasis added).

be merely a "known," not an "intended," consequence.[49] Prosser and Keeton, leading American treatise writers on tort, have noted that there is "some conflict between the two major pronouncements on the subject [of intent] by the American Law Institute -- one in the Restatement -- now the Second Restatement -- of Torts and the other in the Model Penal Code," but have themselves offered no analysis or argument regarding which is to be preferred. Nor has the American Law Institute offered any explanation for its use of competing definitions in the law of crime and tort.[50]

Modern American criminal law stands, too, in "fundamental disagreement" with the dominant view of intent in the criminal law in Britain.[51] In describing the state of the English criminal law of mens rea, Sir John Smith and Brian Hogan, in their treatise on criminal law, acknowledge that "[o]ne view is that . . . a result should never be regarded as intended unless it was the actor's purpose," and that "[t]his is often considered to be the ordinary meaning given to the word by people generally," but proceed to observe that the criminal courts in England "have consistently given the word a wider meaning, sometimes described as 'oblique'

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[49]Model Penal Code § 2.02(b)(ii).

[50]Prosser and Keeton 33-34.

[51]See Model Penal Code § 2.02, cmt. 2.

as distinct from 'direct' intention."[52] In fact, the issue of "oblique" intent (foresight), especially in the context of murder, has generated substantial debate in England since at least 1961.[53] Most recently, in a 1991 House of Lords decision, Regina v. Woollin, the Lords suggested that juries should be instructed that they may "infer the necessary intention" for a murder conviction when they find that a defendant "realises that is for all practical purposes inevitable that his actions will result in death or serious harm, however

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[52]Sir John Smith and Brian Hogan, Criminal Law 57 (8th ed. 1996) (hereinafter, "Smith & Hogan, Criminal Law"). For similar views by other English criminal textbook writers, see, e.g., Ashworth, Criminal Law 149-53; Williams, Criminal Law 84-87. But see Alan R. White, Grounds of Liability: An Introduction to the Philosophy of the Law 82-92 (1985) (arguing for respecting intent/foresight distinction in English criminal law).

[53]In Director of Public Prosecutions v. Smith, [1961] A.C. 290, the Lords effectively turned "intent to inflict grievous bodily harm" into an objective "reasonable person test." There, the Lords held that the defendant committed murder when he drove off with a policeman clinging to his car not because he wished to do the officer harm, but because the death would have been foreseeable by reasonable person in his position. Smith's equation of intent not with what the defendant intended or foresaw, but with what a "reasonable person" would have foreseen (a result Holmes might have applauded) was met with "widespread and severe criticism." Regina v. Woollin, [1999] A.C. 82. In 1967, Parliament reversed Smith's "reasonable person" test, see The Criminal Justice Act, 1967 § 8, but, since then, the law surrounding the mens rea element for murder has been "in a state of disarray" and a source of much dispute. Regina v. Hyam, [1975] A.C. 55. See also Regina v. Moloney, [1985] A.C. 905; Regina v. Nedrick, [1986] 1 W.L.R. 1025; Regina v. Hancock, [1986] A.C. 455.

little he may have desired or wished it to happen."[54]

The Lords' proposed instruction speaks, of course, merely of how juries may infer intent, and it is surely true that the fact a defendant foresaw a consequence as practically inevitable is customarily accepted as probative evidence on the question whether he also intended it.[55] To the extent that Lords' proposed instruction suggests only that, it is perhaps relatively unremarkable. But the Lords' proposed instruction also goes on to say that an inference that a particular result was intended may be "irresistible" even when the defendant did not actually "desire[] or wish[]" it to happen. The term "desire[] or wish[]," while ambiguous, seems clearly to refer to intention (rather than motivation); as such, the Lords seem to be suggesting to lower courts that they instruct juries that intention should (or must) be inferred (because doing so is "irresistible") whenever a person foresees death as "for all practical purposes inevitable" -- thus conflating the conceptions of intention and foresight. Indeed, one can make a strong argument, as Lord Steyn has, that the upshot of Woollin is that "a

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[54]Regina v. Woollin, [1999] 1 A.C. 82, 96.

[55]The conventional view that intent may be inferred from foresight is the focus of a provocative challenge by M. Cathleen Kaveny in Inferring Intention from Foresight, 120 L.Q.R. 81, 86 (forthcoming, January 2004).

result foreseen as virtually certain is an intended result."[56]

Emphasizing the transatlantic disagreement of opinion (at least in the criminal law) over the intent/foresight distinction, the U.S. Supreme Court, albeit in a different context, has expressly rejected the effort to thrust so much (artificially) into the definition of intent. In Tison v. Arizona,[57] two petitioners, brothers, had planned and effected the escape of their father from a prison where he was serving a life sentence, remarkably, for having killed a guard during a previous escape. The brothers entered the prison with a chest full of guns, armed their father and another convicted murderer, later helped to abduct and rob a family of four, and ultimately stood by and watched as their father and the other convicted murderer killed members of that family with shotguns. Under the Court's Eighth Amendment jurisprudence at the time of Tison, it was acceptable under the rule announced in Emmund v. Florida[58] to execute an individual convicted of felony murder, even though he did not actually commit the killing, so long as he was additionally guilty of the "aggravating circumstance"

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[56]Id. at 93 (emphasis added).

[57]481 U.S. 137 (1987).

[58]458 U.S. 782 (1982).

of having "intended" the killing. In Tison, the Court confronted a ruling by Arizona's Supreme Court ordering the execution of the two petitioning brothers on the ground that they had "intended" the deaths carried out by their father and the other convict. The Arizona court expressly recognized, however, that the brothers "did not specifically intend" the deaths, but deemed this of "little significance."[59] In the Arizona court's view, much like the House Lords' view in Woollin, intent to kill "includes the situation in which the defendant . . . contemplated or anticipated [viz., foresaw] that lethal force would or might be used."[60]

The U.S. Supreme Court, however, held that this definition of "intent" wrongly conflated intent with "a species of foreseeability":[61]

> Participants in violent felonies like armed robberies can frequently 'anticipat[e] that lethal force . . . might be used . . . in accomplishing the underlying felony[,]' . . . but [t]he Arizona Supreme Court's attempted reformulation of intent to kill amounts to little more than a restatement of the felony-murder rule itself. Petitioners do not fall within the 'intent to kill' category of felony murderer for which [the U.S. Supreme Court's prior holding in] Emmund explicitly finds the death penalty permissible under the Eighth Amendment.[62]

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[59]481 U.S. at 143 (internal quotation marks omitted).

[60]Id. (internal quotation marks omitted).

[61]Id. at 150.

[62]Id. at 151.

While ultimately agreeing that petitioners could be candidates for execution, the Court, rather than manipulate the definition of "intent" as the Arizona court had sought to do (and Woollin did), instead chose a simpler course, extending its precedent in Emmund to permit the execution of certain felony murder convicts even when they do not intend to kill, holding that the Eighth Amendment does not prohibit the death penalty for defendants whose participation in a felony that results in murder is major and whose mental state qualifies as at least reckless indifference to the value of human life, though, the Court emphasized, defendants must also continue to be given the opportunity in such circumstances to argue to the jury that the absence of intent mitigates their offense and thus makes capital punishment inappropriate.[63]

Tison illustrates that some American courts, in

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[63]Id. at 154-58 (discussing, inter alia, Lockett, 438 U.S. at 625-26; see n.28, supra). While the Court's holding clearly distinguishes between intent and at least some species of foreseeability, in dicta the Court arguably created some needless confusion. Quoting the passage from LaFave and Scott's treatise discussed above, see p.131, supra, the Court noted that "[t]raditionally one intends certain consequences when he desires that his acts cause those consequences or knows that those consequences are substantially certain to result." Id. at 150 (internal quotation marks omitted). But, in its dicta, the Court would have been better to acknowledge the next sentence from LaFave and Scott, cited above, explaining that, "the modern view . . . is that it is better to draw a distinction between intent (or purpose) on the one hand and knowledge on the other." See p.131, supra.

contrast to their English counterparts, see value in and are willing to police the intent/foresight distinction, at least when it comes to setting certain standards of criminal liability and punishment. But, as Tison also illustrates, this is not to say that merely foreseen crimes will never receive comparable punishments, as Glanville Williams seems to fear; foreseen or reckless crimes can subject a defendant to penalties similar to those for intentional ones, particularly in the presence of certain additional "aggravating circumstances" strongly suggestive of indifference to the value of human life -- including (as in Tison) cases where the defendant engaged in multiple counts of the same conduct and unlawfully restrained victims (kidnaping), or (as in Williams's hypothetical airplane case) sought to promote terrorism.[64]

### IV.6 Distinguishing Assisted Suicide and Euthanasia from the Right to Refuse: Intending v. Foreseeing Death

Having sought to establish that there is a rational line to be drawn between intended and foreseen consequences, the question arises whether such a distinction applies to our case: by reference to the

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[64] See generally Federal Sentencing Law and Practice §§ 3A.1.3, 3A1.4, 3D1.1 (Thomas W. Hutchison, et al., eds. 2003) (discussing sentencing enhancements for any crime involving a terrorist plot, multiple counts, or the physical restraint of a victim).

intent-foresight line, can assisted suicide and euthanasia, on the one hand, be distinguished, on the other hand, from conduct putting into effect a choice made pursuant to right to refuse? I believe the answer is "yes." While the principal and assistant must indubitably intend to kill in the case of assisted suicide and euthanasia, such an intent is not necessarily present when persons exercise the right to refuse (and those who assist them need not intentionally help kill).

*Suicide*

The principle of double effect is central to the definition of suicide. Self-destruction without an intent to die -- even when death is foreseen -- has never qualified as suicide. The soldier who falls on a hand grenade in order to save his mates may know his "number is up," but he hardly commits an act of suicide. Augustine's Christian martyrs may have seen death as a certainty for refusing to renounce their beliefs, but they did not seek it out. Death is, at most, an accepted side-effect of such decisions (to save one's mates, to remain faithful to one's religious beliefs, etc.).

Augustine and Aquinas (and arguably Aristotle) condemned suicide precisely because it represents an intentional rejection of human life. Augustine

endorsed the true Christian martyr's acceptance of death, but not the Donatists' deliberate choice to seek death out. Aquinas endorsed lethal acts by private persons where the intent is to stop aggression (self-defense), but not where the intent is to kill.

Aristotle suggested that only intended wrongs are always and by definition unjust, and intimated that suicide is wrong because it involves an intentional act against the "right principle" of life.[65]

The common law, likewise, traditionally took care to limit the definition of suicide to intentional self-destruction, for fear that any lesser mens rea standard would sweep in too much acceptable conduct. Edmund Wingate explained in the seventeenth century that to be "felo de se [a person must] destroy himself out of premeditated hatred against his own life."[66] Blackstone said that, to qualify as suicide, the act had be "deliberate[]" or part of an "unlawful malicious act."[67] Hale held that suicide consists of one who "voluntarily kill[s] himself."[68] And Coke expressly distinguished

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[65]See Ch. III, supra.

[66]Edmund Wingate, Justice Revived; Being the Whole Office of a Country JP Briefly, and Yet More Methodically and Fully than Ever Yet Extant 61, 88 (1661).

[67]Blackstone, Commentaries 189.

[68]1 Hale, Pleas 411.

between intentional acts of suicide, which he thoroughly condemned, and accidental acts of self-killing, such as cutting off a limb to prevent the spread of gangrene and bleeding to death, which Coke excused.[69] As a commentary to the Model Penal Code explains, the crime of suicide traditionally consisted only "of the intentional self-destruction by person of sound mind and sufficient age,"[70] and not actions of self-destruction undertaken negligently or recklessly, or even actions, like the soldier who jumped on the grenade, undertaken knowing that death is sure to result.

*Euthanasia and Assisted Suicide*

As with suicide, intent inheres in the very definition of euthanasia, which, as we have seen, is an act intended to kill the patient, albeit by a person motivated by a sense of compassion or mercy. Dr. Kevorkian's planned killing videotaped for *60 Minutes* and described in Chapter I vividly illustrates the point.[71] Intent is equally central to our concept of assisted suicide. When General Eisenhower ordered the

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[69]Coke, Third Institute 54.

[70]Model Penal Code § 210.5, cmt. 1, at 91-92 (emphasis added).

[71]See also Ch. III, supra (citing cases and statutes defining euthanasia as a species of murder -- i.e., intentional homicide).

D-Day invasion, "he knew that he was sending many American soldiers to certain death, despite his best efforts to minimize casualties. His purpose, though, was to liberate the beaches, liberate France, and liberate Europe from the Nazis," not to assist his troops in purposely ending their own lives.[72] On the other hand, when the doctor prescribes pills intending that the patient use them to kill himself intentionally, that is plainly an act of assisted suicide.

While American state statutes banning assisted suicide were passed at different times and use many different formulations,[73] they almost universally require that the assister actually intends to help the principal kill himself. That is, to be liable, the assistant must have as one of his purposes a wish to see the patient dead; he must freely will that result. Wisconsin's statute is simple, but emblematic of the assisted suicide laws found in a majority of American states, holding that "[w]hoever with intent that another take his or her own life assists such person to

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[72]Compassion in Dying, 79 F.3d at 858 (Klienfeld, J., dissenting) (emphasis added). Chief Justice Rehnquist adopted Judge Klienfeld's analogy. See Quill, 521 U.S. at 802.

[73]See Appendix A.

commit suicide is guilty of a Class D felony."[74] Texas similarly provides that "a person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide."[75] Though it uses the word "deliberately" in lieu of "intentionally" or "purposefully," California conveys the same meaning: "Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony."[76] Virginia, too, holds it unlawful for a person "with the purpose of assisting another person to commit or attempt to commit suicide . . . [to] provide[] the physical means by which another person commits or attempts to commit suicide."[77] Many other analogous examples can be found in Appendix A.

One might ask why states have so focused on the intent of the assister? The answer can be found in a structural feature of American aiding and abetting law. Courts and statutes have long required proof of "a true purpose to effect the criminal result,"[78] not just mere

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[74]Wis. Stat. Ann. § 940.12 (emphasis added).

[75]Tex. Penal Code Ann. § 22.08 (emphasis added).

[76]Cal. Penal Code § 401.

[77]Va. Code Ann. § 8.01-622.1 (emphasis added).

[78]Model Penal Code § 2.06, cmt. 6(c). See also id. § 2.06(3)(a); Josephine R. Potuto, et al. (eds.), Federal Criminal Jury Instructions § 10.01A[3] & cmt.

foresight (knowledge), to establish any aiding or abetting offense, not just assisted suicide, out fear that "a requirement of less than purposeful conduct would run the serious risk of over inclusiveness."[79] As classically expressed by Judge Learned Hand,

> [i]t is not enough that [a defendant] does not forgo a normally lawfully activity, of the fruits of which he knows that others will make an unlawful use; he must in some sense promote their venture himself, make it his own, have a stake in its outcome. This distinction is . . . important [to prevent prosecutors from] sweep[ing] within the drag-net of conspiracy all those who have been associated in any degree whatever with the main offenders. That there are opportunities of great oppression in such a doctrine is very plain, and it is only by circumscribing the scope of such all comprehensive indictments that they can be avoided.[80]

Simply put, the requirement of intention to assist the principal achieve his purpose serves as a break against arguably overzealous prosecution and interference in private affairs, such as with "a utility [that] provides telephone or telegraph service, knowing it is used for bookmaking[;] [a]n employee [who] puts through a shipment in the course of his employment though he knows the shipment is illegal[;] [a] farm boy [who] clears the ground for setting up a still, knowing that

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at I-394-I395 (1993).

[79]Model Penal Code § 2.06, cmt. 6(c).

[80]United States v. Falcone, 109 F.2d 579, 581 (2d Cir.), aff'd without passing on the issue, 311 U.S. 205 (1940); United States v. Peoni, 100 F.2d 401 (2d Cir. 1938) (Hand, J.).

the venture is illicit."[81] American aiding and abetting law follows a "sturdy individualist approach,"[82] seeking to avoid writing the moral dictum of being our brothers' keepers into the positive law, and focusing opprobrium instead on deliberate choices to do (or assist a) wrong.[83]

The intent requirement serves precisely this government-limiting and liberty-maximizing function in the law of assisted suicide, restricting the scope of possible state interference and leaving maximum room for unfettered private conduct and human freedom. For example, "one who sells readily available goods to another who states that he intends to kill himself" will not be held liable for assisted suicide so long as the seller does not actually intend to help kill.[84] So, too, as we saw in Chapter I, Dr. Quill was not prosecuted or professionally disciplined for administering barbiturates to an unnamed patient described in a medical journal, in part, because

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[81]Model Penal Code § 2.06, cmt. 6(c).

[82]Ashworth, Criminal Law 377.

[83]English law, again, does not entirely follow the American approach; though there is a "conflict of authority," many English courts would find secondary liability when the accomplice knows of the principal's intended course of action. See id. at 277-78; Smith & Hogan, Criminal Law 137.

[84]Model Penal Code § 210.5 cmt. 2, at 102.

questions existed about whether he intended (rather than merely foresaw as possible) that the patient would use the drugs he prescribed for her insomnia to kill herself.[85]

*The Right to Refuse*

So far, we have seen that there is some basis in moral theory and legal doctrine for distinguishing between intentional conduct and foreseen but unintended

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[85]While intent is the traditional and vastly more predominant mens rea rule for aiding and abetting crimes like assisted suicide, states are, of course, free to legislate different rules and a few, such as Maryland and Iowa, have done so, enacting statutes banning the knowing assistance of suicide. See Appendix A. The traditional intent requirement associated with aiding and abetting liability applies, moreover, only to prosecutions for secondary liability; the state is free to try to secure a conviction on the basis of primary liability. Cases of euthanasia, where the assister intentionally acts as the causal agent of death, are treated, as explored in Chapter III, as a form of murder. But primary liability can also be secured on lesser showings of mens rea -- laws exist in almost every jurisdiction treating reckless or negligent homicide as lesser offenses. To win, of course, the prosecutor must convince the jury not only of the requisite mental element, but also that the doctor did not just assist the death (as in cases of assisted suicide), but actually was its cause. This also poses a significant hurdle and safeguard against "drag-net" prosecutions. But while such cases are not frequent and (deliberately) hard to prove, neither are they unheard of. See, e.g., People v. Duffy, 185 A.D.2d 371, 586 N.Y.S.2d 150 (N.Y. App. Div. 1992); State v. Bauer, 471 N.W.2d 363 (Minn. App. 1991); People v. Cleaves, 229 Cal. App. 3d 367, 280 Cal. Rptr. 146 (1991); Hinson v. State, 18 Ark. App. 14, 709 S.W.2d 106 (1986); Chanslor v. State, 697 S.W.2d 393 (Tex. App. 1985); People v. Campbell, 124 Mich. App. 333, 335 N.W.2d 27 (1983); State v. Marti, 290 N.W.2d 570 (Iowa 1980); Commonwealth v. Schwartzentruver, 389 A.2d 181 (Pa. Super. Ct. 1978); Persampieri v. Commonwealth, 343 Mass. 19, 175 N.E.2d 387 (1961).

side-effects. We have also seen that euthanasia is an act intended to kill and that assisted suicide is also, by its traditional definition, an act taken with the intention of helping another person end life. While assisted suicide and euthanasia both involve situations where life is intentionally ended by principal and assister, the question remains whether death is intentionally sought and intentionally aided in cases where patients exercise the right to refuse treatment and physicians or others assist them. The answer is: not necessarily.

To be sure, a patient <u>can</u> refuse care with the intention of dying, and those who assist him can intentionally assist in the taking of life. To this extent, a right to refuse care and the proffered right to assisted suicide and euthanasia <u>can</u> overlap, and this is a point to which I will return to consider in Chapter X. For now, though, I wish to explore the point that assisted suicide <u>always</u> involves, on the part of the principal, an intent to kill and also require that the assistant intentionally participate in a scheme to end life. By contrast, a patient exercising the right to refuse need <u>not</u> intend to end life, and those who assist need <u>not</u> intentionally participate in a scheme to take life.

In exercising the right to refuse, patients

sometimes wish to avoid further pain associated with invasive treatments and tubes and the poking and prodding inherent in modern medical care. They sometimes wish to avoid the sense of indignity that dependence on medical machinery can bring. They sometimes wish simply to go home from the hospital, to be with loved ones, to avoid the endless sleepless hospital nights, to restore their privacy. None of these reasons -- or any of the other countless reasons for refusing care expressed every day by persons confronting the inevitable death we all face -- necessarily betokens an intent to die. The patient may fully <u>foresee</u> and <u>accept</u> death as the inevitable without necessarily having any <u>intention</u> of bringing death about.

Just as the legitimate claimant to self-defense may <u>know</u> that he will cause death in an effort to save himself, so, too, the patient seeking the removal of an oxygen mask or feeding tube may <u>know</u> death will result. In both instances, the consequential death may be a result deeply unwanted and a cause for great sadness to all involved. Indeed, in modern medical practice, where life can often be prolonged so long, it seems entirely plausible to think that the great bulk of cases where life-sustaining treatment is withdrawn involve just this scenario. Everyone involved

frequently wishes that their father, mother, son, or daughter could continue on. But everyone in the room also acknowledges that life cannot be prolonged forever wholly dependent on medical machinery. At some point, the treatment becomes unfairly burdensome, brings too little benefit, the machine has to be removed, and the loss of life must be accepted. Death cannot be cheated forever, and at some point it may become unfair to expect resources to be dedicated exclusively to a patient when they could do more good elsewhere. But none of this means that the patient intends to kill himself, or that anyone assisting him intentionally or even knowingly helps the patient commit suicide (i.e., seek death intentionally). In fact, the decision to discontinue care is ordinarily a painful one and a cause for deep sadness, not a cause for celebration or seen as the vindication of anyone's wish to kill or help kill.

What about, we might ask, the case where the patient and the physician do not share the same mens rea? What if the patient refuses any further treatment with a manifest intent to die (say, to get insurance proceeds now for his family), and the doctor knows it: can the doctor still discontinue care in the face of a suicidal request? If the doctor discontinues care without an intent to help kill, but simply, say, to

fulfill a professional duty to discontinue services when they are no longer wanted and permit the patient/client to go his own way, the act is not one of assisted suicide, as that offense is traditionally defined in American law, even though the doctor may know the patient intends to die. So long as the doctor himself acts with the purpose of fulfilling his professional responsibility and without an intent to kill, the requisite mental element for assisted suicide is not satisfied.[86]

The American Medical Association ("AMA") has endorsed the use of double effect doctrine and expressly relied upon it to outline medically acceptable acts of withdrawing care and to distinguish them from medically impermissible acts of killing. In the AMA's formulation, the "withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmalfeasance," while assisting suicide is always "contrary to the prohibition against [intentionally] using the tools of

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[86]Of course, any person is privileged at law to interfere with a suicide attempt; thus, a doctor convinced that the patient seeking to discontinue care intends to die could intercede but, even so, the legal privilege to intercede imposes no duty on the physician to act. While states can go beyond the traditional understanding of assisted suicide and enact laws proscribing more than intentional acts designed to assist a suicide, very few have done so. See n.85, supra.

medicine to cause a patient's death."[87] While physicians may also prescribe death-inducing dosages of palliative medicines where "they can point to a concomitant pain-relieving purpose,"[88] the AMA instructs that if a doctor undertakes such treatment "for the purpose of causing death," then "the physician . . . exceed[s] the bounds of ethical medical practice."[89] The AMA's view of purposeful killing applies, moreover, whether the physician intends death as an end or as a means to some further purpose, such as relieving suffering: intentional killing is out-of-bounds "regardless what other purpose the physician may point to."[90]

In England, the Select Committee of the House of Lords, charged with reconsidering the 1961 Suicide Act, likewise has drawn a firm line between the provision of

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[87]American Medical Association, Council on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 Journ. of the Amer. Med. Ass'n. 2229, 2230-31, 2233 (1992).

[88]Motion for Leave to File Brief as Amicus Curiae and Brief of the American Medical Association, the California Medical Association, and the Society of Critical Care Medicine as Amicus Curiae in Support of Petitioners, State of Washington v. Glucksberg, No. 96-110, at 15, on Petition for Writ of Certiorari (Aug. 19, 1996) (emphasis added) (hereinafter, "AMA, Amicus Brief"). See also Brief of the American Hospital Association as Amicus Curiae in Support of Petitioners, State of Washington v. Glucksberg, No. 96-110.

[89]AMA, Amicus Brief at 15 (emphasis added).

[90]Id.

potentially lethal dosages of pain killers in response to pain and assisted suicide, and done so with express reference to the principle of double effect:

> The adequate relief of pain and suffering in terminally ill patients depends on doctors being able to do all that is necessary and possible [to relieve pain]. In many cases this will mean the use of opiates or sedative drugs in increasing doses. In some cases patients may in consequence die sooner than they would otherwise have done but this is not in our view a reason for withholding treatment that would give relief as long as the doctor acts in accordance with responsible medical practice with the objective of relieving pain or distress, and with no intention to kill. . . . Some witnesses suggested that the double effect of some therapeutic drugs when given in large doses was being used as a cloak for what in effect amounted to widespread euthanasia, and suggested that this implied medical hypocrisy. We reject that charge while acknowledging that the doctor's intention, and evaluation of the pain and distress suffered by the patient, are of crucial significance in judging double effect.[91]

Very much the same analysis can be applied in the right to refuse context: when care is refused it means that a patient will die sooner than he would have otherwise, but this does not necessarily mean that, in all cases, the patient has formed an intent to end life or that those assisting him intend to help kill.

Having proceeded this far, I believe we are now in a position to offer at least a tentative answer to the fairness or equal protection question, drawing, as the AMA and the House of Lords have suggested, a (legally

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[91]House of Lords Report HL Paper, 21-I of 1993-1994 Session, vol. 1 paras. 242, 243.

and morally sound) intent-based distinction between, on the one hand, the right to refuse, and, on the other hand, the proffered right to assisted suicide and euthanasia. In cases of refusing care, death need not be intended by the principal or assistant, while, in cases of euthanasia, death must be intended by the killer, and in cases of assisted suicide one must intentionally assist the principal in his objective of intentionally ending of life.

### *Assisted Suicide v. Euthanasia: A Tenable Distinction?*

Having suggested that we can rationally differentiate refusals of care from acts of assisted suicide and euthanasia, one might, parenthetically almost, ask whether we can or should draw a similar moral line between assisted suicide and euthanasia? Some advocates of assisted suicide, especially in the United States, have sought to draw just such a distinction, arguing for the legalization of assisted suicide without (at least expressly) seeking legalization of euthanasia. One might wonder whether this is a purely tactical choice, expressive only of a desire to fight piecemeal policy battles, rather than immediately commit to a broader political war that could be more difficult to win and doom any chance of change. Tellingly, outside the United States few advocates of assisted suicide draw any moral or legal

distinction between assisted suicide and euthanasia.[92]

Within the United States, those seeking to justify treating assisted suicide differently from euthanasia often point out that the patient exercises more control in assisted suicide, remaining the final causal actor in his or her own death, while in euthanasia another person assumes that role, thus creating a greater chance for physician malfeasance. But does this distinction withstand scrutiny, at least on moral grounds? In cases of assisted suicide and euthanasia alike, the patient forms an intent to die, and the physician intentionally helps the patient end his or her life. Indeed, as Dutch bioethicists Gerrit Kimsma and Evert van Leeuwen have explained, in the Netherlands the acts are "considered to be identical because intentionally and effectively they both involve

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[92]See Gerrit Kimsma and Evert van Leeuwen, Euthanasia and Assisted Suicide in the Netherlands and the USA: Comparing Practices, Justifications and Key Concepts in Bioethics and Law in Asking to Die: Inside the Dutch Debate About Euthanasia 35, 51 (David C. Thomasma, ed. 1998) (hereinafter, "Kisma, Euthanasia and Assisted Suicide in the Netherlands and the USA") (explaining that, "[i]n the Netherlands no distinct moral difference is maintained between [voluntary active euthanasia] and [physician assisted suicide]"); John Griffiths, et al., Euthanasia & Law in the Netherlands 113 (1998) (hereinafter, "Griffiths, Euthanasia & Law") ("from the point of view of the justification of necessity, [the practices] are not distinguished").

actively assisting death."[93] The physical difference, too, between assisted suicide and euthanasia need not be, and frequently isn't, very great: as John Keown has asked, "[w]hat, for example, is the supposed difference between the doctor handing a lethal pill to a patient; placing the pill on the patient's tongue; and dropping it down the patient's throat?"[94] Even the Ninth Circuit sitting en banc virtually admitted that, in its view, any distinction between assisted suicide and euthanasia cannot, ultimately, be sustained: "We would be less than candid," it wrote, "if we did not acknowledge that . . . we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination" of life -- not between the means used to effect that purpose.[95]

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[93]Kisma, Euthanasia and Assisted Suicide in the Netherlands and the USA 51.

[94]John Keown, Euthanasia, Ethics and Public Policy 33 (2002) (hereinafter, "Keown, EEPP"). See also Kisma, Euthanasia and Assisted Suicide in the Netherlands and the USA at 51 (arguing that there is no "difference . . . perceived if a physician hands over a cup to drink or gives an injection by needle"); Rights of the Terminally Ill Act 1995 (N. Terr. Austl.) §§ 2-4 (while only briefly operative, this statute, purporting to legalize assisted suicide, actually defined "assist[ance]" in suicide to embrace euthanasia -- viz., to include "the administration of a substance to the patient").

[95]79 F.3d at 831-32; see also Ch. II.1, supra. Richard Epstein has criticized the Ninth Circuit for not making even more explicit that no tenable moral distinction can be drawn between assisted suicide and euthanasia. Epstein, Mortal Peril 340.

## IV.7 Some (Additional) Criticisms of Double Effect as Applied to the Assisted Suicide Debate

We have already considered several general criticisms of the principle of double effect and the significance of the role of intention in the law,[96] but additional objections have also been leveled more specifically against the application of the principle of double effect to the assisted suicide question, and these, too, merit consideration.

### *The Intended Means/Side-Effect Problem*

Some commentators have argued that the principle of double effect fails to take into account "multilayered or partial intentions" in cases of assisted suicide and euthanasia:

> Oftentimes, clinicians will not act with one exclusive intent in medicating a terminally ill patient, but will rather hold a variety of intentions which may or may not include offering the patient the possibility of death when suffering becomes overwhelming and no other acceptable means of escape are available. Because the rule of double effect views clinicians' intentions as being simplistic and one-dimensional, it fails to acknowledge the inescapable multiplicity of intentions which are present in most double effect situations where one intention may not rise above the rest to become the true purpose of a practitioner's actions.[97]

The point here seems to be that the intention to kill is not always the only or even the dominant intention at work in cases of assisted suicide and euthanasia; other

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[96]See Ch. IV.5, supra.

[97]Thompson, Double Effect 1057.

intentions, most particularly the desire to end suffering, are also present.

This observation is not, however, at all inconsistent with the principle of double effect which recognizes that one may not only intend something as an end unto itself -- the final object or purpose of one's behavior -- but may also intend something as a means to some further purpose or end. For example, I may intend, as an end, to get some rest. As a means of accomplishing that object, I may intend to go on vacation. In such a scenario, failing to achieve my intended means would be as much a frustration of my designs and aims as failing to achieve my intended ends or final goal.

John Griffiths, Professor of Sociology of Law at the University of Groningen in the Netherlands, has argued that the difference between intended means and unintended side-effects "is a pure ipse dixit. . . . the way an act is described determines which are to be considered means and which side-effects"[98] And, to be sure, what qualifies as an intended means as opposed to an unintended side-effect is not always free from doubt. The problem may be illustrated by this example: A party of explorers is trapped in a case because a fat member of the party is lodged in the only opening. If

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[98]Griffiths, Euthanasia & Law 164-65.

a member of the party explodes a charge next to the fat man, should we say that he intended the fat man's death as a means, or that the death was a mere side-effect of the desire to free the party?[99] The problem also lends itself to more practical illustration. For example, what if a woman with a serious heart condition becomes pregnant and both she and the fetus will die unless the fetus is removed? If the fetus is removed, one might ask whether the consequential death of the fetus is better described as an intended means, or as a mere side-effect of saving the pregnant woman.[100]

In all such examples, whether we are inclined to label an action as a means or as a side-effect turns on whether we view the factual sequence more in its granular detail or as a unitary whole. The more we break down the sequence of events into discrete bits, the more the actor's conduct appears intentional. Thus, if we say that the cave explorer pulled dynamite sticks out of his back pack, placed them near the fat man, struck a match, lit a fuse, and then ran for cover, the fat man's death takes on an intentional hue.

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[99]E.g., Helga Kuhse, The Sanctity of Life Doctrine in Medicine 97 (1987) (hereinafter, "Kuhse, Sanctity of Life Doctrine"); John Finnis, Intention and Double Effect in Liability and Responsibility 55-61 (R.G. Frey and Christopher W. Morris, eds. 1991).

[100]Kuhse, Sanctity of Life Doctrine 94.

To the extent we focus on the conduct as a unitary whole aimed at escaping the cave, the fat man's death seems more of a side-effect.

Some have sought to resolve intended means versus side-effect problems with a counterfactual hypothetical, asking whether, if the questionable result at issue could have been avoided (e.g., the fat man could have lived; the fetus could not have been destroyed), but all the other positive events also occurred (e.g., the party of spelunkers and the pregnant woman lived), would the actor still have chosen to act as he or she did?[101] Because the death of the fat man or fetus is not required to achieve the wished-for results, the reasoning goes, they are not intended means but only side-effects.

While such a counterfactual hypothetical may often prove useful in drawing out and isolating an agent's intentions, it is an incomplete answer. It does not focus directly on the actor's actual intentions and state of mind, but replaces the inquiry with a hypothetical construct. And the construct can go awry, for there is always the possibility that the party of the spelunkers did wish the fat man dead, or that the pregnant woman did wish to terminate her pregnancy.

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[101] E.g., Phillipa Foot, The Problem of Abortion and the Doctrine of Double Effect, in Killing and Letting Die 156-65 (Bonnie Steinbock, ed. 1980).

Intentions are complex and fact- and individual-specific, and are not readily analyzable from the outside by what-if hypotheticals.

Ultimately, however, we do not need any construct to know our own intentions. As to the intentions of other persons, Griffiths argues that discerning intentions from side-effects is practically impossible or fruitless: while "God sees everything[,] . . . for purposes of secular morality and legal control, making the responsibility of an actor dependent on his motive is unacceptable. . . . It comes as no surprise that the criminal law rejects the idea of liability based on . . . subjective intentions."[102] But, in the first place, we are concerned not with motives, but with intentions; in the second place, American criminal law deals everyday in the question of intention, resting, as we have seen, many and various kinds of legal duty and penalty on the presence or absence of particular intentions. To dismiss any reliance on subjective intent as somehow a confused religious enterprise is simply to ignore entire chapters of secular law and their connection to individual free will and government restraint.[103] To be

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[102]Griffiths, Euthanasia & Law 166.

[103]See Ch. IV.4. Incidentally, Griffiths is also incorrect in suggesting that motives are irrelevant to secular law -- at least in America. By way of example, consider recent "hate crimes" legislation: these laws, by definition, focus on criminal acts motivated by

sure, determining whether other persons did or did not intend particular results may require inference based on an intensive examinations of the facts, but the absence of any systematic meta-theory for distinguishing between means and side-effects should not obscure the fact that what is and is not within the scope of the actor's intentions is precisely the sort of question of fact that judges and juries are accustomed to and charged with sorting out on a daily basis.

Within the realm of assisted suicide and euthanasia, moreover, the intended means-versus-side-effect problem often is not so acute. Dr. Kevorkian illustrates the point. As his final object or end, Kevorkian may, perhaps, intend to relieve the suffering of his "patients," or to accommodate their judgment that life is no longer worth living, or to further his own judgment that they are better off dead than alive. But, at the same time, to accomplish any such ultimate end, as his means Kevorkian indubitably takes steps intentionally designed to help end life. Thus, in a case where the potassium chloride drip he fashioned failed to kill one of his patients, Kevorkian ran off

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distaste for particular minority groups, and establishing the defendant's motive is an essential element of the government's proof. See, e.g., Apprendi v. New Jersey, 530 U.S. 466 (2000).

to find a canister of carbon monoxide to allow his patient finish the job of killing herself.[104] There is little ambiguity about the fact that Kevorkian intends to help kill.

Kevorkian's 1994 acquittal on assisted suicide charges (he was found guilty of murder in a 1999 euthanasia case) amplifies the point. The trial judge correctly held that assisted suicide is a "specific-intent" crime in the State of Michigan. But the judge also adopted an unusual interpretation of what proof is required to establish specific intent. The court instructed the jury that it could find Kevorkian guilty only if it found he "intended solely to cause" death. Thus, the jury was obligated to acquit Dr. Kevorkian if it found that he intended to kill and had some other purpose in mind, such as relieving suffering. Chief Justice Rehnquist, unfortunately, used a somewhat similar, if less demanding, formulation in describing assisted suicide when he stated that a doctor assisting a suicide "must[,] necessarily and indubitably, intend primarily that the patient be made dead."[105]

In essence, under the instruction given in Kevorkian's 1994 trial (and arguably under the

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[104]Kevorkian, 447 Mich. at 483-84, 527 N.W.2d at 733-34.

[105]Quill, 521 U.S. at 802 (emphasis added).

definition suggested by Chief Justice Rehnquist), if the death of a patient is part of (or, in Chief Justice Renquist's formulation, primarily the result of) some larger goal of relieving suffering, it may be treated as a unintended side-effect rather than an intended means. But, while no single meta-theory may exist to separate intended means from unintended side-effects, this goes too far. The Kevorkian court's instruction, if correct, would make it impossible to obtain a conviction for assisted suicide so long as the assistant intends to cause death only as a means to some other end. The instruction, if correct, would mean that the Roman-style entertainer who assists volunteers taking their lives in order to amuse his audience would go free, since he intends death merely as a means to some other (primary) end. It would also mean that Jim Jones, of Jonestown Massacre fame, would go free on the grounds that he intended to kill his followers only as a means of making a political point to "protest[] the conditions of an inhumane world."[106] Those who help kill off grandpa as a means to the end of cashing in on his life insurance policy might have

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[106]The Jonestown Massacre (Karl Eden, ed. 1993). Of course, it became clear from subsequent investigation that many who died with Jones and in similar tragedies did not intend to die as either a means or an end, but were coerced or deceived -- i.e., straightforwardly murdered.

an equally good defense. None of this comports with what we understand to be assisted suicide or euthanasia, acts which, by their definition, include where death is intended -- whether as an end or as a means.

*Criticisms from Other Quarters*

Justice Stevens, we might recall, wrote separately in Glucksberg to argue that any distinction between suicide and refusing life-saving care based on intent is "illusory."[107] Justice Stevens rested his conclusion on the observation that a physician discontinuing care "could be doing so with an intent to harm or kill that patient; conversely, a doctor who prescribes lethal medication does not necessarily intend the patient's death -- rather that doctor may seek simply to ease the patient's suffering and to comply with her wishes."[108] As we have seen, however, Justice Steven's premise is mistaken: while an intention to kill -- either as an end or as a means -- is necessarily present in the exercise of a right to assisted suicide or euthanasia, it is not necessarily present in the exercise of the right to refuse care. And Justice Stevens's hypothetical fails to help illuminate anything, seeming instead to conflate very different things. Justice

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[107]521 U.S. at 750-51.

[108]Id.

Stevens supposes a doctor who prescribes potentially lethal pain killers to relieve suffering or comply with a patient's wishes. But, critically, he doesn't discuss the operative legal question -- the patient's and physician's state of mind. If the doctor and patient simply intend to relieve pain, that is no act of suicide or assisted suicide. If, however, the patient intends to kill himself and the doctor intends to help in that process that is assisted suicide.

Like Justice Stevens, a Harvard Law Review Note has argued that reliance on an intent-based distinction is misplaced, this time for three reasons:

> First, many patients who want treatment discontinued know that they will die without it and often clearly express a desire to end their suffering. Second, conditioning a patient's rights on their intentions and motivations undermines their right of self-determination because it enables physicians or judges to override the patient's decision if it does not comport with the physicians' or judges' values. Finally, claims that a patient is not committing suicide because he wants only a natural death, not self-destruction, assume that the discontinuation of life-sustaining treatment does not "cause" a patient's death. . . . This argument fails to distinguish objectively the withdrawal of life-sustaining treatment from physician-assisted suicide because it is laden with policy judgments, not simply based on objective facts.[109]

Each of the Note's contentions, however, seems highly questionable.

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[109]Note, The Right to Die and Physician-Assisted Suicide, 105 Harv. L. Rev. 2030 (1991) (citations omitted).

The Note stresses that patients "who want treatment discontinued" may "know that they will die without it" (emphasis added), but this is not the same thing as intending death. It is the act of the soldier marching into battle, the martyr refusing to recant -- not an act of suicide; thus, the Note itself tacitly acknowledges the key distinction: refusing care can be done without the patient intending death, only foreseeing it. The Note's subsequent assertion that conditioning a right to receive assistance in committing suicide on the patient's intent interferes with a "right of self-determination," does not directly address the existence of a rational intent-based distinction and assumes the premise that there is a right of self-determination unlimited by any requirement of respect for life, a question we shall confront in later chapters. Finally, the Note asserts that some controversial view of causation is at work. But an intent-based analysis presupposes no particular view of causation or what constitutes a "natural" death; an intent-based analysis stands independent and apart from any argument over causation.

Some, such as Dr. Quill, argue that any intent-based distinction between assisted suicide and the right to refuse treatment is, as a practical matter, too

difficult to validate externally. Clinicians familiar with the requirements of the rule may learn to express their intentions in performing ambiguous acts such as providing terminal sedation in terms of foreseen but unintended consequences, at the same time, other clinicians may reasonably interpret these acts as clear violations of the rule.[110]

John Griffiths, similarly, has submitted that focusing on intentions in the context of assisted suicide and refusals of care "would undermine every possibility of effective control by making those responsible for control dependent on information possess[ed] only by those whose behavior is to be controlled."[111]

These objections, however, merely return us to the generic problem of separating intended from unintended consequences that we discussed above. Inquiries into the intentions of individual patients in individual cases may be difficult, consume substantial resources, and risk divergent results in similar cases. But these same administrative concerns could be raised about virtually every case in which intent is an issue, and do little to suggest that an intent-based distinction lacks moral force or is inappropriate for use in a judicial setting. And it seems somewhat surprising that Quill and Griffiths would complain about any supposed difficulties in enforcing an intent-based

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[110]Quill, The Rule of Double Effect.

[111]Griffiths, Euthanasia & Law 166.

distinction: the strict mens rea requirement associated with assisted suicide is expressly designed to maximize room for individual liberty and prevent over-prosecution -- such as against the drugstore owner who simply sells over-the-counter medications (if perhaps knowingly or negligently) to a client exhibiting suicidal tendencies; or as against the doctor who recklessly prescribes sleeping pills to a patient who is depressed and talking of killing herself. The choice to enforce a strict mens rea requirement was deliberately made to protect against what Judge Learned Hand called the "drag-net" effect of secondary liability, restricting legal liability to those who "in some sense promote their venture [themselves], make it [their] own, have a stake in its outcome." Quill himself avoided prosecution for assisted suicide precisely because the government was not certain it could meet the strict mens rea standard of proof he criticizes. And Quill's arguments about the difficulties associated with the administration of intent-based laws could be used as easily to argue for lowering the mens rea requirement (say, to knowledge) and expanding the reach of criminal liability as much as for dropping laws against assisted suicide altogether.[112] Notably, too, Griffiths concedes that his

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[112]See n.85, supra.

own research has found that focusing on intent to distinguish between assisted suicide and refusals of care actually fits with the "subjective experience of [many] doctors,"[113] and he acknowledges that a "legal regime that treats things [doctors] consider profoundly different as one undifferentiated whole [i.e., conflating intended and foreseen deaths] will presumably not be capable of commanding their support."[114]

## IV.8 Conclusion

We have seen that the act-omission distinction and the natural-unnatural (causation) distinction fail to differentiate meaningfully between the right to refuse treatment and the proposed right to receive assistance in suicide. We have also seen, however, that a morally significant distinction does exist, insofar as one practice (the right to refuse) need never involve an intent to kill on the part of the patient or his assistant, while the other (assisted suicide) always involves an intent to kill on the part of the principal, and an intent to help kill on the part of the assistant. At the same time, we have discussed potential problems with this distinction, including the fact that the right to refuse can be used by

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[113] Id. at 271.

[114] Id. at 297 n.65.

individuals to effectuate acts of intentional self-destruction. For purposes of doctrinal equal protection review, however, only a "rational" distinction is necessary to sustain state laws against assisted suicide and euthanasia; the fact that the right to refuse need not entail an intent to kill seems to qualify. Further, while I have suggested that the right to refuse might be rationally distinguished from assisted suicide and euthanasia, it is important to note that I have not shown that this distinction is more than merely rational. That is, I have answered the limited procedural fairness question, but not the underlying substantive question whether assisted suicide and euthanasia (or the right to refuse, when an intent to kill is present) are practices that should be encouraged or discouraged. Those questions I take up in forthcoming Chapters.

# CHAPTER V

## CASEY AND CRUZAN: DO THEY INTIMATE A RIGHT TO ASSISTED SUICIDE AND EUTHANASIA?

### V.1 Introduction

If history and principles of fairness do not sustain a right to receive assistance in suicide or a right to euthanasia, some would invite us to look to principles of moral autonomy and the legal doctrine that has grown up around those principles. Judges Rothstein and Reinhardt found persuasive the argument that all persons have an inherent (substantive due process) right to choose their own "destinies." So did Justices Stevens and Souter -- and Justice O'Connor declined to reveal her cards. These voices (and votes) suggest that autonomy-based arguments will be heard again when an as-applied legal challenge to a state law banning assisted suicide makes its way to the U.S. Supreme Court. Neither are "autonomy" arguments exclusively judicial in nature. Many legislative advocates of assisted suicide and euthanasia argue that proper respect for individual choice compels legalization.

In this Chapter, I address the doctrinal question whether Casey and Cruzan specifically, and substantive due process doctrine more generally, are hardy enough to sustain a constitutionally protected autonomy interest that could, in turn, sustain a right to assistance in suicide and euthanasia. In Chapter VI, I then consider whether principles of personal autonomy, as developed by contemporary moral theorists independently of legal doctrine, provide a persuasive analytical basis for legalization.

## V.2 The "Reasoned Judgment" Test and Its Critics

In Glucksberg, Chief Justice Rehnquist gave short shrift to arguments based on Casey and Cruzan, summarily dismissing the notion that they might sustain a constitutional right to receive assistance in committing suicide.[1] While his analysis was sufficient for the three other members of the Court who adopted it as their opinion, it was apparently insufficient for the remaining (majority of) justices. Given that an as-applied challenge seems virtually certain to return to the Supreme Court, the reach of Casey and Cruzan will remain a focal point of discussion.

On its face, the Constitution's due process guarantee seems concerned with the fairness of the procedures government employs when abridging individual

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[1]See 521 U.S. at 723-27.

rights. It provides, after all, merely that the state shall not "deprive any person of life, liberty, or property, without due process of law."[2] Notwithstanding its procedural tenor, and arguments by commentators as diverse as John Hart Ely and Robert Bork,[3] the Supreme Court has held in case after case that due process contains a "substantive" component -- one that absolutely "bars certain governmental actions regardless of the fairness of the procedures used to implement them."[4] As Justice Brandeis (joined by Justice Holmes) put it,

> [d]espite arguments to the contrary which had seemed to me persuasive, it is settled that the due process clause of the Fourteenth Amendment applies to matters of substantive law as well as to matters of procedure. Thus all fundamental rights comprised within the term liberty are protected by the Federal Constitution from

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[2]U.S. Const. Amend. V and XIV (emphasis added).

[3]See, e.g., Ely, Democracy and Distrust 18 ("[T]here is simply no avoiding the fact that the word that follows 'due' is 'process.' . . . Familiarity breeds inattention, and we apparently need periodic reminding that 'substantive due process' is a contradiction in terms -- sort of like 'green pastel redness.'"); Bork, The Tempting of America 238 ("[Since the recognition of substantive due process] involved transforming the clause from one about due process to due substance, without any guide in constitutional text, history, or structure as to what substance might be due, there was then no limitation on its meaning, natural or otherwise. The clause now 'means' anything that can attract five votes on the Court.").

[4]Daniels v. Williams, 474 U.S. 327 (1986).

invasion by the States.[5]

But how are the courts to determine what "substantive" rights due process shelters from legislative or executive encroachment? While history has proven to be the most persistently popular tool with the Supreme Court, much academic literature over at least the past half-century has pressed the alternative and more expansive view that the Court should serve, in Henry Hart's words, as a "voice of reason, charged with the creative function of discerning afresh and of articulating and developing impersonal and durable values."[6] In Ronald Dworkin's view, the Court's role is to define our "constitutional morality," which in turn requires the Court to elucidate "the political morality presupposed by the law and institutions of the community."[7] Charles Curtis similarly sought to convince members of the Supreme Court that it should "articulate a creed for the era," by becoming the

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[5]Whitney v. California, 274 U.S. 357, 373 (1927). See also Bowers, 478 U.S. at 191 ("[D]espite the language of the Due Process Clauses of the Fifth and Fourteenth Amendments, which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which those Clauses have been interpreted to have substantive content.").

[6]Henry Hart, Foreword: The Time Chart of the Justices, 73 Harv. L. Rev. 84, 99 (1959).

[7]Ronald Dworkin, Taking Rights Seriously 126, 149 (1977).

nation's "philosopher."[8]

This vision of substantive due process adjudication, limited not to questions of process or the views of past majorities, is the vision that at least some of the Justices and Judges in the assisted suicide cases had in mind. Justice Souter wrote of due process adjudication as an exercise "incapable of any general formula," and dependent instead on "the usual canons of critical discourse."[9] Judge Reinhardt rested heavily on Casey's description of substantive due process adjudication as an exercise in applying "reasoned judgment." And, of course, the Casey plurality itself spoke of due process as protecting "the most intimate and personal choices a person may make in a lifetime."[10]

That said, the "reasoned judgment" test, like the history test, is not without its critics or difficulties. If the task of recognizing new rights is one of engaging in moral reasoning and critical discourse about what broad moral imperatives such as autonomy entail, one might ask whether judges are any more competent at the task (or deserve any more deference) than legislators, or whether substantive due

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[8]Charles Curtis, Lions Under the Throne 335 (1947).

[9]Glucksberg, 521 U.S. at 769.

[10]Casey, 505 U.S. at 851.

process doctrine is anything more than cover for outright judicial choice. How many moral philosophers actually agree, after all, about what generic moral imperatives such as "autonomy" entail? As Justice Scalia has put the point, albeit in dissent:

> [I]t is obvious to anyone applying "reasoned judgment" that the same adjectives can be applied to many forms of conduct that this Court . . . has held are <u>not</u> entitled to constitutional protection . . . . It is not reasoned judgment that supports the Court's decision; only personal predilection. . . . [W]hen a strict interpretation of the Constitution . . . is abandoned . . . we are under the government of individual men, who for the time being have power to declare what the Constitution is, according to their own views of what it ought to mean.[11]

One might further ask whether it is bold enough to hold that the procedurally oriented language of the due process guarantee contains the enumerated substantive rights of the Bill of Rights; to go any further -- to hold that the clause is also the repository of other substantive rights nowhere enumerated in the text of the Constitution or its amendments, and thus entirely dependent for their legitimacy solely on the "reasoned judgment" of five judges, is to stretch the clause beyond recognition.

Such questions are both old and new. As initially drafted, the Bill of Rights prevented the <u>federal</u> government from infringing certain familiar substantive

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[11]<u>Id.</u> at 984 (Scalia, J., dissenting) (internal quotation marks omitted).

rights -- the right to free speech, the right to be free from unreasonable searches and seizures, the right to free association in religious matters, and the like -- but the document did not prevent infringement of these rights by <u>state</u> governments. In a battle waged intermittently over the first half of the twentieth century, the Supreme Court concluded that most of the substantive rights afforded as against the federal government in the Bill of Rights are of such fundamental importance that they practically inhere in the notion of "due process." And since the Fourteenth Amendment's due process clause protects the people as against state governments, this meant that the states, too, were bound to respect at least most of the rights enumerated in Bill of Rights, as rights said to be "incorporated" into the reach of the Fourteenth Amendment.

In his early years on the Supreme Court, Justice Hugo Black led the battle to expand due process to "incorporate" the full substance of the Bill of Rights into the Fourteenth Amendment's restrictions on the states. In Justice Black's later years, however, the Court moved past the Bill of Rights incorporation debate and began to declare new nontextual substantive due process rights enforceable against the states. When it did so, the Court left behind Justice Black,

who continued to argue that incorporation should be both the floor and the ceiling of substantive due process doctrine.[12]

Justice Black's incorporation-but-no-more position toward substantive due process never managed to attract a majority of the Court. Instead, the Court gravitated variously toward the muscular notion that reasoned judgment is a reliable guide in the creation of non-textual rights and the somewhat more modest (but majoritarian and still arguably extra-textual) notion that history can provide an objective way to decide whether to recognize such rights. Interestingly, however, Justice Black's position has found two important new converts to his due process views in recent years.

In his first several years as a member of the Supreme Court, Justice Scalia conceded the constitutional legitimacy of non-textual substantive due process rights, seeking only to limit the creation of any new rights to those deeply ingrained in the nation's history -- as he did in Michael H.[13] Even in

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[12]See, e.g., Adamson v. California, 332 U.S. 46, 68 (1947) (Black, J., dissenting); Griswold v. Connecticut, 381 U.S. 479, 507 (1965) (Black, J., dissenting); Stovall v. Denno, 388 U.S. 293, 305 (1967) (Black, J., dissenting); In re Winship, 397 U.S. 358, 376 (1970).

[13]See 491 U.S. 122 (1989) (denying asserted nontextual due process right only because of lack of

the midst of the contentious abortion debate in Casey, Justice Scalia did not suggest that the Court should abandon the history test and the recognition of non-textual substantive due process rights, dissenting solely because, in his view, the right to abortion lacked sufficient basis in the historical record.[14] It appears, however, that the experience of Casey may have induced Justice Scalia to reconsider his views. Rumors persist of considerable acrimony among Court members during deliberations in Casey, arising allegedly because a majority of the justices at conference voted to overturn the abortion right, only to have subsequent behind-the-scenes machinations lead one or more justices to "flip," and thereby alter the outcome.[15] In any event, just a year after Casey's reaffirmation of the abortion right, Justice Scalia announced that, while he would continue "to accept the proposition that [due process], despite its textual limitation to

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historical evidence suggesting its importance).

[14]See Casey, 505 U.S. at 984 (Scalia, J., dissenting).

[15]Much light on this bit of backstage Court history may be shed when the Library of Congress makes public Justice Blackmun's Court papers, an event scheduled for five years after his death in 1999. See Library of Congress press release, Justice Blackmun Gives His Papers to Library (May 13, 1997). Justice Blackmun was widely known to have retained in his files detailed notes of justices' discussions during their private conferences, as well as working drafts of Court opinions.

procedure, incorporates certain guarantees specified in the Bill of Rights," he would no longer "accept the proposition that [due process] is the secret repository of all sorts of other unenumerated, substantive rights."[16] Since he joined the Court, Justice Thomas has concurred in Justice Scalia's statements rejecting all non-incorporation substantive due process doctrine.[17]

Though their position now may seem lonely, Justices Scalia and Thomas take a stand that has been in fashion before and may be again. Dred Scott v. Sandford,[18] in which the Court overruled the Missouri Compromise in part on the proto-substantive due process ground that it denied slaveholders their due process property interest in their slaves, is one of the Court's most reviled opinions. Decisions invalidating economic welfare legislation and portions of the New Deal, for supposedly interfering with the substantive

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[16]TXO Production Corp. v. Alliance Resources Corp., 509 U.S. 443, 470 (1993). See also Albright v. Oliver, 510 U.S. 266, 275 (1994); United States v. Carlton, 512 U.S. 26, 39 (1994) (Scalia, J., concurring in the judgment) ("If I thought that 'substantive due process' were a constitutional right rather than an oxymoron . . . .").

[17]See, e.g., TXO, 509 U.S. at 470; Carlton, 512 U.S. at 39.

[18]19 How. 393, 450 (1857).

due process right of private contract, are similarly discredited today.[19]

The precedential basis regularly relied upon by commentators and judges who seek to ensconce a "reasoned judgment" test in due process doctrine can also be easily overstated. Palko v. Connecticut is "much-quoted"[20] as a leading case espousing a reasoned judgment approach to due process, speaking of the constitutional inquiry as one into whether the asserted right is "implicit in the concept of ordered liberty."[21] But the Court did not actually recognize the proposed right in that case. In Roe v. Wade, the Court did endorse a new nontextual right in the face of substantial contrary history,[22] but its opinion cannot be taken as a ringing endorsement of a "reasoned judgment" approach to substantive due process adjudication: the Court there claimed that a hodge-podge of doctrines and theories supported its result, with substantive due process only thrown into the mix

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[19]This extensive line of cases is, perhaps most associated today with an early decision, Lochner v. New York, 198 U.S. 45 (1905), in part because of Justice Holmes's (ultimately triumphant) dissent.

[20]Moore, 431 U.S. 494, 546 (White, J., dissenting).

[21]302 U.S. 319, 325 (1937).

[22]See 410 U.S. at 129-41 (detailing ancient, common law, and contemporary legal provisions against abortion).

as just one more element -- one, moreover, that received relatively little attention in the text of the Roe opinion.[23]

Like Palko and Roe, Loving v. Virginia, where the Court struck down state laws prohibiting interracial marriage, is often cited as a leading authority for the "reasoned judgment" approach. Indeed, the Ninth Circuit en banc majority in Compassion in Dying insisted that

> [w]ere history our sole guide, the Virginia anti-miscegenation statute that the Court unanimously overturned in Loving . . . as violative of substantive due process and the Equal Protection Clause would still be in force because such anti-miscegenation laws were commonplace both when the United States was founded and when the Fourteenth Amendment was adopted.[24]

But the Ninth Circuit helps call into question its own thesis. The Court in Loving analyzed the anti-miscegenation law at issue not just -- or even primarily -- under a due process lens. Instead, the Loving court rested its decision almost entirely on a traditional equal protection analysis; its appeal to due process came as an after-thought appended to the tail of the opinion.[25]

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[23]Id. at 152-56.

[24]79 F.3d at 805.

[25]388 U.S. 1.

## V.3 Casey-Based Arguments

The strongest, most explicit defense of a purely reason-based approach to substantive due process in the Court's jurisprudence lies in Casey's reaffirmation of the right to abortion. Aware of twenty years' worth of criticism leveled at Roe v. Wade, the plurality in Casey sought to provide a firmer basis for the abortion right and to shore up the reasoning behind Roe's result.

In doing so, the Casey plurality purposefully eschewed any effort to examine the history of abortion regulation, stressing instead the importance of "reasoned judgment" in assessing whether to continue recognizing the constitutional right to abortion. Applying such judgment in Section II of its opinion, the plurality examined past Court decisions protecting the right to use contraception, marry interracially, and exercise control in the childrearing process, and claimed it could discern an overriding moral/philosophical principle:

> At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion of the State.[26]

From this principle the Court concluded an abortion

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[26]505 U.S. at 852.

right necessarily followed. While forcing a woman to carry an unwanted pregnancy may "ennoble[] her in the eyes of others," her

> suffering is too intimate and personal for the State to insist, without more, upon its own vision of a woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.[27]

It is precisely on the basis of Casey's "mystery of life" language that the Ninth Circuit en banc panel and Justice Stevens concluded that Casey provides an "almost prescriptive" mandate requiring recognition of a fundamental liberty interest in the receipt of assistance in committing suicide, regardless what history might say otherwise.[28] Assisted suicide, like abortion, is central to one's "concept of existence, of meaning, of the universe, and of the mystery of human life."

But it is far from clear whether Casey's autonomy argument is properly understood as anything more than dictum. First, the Casey plurality opinion actually cited two reasons for reaffirming the abortion right recognized in Roe. In Section II of its opinion, the plurality argued that abortion is fundamental to

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[27] Id.

[28] See generally Compassion in Dying, 79 F.3d at 813 (citations omitted).

individual autonomy, as Justice Stevens and others stress. But, in Section III, the plurality argued that the doctrine of stare decisis required continued respect for Roe's basic teachings.[29] Casey's reliance on stare decisis was the narrower of the two grounds for decision offered by the plurality and it was, standing alone, sufficient to decide the controversy before the Court. Consequently, the single-paragraph autonomy discussion upon which the Ninth Circuit and Justice Stevens so heavily relied in the assisted suicide cases is not only the view of a three-judge plurality, but arguably dicta even in that plurality's decision.

At this point, one might recall Loving, where the Court also employed two rationales in sustaining the creation of a new non-textual right, one of which was a "reasoned judgment" substantive due process analysis, and the other of which was a narrower, traditional equal protection holding. While some initially held out hope after Loving that the decision would act to free future due process adjudication from dependence on history and custom, a majority of the Supreme Court has never read the decision so broadly; instead, the Court quickly reverted to the history test in its substantive due process decisions. Similarly, in time Casey may

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[29]See 505 U.S. at 854-58.

come to be read primarily as a stare decisis decision.

On the other side of this coin, in its 2003 decision overturning Bowers and recognizing a constitutional right to private consensual homosexual sodomy, the Supreme Court expressly built on the "reasoned judgment" foundation set down by Casey, noting that, "[p]ersons in a homosexual relationship may seek autonomy for these purposes [i.e., in Casey's prose, to "define one's own concept of existence, of meaning, of the universe, and of the mystery of human life"], just as heterosexual persons do. The decision in Bowers would deny them this right."[30] How far Casey's "reasoned judgment" analysis will be extended, thus, remains to be seen.

Buttressing the view that Casey is best read essentially as a stare decisis decision, however, is the fact that the plurality decision did not mention, let alone register any dissatisfaction with, the Court's substantial body of cases advancing and applying the history test. Snyder v. Massachusetts and Moore v. City of East Cleveland are nowhere cited in Section II of the Casey plurality opinion and, thus, can hardly be said to be supplanted. Nor did Lawrence, applying Casey in the arena of homosexual sodomy, express any disagreement with earlier history test

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[30]Id.

cases or with Glucksberg, another and very recent application of the history test.

Admittedly, the Casey plurality did denounce one application of the history test in Section II -- footnote 6 of Michael H.,[31] which, the Casey plurality stated, would have required the Court to ask whether the asserted liberty interest before it was "at the most specific level . . . protected against governmental interference when the Fourteenth Amendment was ratified."[32] But even this does not purport to reject the history test generally. Michael H.'s version of the history test, requiring focus on the "most specific level" of tradition available, is but one way of applying the history test; two members of Casey's plurality supplied an alternative method of applying the history test in Michael H. itself.[33] Moreover, the Casey plurality arguably criticized a straw-man of its own creation, not the version of the history test actually advanced in Michael H. Michael H. did not seek to limit fundamental liberty interests only to those practices, defined at the most specific level, that were protected when the Fourteenth Amendment was ratified; rather, Michael H. merely

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[31]491 U.S. at 127 n.6.

[32]505 U.S. at 847.

[33]See Ch. III.2, supra.

suggested that courts may not disregard a specific, relevant tradition protecting, or denying protection to, the asserted right.[34]

The Ninth Circuit and Justice Stevens's broader reading of Casey, focusing exclusively on its autonomy discussion without regard to its central stare decisis holding, is also open to question on the ground that it proves too much. If the Constitution protects as a fundamental liberty interest "intimate" or "personal" decisions, the Court arguably would have to support future autonomy-based constitutional challenges to laws banning any private consensual act of any significance to the participants in defining their "own concept of existence." As Judge O'Scannlain queried in dissent in the Ninth Circuit's proceedings:

> If physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and, indeed, the use of illicit drugs.[35]

Justice Scalia raised much the same question in Lawrence, contending that "State laws against bigamy, same-sex marriage, adult incest, prostitution, masturbation, adultery, fornication, bestiality, and

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[34]See id.

[35]Compassion in Dying v. Washington, 85 F.3d at 1444 (dissenting from denial of rehearing en banc by the full court).

obscenity"[36] are all at risk if we take seriously what Justice Scalia derided as Casey's "famed sweet-mystery-of-life passage."[37] Such a result would certainly appear inconsistent with Justice O'Connor's opinion in Casey that abortion is "unique" in American due process jurisprudence.[38]

Finally, even if we do read Casey as recognizing a broad substantive due process right to personal autonomy concerning private and self-definitional matters, there is only one person's autonomy interest at risk in the abortion context: the woman's, for, under Roe's express holding, a fetus does not qualify as a person.[39] By contrast, there are "autonomy" interests belonging to persons on both sides of the assisted suicide and euthanasia issue -- the interest of those persons who wish to control the timing of

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[36]123 S. Ct. at 2490.

[37]Id. at 2489.

[38]See 505 U.S. at 852. As Justice Scalia put it, Casey's autonomy language either "'casts some doubt' upon either the totality of our jurisprudence or else (presumably the right answer) nothing at all." Lawrence, 123 S. Ct. at 1289 (Scalia, J., dissenting).

[39]See 410 U.S. at 158 (1973) (emphasizing that the fetus is not a protected "person" under the Fourteenth Amendment). But see Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 791-92 (1986) (White J. dissenting) (arguing that the right to terminate a pregnancy differs from the right to use contraceptives because the former involves the death of a person while the latter does not).

their deaths and the interest of those vulnerable individuals whose lives may be taken without their consent due to mistake, abuse, or pressure. In Roe, the Court expressly held that, had it found the fetus to be a "person" for purposes of the Fourteenth Amendment, it could not have created a right to abortion because no constitutional basis exists for preferring the mother's liberty interests over the child's life.[40] That reasoning suggests that even a court reading Casey broadly to embrace a constitutional autonomy interest would have difficulty deciding whether to prefer the autonomy interest of those who seek to die over the autonomy interest of those who fear inadvertent or wrongful death at the hands of an assisted suicide regime.

### V.4 Cruzan-Based Arguments

In arguing that Cruzan implies a right to assisted suicide, the Ninth Circuit en banc court characterized Cruzan as "recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death."[41] From that premise, the Ninth Circuit argued that, if an individual has a right, or protected liberty interest,

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[40]Roe, 410 U.S. at 158.

[41]79 F.3d at 816.

to commit suicide, he or she must have a right to assistance in committing suicide, otherwise "the state's prohibition on assistance [would] unconstitutionally restrict[] the exercise of that liberty interest."[42]

The Ninth Circuit's interpretation of Cruzan is arguably less an application of the case than a very substantial extension of it. Nancy Cruzan suffered severe injuries in an automobile accident and was left in an apparently permanent comatose state. Cruzan's care was being provided at state expense, but her parents sought to have tubes carrying food and water into their daughter removed. A Missouri state trial court authorized the termination, finding that a person in Cruzan's condition has a fundamental constitutional right to refuse care, but the Missouri state supreme court reversed. While recognizing a right to refuse treatment embodied in the common law doctrine of battery and informed consent, the state supreme court rejected the argument that Cruzan's parents were entitled to assume those rights in the event of her incompetency without a written living will or competent evidence of her wishes.

The majority of the United States Supreme Court began its own analysis of the case by examining the

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[42]Id. at 801 (citing Roe).

common law and observing that it has traditionally supplied a right to be free from physical intrusion without consent:

> At common law, even the touching of one person by another without consent and without legal justification was a battery. Before the turn of the century, this Court observed that no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person. . . . This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical purposes. . . . The informed consent doctrine has become firmly entrenched in American tort law.[43]

The Court next noted that a "logical corollary" has arisen to the common law doctrine of informed consent in the form of a "right not to consent, that is, to refuse treatment."[44] Recognizing that the "logic of the[se] cases would embrace" a liberty interest of constitutional dimension, the Court nonetheless stopped short even of recognizing a constitutionally based right to refuse life-sustaining care, because "the dramatic consequences involved in refusal of such treatment [i.e., death] would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible."[45] And, indeed, as we saw in Chapter III, the right to be free from unwanted

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[43]497 U.S. at 278 (internal quotation marks omitted).

[44]Id.

[45]Id. at 279.

intrusions is well-entrenched yet not absolute; at common law and under state statutes, for example, persons have long been privileged to interfere with suicide attempts, committing what, in other circumstances, would be deemed to be a battery.

Instead, proceeding cautiously, the Court opted, "for purposes of this case," to "assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[46] Assuming such a right, the Court proceeded to hold that Missouri had legitimate reasons for requiring either clear evidence of Cruzan's wishes before allowing her care to be discontinued.[47]

The Supreme Court did not discuss or endorse any

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[46]Id.

[47]The Court held, specifically, that Missouri had a legitimate interest in ensuring that any decision to refuse life-sustaining care is a personal one made by the patient, not by surrogates, in order to ensure against cases of abuse and mistake: "It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, there will, of course, be some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations." Cruzan, 497 U.S. at 281 (internal quotation marks omitted). The Court also held that a "State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." Id.

generic constitutional interest in hastening death, as the Ninth Circuit seemed to suppose, but, instead, justified its assumption that the Constitution protects a right to refuse life-sustaining care on the basis that the administration of unwanted medical treatment is a form of battery -- i.e., an unlicensed touching that offends historical common law principles. Assisted suicide and euthanasia, meanwhile, are not encompassed within the common law concern for unlicensed touchings: neither an unwanted touching (i.e., the administration of medicine) nor a lack of consent is involved in cases of assisted suicide and euthanasia. The common law's interest in protecting bodily integrity from unwanted physical invasions -- the interest the Court in Cruzan sought to protect -- simply is not at issue in cases covered by the proffered right to consensual assisted suicide or euthanasia. Moreover, the Supreme Court in Cruzan took great pains to make clear that its due process analysis was based on a historical analysis of the development of the common law; the Court was willing to consider embedding recognized common law principles in the Constitution, but nothing in its opinion suggested that it was willing to recognize rights (such as those to assisted suicide and euthanasia) that lack such antecedents.

## V.5 Conclusion

Many noted constitutional theorists over the last half-century have suggested that members of the Supreme Court should employ "reasoned judgment" in substantive due process disputes, resolving cases, as Justice Souter put it, by employing "the usual canons of critical discourse" and doctrinal decisionmaking. Such a methodology, however, arguably offers less certainty and guidance than the competing history test, and its application by the plurality in Casey is apparently responsible for leading at least two Justices to reconsider Justice Black's view that the substantive component of the due process clause should be interpreted to incorporate against the states the textual rights found in the Bill of Rights, and no more. Acknowledging, however, the vitality of the "reasoned judgment" approach to substantive due process inquiries, we considered arguments based on Roe, Palko, and Loving, as well as Casey and Cruzan. We found ample language in Casey to support an assisted suicide right, but we also found that the same language could be employed to support a right to participate in an array of currently unlawful activities. Given Casey's alternative and sufficient stare decisis holding, we considered whether the decision's broader language about the nature and extent of personal autonomy rights

might be considered dicta, and noted that, quite unlike the abortion debate, autonomy interests here lie on both sides of the debate. We then considered an argument for assisted suicide based on Cruzan and found that the case rested not on any assumption about the existence of an autonomy-based right to hasten death, but on traditional common law concepts of battery; while a right to refuse implicates the common law right to avoid non-consensual touchings, the putative right to assisted suicide and euthanasia simply does not.

# CHAPTER VI

## AUTONOMY THEORY, ASSISTED SUICIDE, AND EUTHANASIA

### VI.1 Introduction

Despite contrary doctrinal arguments, some judges may conclude that constitutional law contains a right to personal autonomy whose boundaries are constrained only by the limits of "reasoned judgment." But merely recognizing such an autonomy interest does not end the assisted suicide analysis; it only raises the next question: what does respect for personal autonomy mean in this context? And if broad personal autonomy interests are protected by substantive due process doctrine, what kind of right to assistance in suicide or euthanasia follows? Unconstrained by constitutional doctrine, legislators likewise will have to face moral-political arguments for legalization based on conceptions of patient "autonomy" and "choice." In what follows, I briefly outline three of the most prominent theories of personal autonomy in contemporary moral-political theory and then turn to consider their potential application to the assisted suicide and

euthanasia debate.[1]

## VI.2 The Political Preconditions to Autonomy

Joseph Raz has identified three preconditions for the exercise of personal autonomy. First, Raz notes that, to exercise autonomy, an individual must be capable of understanding his options and choosing between them:

> If a person is to be a maker or author of his own life then he must have the mental abilities to form intentions of a sufficiently complex kind, and plan their execution. These include minimum rationality, the ability to comprehend the means required to realize his goals, the mental faculties to plan actions, etc. For a person to enjoy an autonomous life he must actually use these faculties to choose what life to have.[2]

Second, Raz argues that one must have a sufficient number of options to choose among for choice to be meaningful. Raz illustrates two aspects of this point. A woman left on a desert island with a carnivorous animal that constantly hunts her may be capable of making autonomous choices, but she has no time to do so. Her thoughts are concerned only with survival. Conversely, a man fallen into a pit with enough food and water to survive for the rest of his natural life

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[1]I do not seek to provide a map to the ever growing debate over autonomy in moral theory. My purpose is solely to outline the autonomy debate in general terms in order to assess its application to the assisted suicide debate, seeking to keep a potentially vast topic within manageable, yet useful bounds.

[2]Joseph Raz, The Morality of Freedom 371 (1988) (hereinafter, "Raz, The Morality of Freedom").

may have the means necessary for survival but his available choices are so limited that they leave little room for autonomy. "His choices are confined to whether to eat now or a little later, whether to sleep now or a little later, whether to scratch his left ear or not."[3] To Raz, one must have both a sufficient number of tools of self-creation at hand and sufficient leisure time to employ them to become, in a true sense, the primary author in writing the story of one's own life.

The third precondition Raz posits is that, for a decision to be autonomous, it must be free from "coercion and manipulation."[4] For an individual's choice to be her own, it must be her choice and not one dictated by another. But this assertion of moral theory, like the question of what constitutes a "sufficient" number of options to choose among, quickly takes us into the realm of political theory: when must the state forswear coercion and manipulation in order to assure adequate respect and room for individual choice?

This question has engendered substantial debate and disagreement; contemporary autonomy theorists answer it in markedly different ways. Some hold that

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[3] Id. at 374.

[4] Id. at 373.

the state must remain neutral between competing conceptions of the good life (the neutrality principle). Others maintain the state need not remain neutral, but may legislate coercively only when harm to others is threatened (the harm principle). Still others challenge the necessity of either the neutrality or harm principle to the full and appropriate flourishing of personal autonomy (perfectionism).

### VI.3 The Neutrality Principle

Neutralists argue that respect for personal autonomy requires government to forswear any interest in promoting particular moral objectives or ends; the state must leave individuals to choose their own values. The state has no role to play in making men and women moral, no role in "perfecting" persons; to the contrary, the state should aspire to an anti-perfectionist ideal.

One of the most familiar briefs for state neutrality is John Rawls's defense of equal liberty in A Theory of Justice. Rawls hypothesizes an original position, a moral vacuum where individuals have not yet established any religious or moral identity or commitments.[5] Rawls argues that, in such a hypothetical original position, rationally self-interested persons would demand the freedom to define and pursue their own

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[5]John Rawls, A Theory of Justice 11 (1989).

views of what constitutes a good life without state interference. Ignorant of, say, what religion he or she would hold in society, a rational person would not permit the state authority to prefer one religion over another. People in the original position

> cannot take chances with their liberty by permitting the dominant religious or moral doctrine to persecute or to suppress others if it wishes. Even granting (what may be questioned) that it is more probable than not that one will turn out to belong to the majority (if a majority exists), to gamble in this way would show that one did not take one's religious or moral convictions seriously, or highly value the liberty to examine one's beliefs.[6]

Accordingly, the state is left free to pursue only those policies and norms that evince equal respect for all competing conceptions of the good.

An array of contemporary theorists have sought to supplement and strengthen Rawls's thesis in various ways.[7] But, for our purposes, the critical fact is that all see state neutrality as an essential ingredient to personal autonomy. For example, David Richards argues that state neutrality alone can ensure "respect [for]

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[6]Raz, The Morality of Freedom 207.

[7]See, e.g., H.L.A. Hart, Law, Liberty, and Morality 30-43 (1963); Bruce Ackerman, Social Justice in the Liberal State 386-89 (1980); Loren Lomasky, Persons, Rights, and the Moral Community 231-54 (1987); Jeremy Waldron, Autonomy and Perfectionism in Raz's Morality of Freedom, 62 So. Cal. L. Rev. 1097, 1127-30 (1989); Ronald Dworkin, Foundations of Liberal Equality in The Tanner Lectures on Human Values 60-70 (Grethe B. Petersen, ed. 1990).

the moral sovereignty of the people themselves, the ideal of the sovereign ethical dignity of the person against which the legitimacy of the contractarian state must be judged."[8] Should the state pursue non-neutral ends, it would "degrade [individuals'] just equal liberty to define their ultimate philosophical and moral aims."[9] Ronald Dworkin similarly submits that government must "impose no sacrifice or constraint on any citizen in virtue of an argument that the citizen could not accept without abandoning this sense of his equal worth," nor should it "enforce private morality."[10]

Although anti-perfectionists like Rawls, Richards, and Dworkin view state neutrality as the critical bulwark of individual autonomy, not all liberal moral

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[8]David A.J. Richards, Toleration and the Constitution 252 (1989) (hereinafter, "Richards, Toleration").

[9]David A.J. Richards, Kantian Ethics and the Harm Principle: A Reply to John Finnis, 87 Colum. L. Rev. 433, at 464 (1987). Note Richards' use of the word "define" and other language that anticipates Casey's autonomy discussion.

[10]Ronald Dworkin, A Matter of Principle 205-06 (1985). In the end, however, Rawls does sanction at least one deviation from strict neutrality. His theory presupposes individuals of equal means and ability pursuing their notions of the good; but, of course, people do not start off life on equal terms materially. Rawls would, thus, permit (pursuant to his difference principle) the state to deviate from equal distribution of primary goods to enable the worst-off sufficient means to pursue their own conceptions of the good. See Rawls, A Theory of Justice 76.

theorists agree. Raz, for one, agrees that for individual autonomy to mean anything the individual must have a "large number of greatly differing pursuits among which [he is] free to choose."[11] Autonomous individuals cannot be left with too few options like the hypothetical Man in the Pit, or with too little time to make meaningful life-defining choices like the Hounded Woman. But to say that a wide range of choices is a precondition to autonomy does not, to Raz, mean that <u>all</u> conceivable options must be available to the individual. A non-neutral perfectionist state might rule out certain ways of life as bad, but, Raz argues, there is no reason to suppose it would leave individuals with insufficient options to lead a fully autonomous life. To the contrary, because there are so many "forms and styles of life which exemplify different virtues and which are incompatible" with each other, even in a perfectionist state ample choices will remain for autonomy to flourish.[12]

Not only can a perfectionist state foreclose evil options without seriously infringing on individuals' opportunities for self-creation, Raz argues it <u>should</u> do so. It should because autonomy is valuable only when exercised in pursuit of a morally upright way of

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[11]Raz, <u>The Morality of Freedom</u> 381.

[12]<u>Id.</u> at 395.

life. A person may be autonomous even when choosing bad ways of life, but Raz argues that

> autonomously choosing the bad makes one's life worse than a comparable non-autonomous life is. Since our concern for autonomy is a concern to enable people to have a good life it furnishes us with reason to secure that autonomy which could be valuable. Providing, preserving or protecting bad options does not enable one to enjoy valuable autonomy.[13]

As for the Rawlsian claim that rationally self-interested individuals would never choose a state that could rule out some competing conceptions of the good, Raz simply disagrees. Individuals in the original position might well permit a perfectionist state to act non-neutrally and rule out bad choices and lifestyles, provided that the state does so in accord with a methodology all can see and accept as fair. Rather than demanding a neutralist state, Raz thinks that rationally self-interested persons might just as easily reach "an agreement to establish a constitutional framework most likely to lead to the pursuit of well-founded ideals, given the information available at any given time."[14]

### VI.4 The Harm Principle

Just as the neutrality principle divides some moral theorists over autonomy's meaning and

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[13] Id. at 412.

[14] Id. at 126.

prerequisites, a debate over whether the state must respect the harm principle divides others.

The harm principle holds that each person must be afforded the right to exercise self-control "[o]ver himself, over his own body and mind," and that the "only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others."[15] The harm principle, thus, differs from the neutrality principle in one significant respect. Where neutrality bars government from promoting any particular version of morality, the harm principle is concerned with the means used to enforce morality. One may accept that government has a role to play in (non-neutrally) encouraging good choices and discouraging evil ones, but also take the view that it may use coercive means (e.g., criminal sanctions) only to prevent those choices which result in harm to others. Thus, assuming bigamy to be immoral but harmless to others, the non-neutral harm principle adherent would allow the state to teach against bigamy and attempt to discourage it (e.g., by refusing to recognize bigamous marriages), but would forbid the state from making bigamy a crime.

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[15]John Stuart Mill, On Liberty 9 (E. Rappaport, ed. 1978).

Introducing the concept of the harm principle of course begs the question: what constitutes "harm"? Must there be a physical invasion before the state can intercede? Most adherents to the harm principle recognize the possibility of non-physical harm. Yet they also seek to rule out definitions of harm that expand it so far as to permit the state to "criminalize conduct solely because the mere thought of it gives offense to others."[16] But their attempts at a narrower definition are usually abstract and opaque, as Raz's own (valiant) effort illustrates: "[o]ne harms another when one's action makes the other person worse off than he was, or is entitled to be, in a way which affects his future well-being."[17]

Despite the inherent difficulties in seeking to differentiate harm from mere offense, many neutralists, including Rawls, Dworkin, and Richards, also adhere to some form of the harm principle.[18] But Raz illustrates

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[16]Richards, Toleration 239.

[17]Raz, The Morality of Freedom 414.

[18]See, e.g., Robert George, Making Men Moral 140 n.24 (1993) (hereinafter, "George, Making Men Moral"). "Rawls says that 'justice as fairness requires us to show that modes of conduct interfere with the basic liberties of others or else violate some obligation or natural duty before they can be restricted.' Inasmuch as, for Rawls, 'obligations' are obligations of fairness and 'natural duties' are owed to others, it seems reasonable to conclude that Rawls himself understands his theory to imply a version of the harm principle which would, at minimum, exclude moral

that one can reject neutralism and endorse the harm principle. While Raz rejects neutrality as unnecessary to ensure personal autonomy, he argues that to disregard the harm principle would be to violate autonomy in two ways:

> First, it [would] violate[] the condition of independence and express[] a relation of domination and an attitude of disrespect for the coerced individual. Second, coercion by criminal penalties [would be] a global and indiscriminate invasion of autonomy. Imprisoning a person prevents him from almost all autonomous pursuits [recall the Man in the Pit]. Other forms of coercion may be less severe, but, they all invade autonomy, and they all, at least in this world, do it in a fairly indiscriminate way. That is, there is no practical way of ensuring that the coercion will restrict the victims' choice of repugnant options but will not interfere with their other choices.[19]

On this account, the harm principle allows individuals all the freedom they want to pursue their own views of the good life -- up to the point where an unwilling

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paternalism." Id. (internal citations omitted).

Other eloquent exponents of the harm principle include Joel Feinberg and Robert Nozick. See, e.g., Joel Feinberg, The Moral Limits of the Criminal Law: Harm to Others (1984); Joel Feinberg, Offense to Others (1985); Joel Feinberg, Harm to Self (1986) (hereinafter, "Feinberg, Harm to Self"); Joel Feinberg, Harmless Wrongdoing (1987); Robert Nozick, Anarchy, State, and Utopia (hereinafter "Nozick, Anarchy") ix (1974) (advocating the harm principle and contending that the state violates individuals' rights if it uses its "coercive apparatus . . . to prohibit activities for their own good or protection"). Whether Nozick is an anti-perfectionist, however, is not altogether clear. See Nozick, Anarchy 48-51.

[19]Raz, The Morality of Freedom 418-19.

person could be harmed. According to the familiar saw, freedom ends where the next person's nose begins. While the state may teach and promote good behavior, allowing it to punish bad conduct that results in no harm to others would, if Raz is right, unduly constrain individual choice and opportunities for self-creation. Worse still on this account, coercive state power is an indiscriminate and unwieldy tool; using it to snuff out bad but purely self-regarding choices may incidentally foreclose other, good choices. Thus, for example, when we try to ban pornography, someone almost always raises the question whether we are also (perhaps inadvertently) infringing upon legitimate artistic expression.[20]

### VI.5 Perfectionism

Some reject not only the neutrality principle, but also the harm principle as an essential precondition of individual autonomy. Patrick Devlin argued that the state should be allowed to pursue any moral ends it wishes in the name of social cohesion, regardless of whether the morality pursued is true. Though coming from a different point of view, more recently Robert George has taken the position that anyone who rejects state neutrality (e.g., Raz) must also, as a matter of logic, reject the harm principle. George insists,

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[20]See id. at 418.

however, that ample room remains for meaningful individual choice and autonomy without the state adhering to either principle. Like Raz, George argues that there are many and varied ways of living a morally upright life, and that individuals should be free to choose from these without state interference.[21] But autonomy is only an instrumental value, George submits, not an absolute one. Individual choice should be respected to the extent (but only to the extent) it is employed toward ends recognized as morally good: "The value of autonomy is . . . conditional upon whether or not one uses one's autonomy for good or ill."[22] Personal choice, on this account, should be permitted only "in so far as [it is an] important means and condition[] to the realization of human goods and the communities they form."[23]

To Raz's claim that the state's use of coercion in the absence of harm to others expresses disrespect for the coerced individual, George replies that coercive laws

> do not, except in the most indirect or implausible senses, deprive the morals offender of any sort of valuable choice. . . . [I]t is difficult to perceive violations of autonomy in the legal prohibition of victimless wrongs if we join Raz .

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[21]George, Making Men Moral 173-75.

[22]Id. at 177.

[23]Id. at 215.

> . . in a perfectionist understanding of autonomy as valuable only when exercised in the pursuit of what is morally good. And this raises the suspicion that Raz smuggles into this argument a non-perfectionist notion of autonomy.[24]

Thus, George asserts, coercing an individual to avoid bad choices does not really deprive him of any meaningful choice at all.

It is, however, not entirely clear that Raz "smuggles" an anti-perfectionist notion of autonomy into his defense of the harm principle, as George suggests. George's submission that the value of human choice depends entirely on the worthiness of the ends chosen may overlook the possibility, latent in the harm principle (though not as explicit as it might be in Raz's work), that the act of choice itself is a meaningful societal good; that there is some real social benefit in permitting and encouraging people to make choices, even if they are "bad" ones. Certainly most parents and teachers would accept as a truism that there is an inherent value in allowing their children and pupils to make and learn from misguided decisions. And our principle of government, at least as embodied in the Declaration of Independence, squarely rests on the conviction that there is inherent value in permitting individuals liberty enough to pursue their

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[24] Id. at 185.

own visions of happiness.[25]

George advances a more powerful argument, I believe, when he contends that the use of coercive laws to prevent victimless bad choices does not display disrespect for the coerced individual, but only disrespect for the bad end chosen. On this view, society intends to condemn the sin, not the sinner: "Conscientious legislators who vote for morals legislation seek to condemn vices -- not people. Indeed, one of their primary concerns is to protect the very people who would, in the absence of laws, against, say, pornography or drugs, fall victim to the very temptation to engage in those vices. . . . Immoral conduct can be banned without thereby expressing contempt for someone who might otherwise fall into it."[26]

Of course, Raz also argues that laws offending the harm principle are dangerously indiscriminate tools, foreclosing not only what we might agree to be repugnant choices, but also incidentally interfering with other, legitimate choices. George concedes as much, but argues that this fact does not demonstrate

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[25]Declaration of Independence ¶ 2 ("We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.").

[26]George, Making Men Moral 185-86.

that the use of coercion is always wrong as a matter of principle. Instead, he submits, it counsels that we should use coercion in the realm of self-regarding choices (and otherwise) both sparingly and prudently:

> [Raz worries] that laws restricting, say, pornography may result in the suppression of legitimate and valuable forms of art and literature. This worry is legitimate . . . . The danger of interfering with morally acceptable choices is a consideration that counts against anti-pornography legislation in the practical reasoning of prudent legislators. But it may not be a conclusive reason. In the circumstances, the good to be achieved may reasonably be judged as worthy of the risks.[27]

George's argument, thus, does not seek to unseat Raz's harm principle, at least as a useful rule-of-thumb. George concedes the need to be wary of the imprecision of coercive penalties, and he acknowledges that they can result in the accidental suppression of upright choices, but he also submits that such practical concerns do not justify the adoption of a rigid rule permitting all consensual or "harmless" conduct. Indeed, George submits that the risk of overinclusive and indiscriminate legislation is not confined to morals legislation where there is no "harmed" party, but also exists "in [other] areas of the criminal (and civil) law. Prudence is required in other areas as well. The controlling moral norms in the face of risks [of indiscriminate coercive

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[27] Id. at 188.

legislation] are, I think, norms of fairness," not the adoption of an absolute rule proscribing any legislation over morals or other "harmless" arenas of human activity.[28] In Cruzan, Justice Scalia advanced a similar view, if in a very different context, in a passage George would no doubt approve: "[w]hat protects us . . . from being assessed a tax of 100% of our income above the subsistence level, from being forbidden to drive cars, or from being required to send our children to school for 10 hours a day," is not rigid adherence to abstract principles, such as the harm principle, but simply "the Equal Protection Clause, which requires the democratic majority to accept for themselves . . . what they impose on you and me.[29]

### VI.6 The Implications of Autonomy Theory for the Assisted Suicide Debate

Turning more directly to the assisted suicide question, it is immediately apparent that George's view of personal autonomy does not (and cannot) command the recognition of a new legal or moral right. Evaluating whether persons should have the right to receive assistance in suicide or euthanasia collapses into an inquiry into the moral uprightness of the acts

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[28] Id.

[29] 497 U.S. at 300 (Scalia, J., concurring).

themselves. George admits that a right to choose a way of life (or death) arises if, but only if, it is consistent with the realization of human goods and the communities they form.[30] Autonomy, to George, is an entirely instrumental good, devoid of independent content or value, and incapable of commanding the recognition of a right to assisted suicide or any other substantive right. To say that assisted suicide advances personal choice and autonomy simply does not, for George, do anything to answer the question whether the practices are worthy of legal approbation. For George, "[t]he saving of souls is the whole reason for the law,"[31] and the question whether to recognize any new legal or moral right should be answered with that goal fixed in mind.

In contrast to perfectionists such as George, some adherents to the harm and neutrality principles claim that their conceptions of autonomy do have substantive content, and many argue that they can provide definitive answers to the assisted suicide and euthanasia question. Some suggest, for example, that assisted suicide or euthanasia are classic "self-regarding" acts and, therefore, "harmless" activities. But is this so? Spouses can be left behind, bereft of

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[30]Id. at 215.

[31]Id. at 34.

their companions. Children may be orphaned. Even the most rational act of suicide can impose real "harms" on third persons, whatever one's understanding of the term. Thus, even while endorsing fully the harm principle, the state would likely be free to use its coercive powers to suppress at least some acts of suicide, assisted suicide, and euthanasia to protect against harms befalling unconsenting persons.

More fundamentally, in a manner somewhat evocative of Robert George's suggestion that the harm principle should be viewed more as a useful rule-of-thumb than an absolute command (and arguably evidence that George is onto something), notable harm principle advocates, including John Stuart Mill and Joel Feinberg, have argued for laws banning completely certain purely consensual practices (e.g., dueling and self-enslavement contracts). Though such practices can be expressive of autonomous impulses and are consensual and, thus, generally "harmless," the argument runs, they cannot be practiced without an undue risk of mistake, abuse, or coercion -- and, thus, harm to third persons.[32] As Feinberg has put it in the context of slavery contracts:

> Since the renunciation of rights is both total and

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[32] See, e.g., Feinberg, Harm to Self 18-19 (dueling); id. at 75-79 (slavery contracts); Mill, On Liberty ch. V, para. 11 (slavery contracts).

irrevocable in this kind of transaction, the standard for voluntariness must be higher than for any other kind of agreement (except perhaps suicide pacts and voluntary euthanasia requests). The risks are so great that the possibility of mistake must be reduced to a minimum . . . . [t]he grounds for suspicion are so powerful that the testing would have to be thorough, time-consuming, and expensive. The legal machinery for testing voluntariness would be so cumbersome and expensive as to be impracticable. Such procedures would, after all, have to be paid for out of tax revenues, the payment of which is mandatory for taxpayers. (And psychiatric consultant fees, among other things are very high.)[33]

While first focused on the costs and burdens of determining assent, Feinberg then turns to the risks of abuse and mistake:

> The more important point is that even expensive legal machinery might be so highly fallible that there could be no sure way of determining voluntariness. . . . The state might be justified simply in presuming nonvoluntariness conclusively in every case as the least risky course. Some rational bargain-makers might be unfairly restrained under this policy, but on the alternative policy, even more people, perhaps, would become unjustly (mistakenly) enslaved.[34]

Feinberg goes even one step further, evoking a familiar common law maxim and suggesting that "[i]t is better (say) that one hundred people be wrongly denied permission to be enslaved than that one be wrongly permitted."[35] Plainly, at least on this account of the harm principle, one must hesitate before legalizing

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[33]Feinberg, Harm to Self at 79.

[34]Id.

[35]Id.

assisted suicide and euthanasia and ask about the costs of the legal machinery necessary to ensure that decisions to die are voluntarily made and not coerced or the product of depression or incompetency. One must consider, too, the risks of abuse and mistake, asking whether, as Feinberg does in the slavery contract context, the killing of some innocent persons without their consent is a price worth paying for the proffered right to receive assistance in dying. Certainly the potential harm associated with a mistaken or wrongful act of assisting suicide -- murder -- is at least as grave as any harm associated with the abusive practice of duelling or consensual slavery contracts. If banning these other practices can be reconciled with the harm principle -- and Feinberg and Mill suggest it can -- the harm principle advocate must offer some explanation why banning assisted suicide and euthanasia cannot.

Assuming for the moment that the harm principle adherent could resolve all questions about the administration of, and the incidence of abuse and mistake in, an assisted suicide regime, what would a right to assisted suicide or euthanasia based on the harm principle look like? Similarly, we might ask, what would be the likely contours of a right to assisted suicide based on the neutrality principle?

Virtually every contemporary proponent of assisted suicide and euthanasia would limit their availability to the terminally ill or those suffering intolerable pain. The referendum passed by Oregon voters in 1994 (like unsuccessful efforts in California and Washington state) focused only on assistance for the terminally ill. The World Federation of Right-to-Die Societies similarly has lobbied for a right available only to the "incurably ill and/or intolerably suffering person who persistently requests that help."[36] In the Netherlands, regulations purport to limit aid-in-dying to patients who are "experiencing intolerable suffering with no prospect of improvement," and require that other alternatives to alleviate the patient's suffering "must have been considered and found wanting."[37]

Of course, defining terms such as "terminally ill" or "intolerably suffering" is a difficult task -- perhaps as difficult as defining "harm." It is commonplace to hear stories of people erroneously informed that they have just months to live. As Judge Noonan noted, definitions of terminal illness are "inherently unstable."[38] But even putting aside such

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[36]See Letter from the World Federation of Right-to-Die Societies, quoted in House of Lords Report HL Paper, 21-I of 1993-1994 Session, vol. 3, at 182.

[37]See id. vol. 1, at 65.

[38]Compassion in Dying, 49 F.3d at 590.

definitional problems, a right limited only to terminally ill persons seems incompatible with full respect for the neutrality and harm principles. While a regime confining the right to assisted suicide to the terminally ill or those suffering grave pain and would advance the autonomy interests of some persons, it would do nothing to advance the autonomy interests of others. Many rational, autonomous (and purportedly "harmless") decisions to die would continue to be suppressed. For example, Christian virgins seeking to avoid rapacious invaders, monks seeking the face of God, Romeos despondent over lost loves, Sardanapolises weary with life, Buddhist monks seeking to protest war through self-immolation, prisoners tired of their confined lives, the handicapped overwhelmed by their disabilities -- all would be barred from seeking assistance in taking their own lives in the manner they think most fitting if the right to assisted suicide and euthanasia is limited to the terminally ill or those suffering grave physical pain.

Put another way, in the assisted suicide regime typically proposed today, the individual's rational and "harmless" choice is a necessary, but not a sufficient, precondition to the exercise of the proffered right. Individuals seeking death must not only rationally and autonomously choose it, they must also receive the

imprimatur of the state that their lives are of a sort that may be taken; the state alone asserts the authority to make the final moral judgment about which lives are worth protecting even against the rational patient's will. Robert Sedler, an ACLU advocate for the right to receive assistance in suicide, makes the point plainly when he states that the ACLU would extend the right only to the "terminally ill or so physically debilitated that it is objectively reasonable for them to find that their life has become unendurable."[39]

Such judgments appear inconsistent with the aspirations behind the harm and neutrality principles. Relying on the neutrality principle, Ronald Dworkin has testified before the British Parliament that "[p]eople disagree about what kind of a death is meaningful for them," and, precisely because of that disagreement, a state neutral between competing conceptions of the good life (and death) must avoid making any judgments or asserting any power in the area:

> [It] is not that we collectively think [assisting suicide or euthanasia] is the decent thing to do, but that we collectively want people to act out of their own conviction.[40]

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[39]Richard Sedler, Constitutional Challenges to Bans on "Assisted Suicide" the View from Without and Within, 21 Hastings Const. L. Quar. 794 (1994) (emphasis added).

[40]Oral Testimony of Ronald Dworkin before the Select Committee on Medical Ethics of the House of Lords, quoted in House of Lords Report HL Paper, 21-I

David Richards has similarly written that

> it is an open question, consistent with the neutral theory of the good, how persons with freedom and rationality will define the meaning of their lives, and no externally defined teleological script is entitled to any special authority or weight in such personal self-definition. Once we see the issue in this way, we can see that the fact of one's own death frames the meaning one gives one's life in widely differing ways.[41]

The harm and neutrality principles, thus, tend toward a right to assisted suicide and euthanasia open to all competent adults.

At this point, one might interject that such paternalistic non-neutral limits on choice <u>can</u> sometimes be justified, even under the neutrality principle. David Richards has argued, for example, that neutralism can

> supply a principle of paternalism and explain its proper scope and limits. From the point of view of the original position, the contractors would know that human beings would be subject to certain kinds of irrationalities with severe consequences, including death and the permanent impairment of health, and they would, accordingly, agree on an insurance principle against certain of these more serious irrationalities in the event they might occur to them.

Richards, however, appears to permit only enough paternalism to ensure a fully competent adult decision (<u>i.e.</u>, enough to prevent "irrationalities"). Richards

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of 1993-1994 Session, vol. 1, at 23, 28.

[41]David A.J. Richards, <u>Sex, Drugs, Death, and the Law</u> 248-49 (1982) (hereinafter, "Richards, <u>Sex, Drugs</u>").

does so out of recognition that, to allow more paternalistic interference than a rudimentary "cooling off" period to ensure that the individual has made a fully rational and considered decision, would radically interfere with autonomous self-creation regarding one of the most intimate and personal of matters.[42]

Using neutralist principles, one might try yet another way of defending a "limited" assisted suicide right, arguing that an assisted suicide and euthanasia right limited to persons suffering from a terminal illness or terrible physical pain represents a rough approximation of the result that rational individuals in the original position, having yet formed no commitment to competing conceptions of the good, would select. Such an argument, however, risks confusing neutralism with majoritarianism. It suggests adopting a policy that many people might select or vote for, but one that not everyone would freely choose if the state remained neutral. Surely there <u>are</u> reasons why some -- perhaps many -- individuals who are not terminally ill or suffering grave pain may wish to die that we would

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[42]<u>See also</u> Dan Brock, <u>Life and Death: Philosophical Essays in Biomedical Ethics</u> 206 (1993) ("[i]f self-determination is a fundamental value, then the great variability among people on this question [of when assisted suicide might be justified] makes it especially important that individuals control the manner, circumstances, and timing of their dying and death").

recognize at least as "rational," and thus worthy of respect by a neutralist state. Who is to call deranged, for example, the peasant in Graham Greene's Tenth Man who was willing to sell his life for his family's financial security? Or the Japanese kamikaze pilots who gave up their lives out of religious and political fidelity to their emperor? Or the self-immolating Buddhist monks who sought to protest the war in Vietnam? We may not agree with these decisions, or make them for ourselves, but it is far from clear we can deem such decisions irrational. Indeed, to hold otherwise would preclude some rational adults from making a putatively harmless and autonomous decision to die in the manner they choose. To comport fully with the neutrality and harm principles, therefore, the state arguably would have to abstain from coercively interfering with any rational adult's private decision to die, whatever the motive or reason for the individual's considered decision.

If I am correct, to the extent that the neutrality and harm principles support a right to assisted suicide and euthanasia, it is not a right that can be easily confined to certain classes of persons based upon their physical condition. Instead, the neutrality and harm principles appear to suggest a right to consensual homicide open to all rational adults. Such a result,

essentially a right to consensual homicide, has no analogy in modern history and goes beyond even Rome's precedent. The prisoner sick of his sentence, the exhibitionist who sets himself on a pyre, the impecunious seeking a better life for his family by selling his life for disposal as a lethal form of amusement, and the terminally ill are all treated equally.[43] Their different conceptions of the good death all have to be respected -- if only after a "cooling off" period.

Neutrality and harm principle advocates are only beginning to discuss the possibility of a consensual homicide right open to all adults; to date, they have tended instead, in their writings, to emphasize the dire medical condition of a particular patient, the

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[43]While Roman-style consensual homicide practices may seem unimaginable in contemporary society, examples of similar and worse can be found in our daily headlines. Armin Meiwes, a 41 year-old German computer expert, was recently arrested for killing, butchering, an eating a willing 43 year-old volunteer he found through Internet chat rooms for like-minded persons called Gourmet, Cannibal Cafe, and Eaten Up. Meiwes apparently had other individuals willing to give up their lives, as well, one of whom he rejected as "too fatty." After his arrest, Meiwes told reporters that he "is confident of a light sentence," expressly invoking neutralist/harm principle themes: "'I think I will be out after four or five years. It isn't as if I killed anyone against their will.'" Alan Hall, German Net Cannibal: Had Londoner on Menu, The Times (July 24, 2003) (emphasis added). Young Japanese men are also now using the Internet in significant numbers to find partners for mutual suicide pacts. See Anthony Faiola, Internet Suicides Plaguing Japan, Washington Post, A1 (Aug. 24, 2003).

unpleasantness of hospital settings, and the compassion of individual physicians like Dr. Quill. But the consistent application of the neutrality and harm principles seems to lead much further.

Gerald Dworkin, for example, advocates the creation of a safeguard "Suicide Board" composed of psychologists "to meet and talk with the person proposing to take his life."[44] But even Dworkin ultimately seems to concede that neutral respect for personal autonomy requires that the approval of such a board would be unnecessary, and that the decision to die (in any fashion) would always rest with the competent adult.[45]

David Richards argues for a right to be assisted in suicide with a vivid discussion of the plight of cancer patients though, in the end, he, too, admits that his argument extends beyond such sympathetic cases to <u>any</u> "voluntarily embraced" decision to die.[46]

Joel Feinberg discusses a British television drama, <u>Whose Life Is It Anyway?</u> In the program, an active young man is paralyzed from the neck down in a car crash who decides that he would rather die than

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[44]Gerald Dworkin, <u>Paternalism</u>, reprinted in <u>Morality and the Law</u> 124 (Robert Baird and Stuart Rosenbaum, eds. 1988).

[45]<u>Id.</u>

[46]Richards, <u>Sex, Drugs</u> 226.

live out his life as a quadriplegic. Feinberg describes the young man's physical plight in detail. Yet, Feinberg ultimately declares that the patient's physical condition is irrelevant to the question whether he should be permitted to die:

> [if] the choice is voluntary enough by reasonable tests, [one should be] firmly committed to a policy of non-interference . . . for the life at stake is [the patient's] life not ours. The person in sovereign control over it is precisely he.[47]

Perhaps most candidly of all, Sherry Colb, professor of law at Rutgers University, has openly criticized those who would make what she calls "the distinction between the terminally ill and everyone else."[48] As Colb puts it, such a distinction

> does not keep faith with the ethical foundation for the right to die. The moral principle that distinguishes physician-assisted suicide from murder is a respect for the autonomy of the individual [i.e., consent?]. According to this principle . . . we should honor that wish [to die] regardless of whether she is terminally ill -- out of compassion and respect for the individual . . . . It is essential in this context that we do not substitute our own judgment about which lives are and are not worth living for that of the individual whose own life is at stake.[49]

Ronald Dworkin, too, illustrates just how far the neutralist's commitment to respect fully autonomous

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[47]Feinberg, Harm to Self 354.

[48]Sherry F. Colb, A Controversy Over the Netherlands' New Euthanasia Legislation, Findlaw.com (Jan. 17, 2001).

[49]Id.

choice might be taken in a hypothetical case involving an elderly woman suffering from Alzheimer's. Earlier, while still competent, the woman in Dworkin's hypothetical expressed a firm desire to be killed when dementia set in. But now, after dementia has set it, she seems to enjoy life and says she wishes to live. Dworkin asks which request we should obey: the earlier, rational request, or the woman's present choice affected by dementia? Dworkin's response is that

> [w]e might consider it morally unforgivable not to try to save the life of someone who plainly enjoys her life, no matter how demented she is, and we might think it beyond imagining that we should actually kill her. We might hate living in a community whose officials might make or license [such a] decision[]. We might have other good reasons for treating [her] as she now wishes, rather than, as, in my imaginary case, she once asked. <u>But still, that violates rather than respects her autonomy</u>.[50]

Though he stops short of saying so expressly, respect for autonomy might, on Dworkin's account, go so far as to require society to <u>ignore</u> the plea for life of the demented aged person in favor of some previously signed document or comment that he or she would rather die than become demented.

To date, no legislative proposal in America or England has sought to reach nearly as far as the neutrality or harm principles might lead us -- even the World Federation of Right-to-Die Societies has yet to

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[50]Dworkin, <u>Life's Dominion</u> 229 (emphasis added).

advocate such a law. But, as some neutralism and harm principle adherents in academia are now beginning to discuss the full consequences of their philosophical commitments, the practical implications that might follow from them are not hard to fathom. To take but one example, Dr. Kevorkian regularly used a machine in the back of his van to kill patients who were neither terminally ill nor suffering intolerable pain, including one middle-age woman in the early stages of Alzheimer's disease still capable of beating her son at tennis -- just no longer able to keep score. The Dutch have recently relaxed their traditional requirement that a candidate for assisted suicide show he or she is suffering intolerable pain, now suggesting, as we shall see in the next Chapter, that those suffering subjectively intolerable psychological pain can also qualify. And, as we shall also soon discuss, terminal patients in Oregon dissatisfied with their lives are already permitted to kill themselves without any requirement that they are suffering, or are even likely to suffer, pain of any kind.

# CHAPTER VII

## UTILITARIAN ARGUMENTS FOR AND AGAINST LEGALIZATION

### VII.1 Introduction

Unlike advocates of neutralism and the harm principle, utilitarians are not propelled by adherence to such principles toward an assisted suicide right open to all rational adults regardless of motive or physical condition. Instead, approaching the question of assisted suicide (like any other) by asking the practical question what legal rule would provide the greatest social benefits with the fewest attendant costs, utilitarianism holds out the possibility of defending a more limited right, one open only to the incurably suffering or terminally ill.

Justices O'Connor and Souter gave hints of utilitarian thinking in Glucksberg and Quill. Before deciding to read the rights to assistance in suicide and euthanasia into the due process or equal protection guarantees of the federal Constitution, both said they wanted to see the results of state legislative experiments. Implicit in their position was a desire

to see whether the practice of assisting suicide and euthanasia would carry with it more benefits than harms. In the legislative arena, too, we commonly hear similar utilitarian arguments for proposed laws, with partisans arguing that enacting a certain provision will (or will not) promote the greatest good for the greatest number.

Plainly, legalizing assisted suicide and euthanasia for those suffering great pain or enduring a terminal illness would carry with it tangible benefits. Persons in such conditions who wish to die, but who either cannot or do not wish to kill themselves without assistance, would be able to do so, thereby avoiding unwanted pain and suffering and fulfilling their own autonomously chosen life plans. What may not be obvious, or at least perhaps not immediately so, is whether there are any costs associated with normalizing assisted suicide and euthanasia if we do so only for competent adults who are, in fact, suffering from great physical pain or a terminal illness. In the balance of this Chapter, I explore this question and empirical evidence gathered in the Netherlands, Oregon, and elsewhere.

Ultimately, I suggest, we cannot rule out the possibility that non-trivial costs will attend the legalization of assisted suicide and euthanasia, even

when it is limited to such narrow classes of persons; then, having suggested that legalization is not an entirely costless enterprise, I pose the critical question: how do we weigh the competing benefits and costs in a consequentialist enterprise? How are we to judge that the benefits associated with normalization are "enough" to outweigh the costs? I see no convincing answer, and ultimately suggest that the project of comparing the benefits and costs of assisted suicide rests on a flawed premise -- viz., that there exists a single scale or currency which we can use to measure fundamentally incommensurate goods.

## VII.2 Dutch Procedures

The Netherlands is one of a very few countries in the Western world with a regularly operating assisted suicide and euthanasia regime.[1] Interestingly, while voluntary euthanasia societies had organized in Britain and the United States by the 1930s, there was no counterpart Dutch movement until considerably later.[2]

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[1]Belgium's law has been in force for only several months, as of this writing, the Australian law was in place for only a matter of months, and little has been published about the Switzerland experience. See Ch. I, supra. Evidence from the brief Australian experience does not suggest that assisted suicide was practiced there with tremendous care. See David Kissane, Deadly Days in Darwin in The Case Against Assisted Suicide: For the Right to End-of-Life Care 192 (Kathleen Foley and Herbert Hendin, eds. 2002).

[2]See Herbert Hendin, The Dutch Experience in The Case Against Assisted Suicide: For the Right to End-of-

In 1973, a Dutch physician was convicted of killing his 78 year-old mother at her request, and the court found the doctor guilty but imposed a conditional one-week jail sentence and one year of probation.[3] This decision has been identified by some as a significant turning point in Dutch law though, in fact, between 1969 and 1980 there were at least three other prosecutions in the Netherlands for assisted suicide, each of which resulted in jail sentences ranging from six to eighteen months.[4] A 1981 case did, however, more clearly portend forthcoming change: there, the court found a 76-year old lay person guilty of assisting a suicide and imposed a conditional sentence of six months subject to one year probation (after finding that a jail term would have been too burdensome on the aged defendant), but expressly opined, in dicta, that a physician might be exempt from punishment for killing a patient suffering severe physical duress.[5]

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Life Care 97, 99 (Kathleen Foley and Herbert Hendin, eds. 2002) (hereinafter, "Hendin, The Dutch Experience").

[3]Griffiths, Euthanasia & Law 52.

[4]Id. at 53.

[5]Id. at 59; see also Hendin, The Dutch Experience. For detailed, if sometimes conflicting, accounts of all Dutch cases and experience prior to 1984's seminal Supreme Court decision, see Carlos Gomez, Regulating Death: Euthanasia and the Case of the Netherlands (1991); Hendin, The Dutch Experience; Griffiths, Euthanasia & Law.

In 1984, events reached a crescendo when the Dutch Supreme Court confronted an act of physician-assisted suicide involving a 93-year-old woman who was bedridden due to a hip fracture, no longer able to eat or drink, and who was slipping in and out of consciousness. At one point, when she regained consciousness, the patient asked to be euthanized, and her physician consented. The case was later reported to the police and ultimately reached the country's Supreme Court. The Court used the dispute to announce an exception to the country's existing penal laws banning the practice of assisted suicide,[6] an exception based on the doctrine of "necessity" or force majeure (*overmacht*):

> in accordance with the norms of medical ethics, and with the expertise which as a professional he must be assumed to possess -- he balanced the duties and interests which, in the case at hand, were in conflict, and made a choice that -- objectively considered, and taking into account the specific circumstances of this case -- was justifiable.[7]

The Dutch Medical Association, at about the same time, set forth certain criteria for assisting suicide or

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[6]See Schoonheim, 1984, 18 Nederlandse Jurisprudentie 1985, no. 106. Article 293 of the Dutch criminal code forbad an individual from taking the life of another even after the latter's "express and earnest request." Article 294 made it unlawful to "intentionally incit[e] another to commit suicide, assist[] in the suicide of another, or procure[] for that other the means to commit suicide." Griffiths, Euthanasia & Law 308 (translating Dutch statutes).

[7]Translated in Griffiths, Euthanasia & Law 327.

performing euthanasia in conformity with the Court's newly recognized necessity defense, and the Minister of Justice announced that physicians following these guidelines would not be prosecuted.[8]

In 1994, the Dutch Supreme Court substantially extended its "necessity" defense, in the Chabot case.[9] There, the Court considered the justifiability or excusability of the killing of a 50 year-old woman (identified in court papers as "Ms. B") by a psychiatrist, Dr. Chabot. Ms. B's son had committed suicide in 1986; in 1988, her father died; in 1990, she was divorced and her second son was injured in a traffic accident. In the course of her son's treatment, cancer was discovered, and he died in 1991. The same year, B attempted suicide, unsuccessfully, using drugs supplied by a doctor. Later, through the Dutch Association of Voluntary Euthanasia, B was referred to a psychiatrist, Dr. Chabot, who examined B in four series of meetings over a five week period, for a total of 24 actual hours (though apparently amounting

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[8]Under the guidelines, a request for assistance in dying had to be "voluntary," "well-considered," "lasting," and the patient had to be experiencing "unacceptable" suffering; the physician was also required to consult a colleague. See Walter Lagerway, trans., Guidelines for Euthanasia, 3 Issues in Law & Medicine 429 (1988).

[9]Nederlandse Jurisprudentie 1994, no. 656. See also Griffiths, Euthanasia & Law 329 (translation of Chabot).

somehow to 30 "billable" hours). Chabot also consulted with four psychiatrists, a clinical psychologist, a general practitioner, and a professor of ethics, though none of these professionals actually examined B. Chabot then concluded that B was suffering psychologically in a manner that was subjectively unbearable to her, and that she was without prospect of improvement. In Chabot's judgment, B's rejection of therapy was well-considered. Seven weeks after meeting B, Chabot supplied lethal medication to her. She consumed the medication and died a half hour later.

The Supreme Court held that, for a request for assisted suicide or euthanasia to be justified on "necessity" grounds, the patient's suffering need not be physical; the patient need not be terminally ill; and purely subjective psychological suffering could qualify a patient for an act of euthanasia. The Court held that Chabot erred only by failing to have the colleagues he consulted examine B before agreeing to help kill her, though the Court ultimately declined to impose any penalty for this oversight.[10] In weighing the future of Dutch practice and regime, John Griffiths, a defender of decriminalization, has surmised that the requirement of unbearable suffering

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[10]Griffiths, Euthanasia & Law 332; John Griffiths, Assisted Suicide in the Netherlands: The *Chabot* Case, 58 Mod. L. Rev. 232 (1995).

in any form, physical or mental, is likely on the way out: "the decision in Chabot may later be seen as having opened the way to a legal development that accepts assistance with suicide to persons who are not 'sick' at all."[11]

Between 1984 and 2002, at least three legislative efforts to codify the judiciary's expanding necessity defense failed.[12] Finally, in 2001, a bill was approved by the Dutch parliament permitting assisted suicide and euthanasia when the physician:

> a. holds the conviction that the request by the patient is voluntary and well-considered;
>
> b. holds the conviction that the patient's suffering is lasting and unbearable;
>
> c. informs the patient about the situation he is in and about his prospects, and the patient holds the conviction that there is no other reasonable solution for the situation he is in;
>
> d. consults with at least one other, independent physician who sees the patient and gives his written opinion on the requirements of due care referred to [above]; and,
>
> e. terminates a life or assists in a suicide with due care.[13]

Under these standards, terminal illness is not a prerequisite to euthanasia, and neither is physical

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[11]Griffiths, Euthanasia & Law 153.

[12]See House of Lords Report HL Paper, 21-I of 1993-1994 Session, vol. 1 at 64.

[13]Parliamentary Year 2000-2001, no. 137., ch. II, art. 2.

ailment of any kind. Suffering need not be objectively proven; evidence regarding the subjective disposition of the patient and the intentions of the physician is sufficient. Procedurally, there is no specified waiting period after the request for euthanasia before it may be performed and no requirement that the patient place his or her wishes in writing.

The law also extends assisted suicide and euthanasia to children:

> If the minor patient has attained an age between sixteen and eighteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request for termination of life or assisted suicide, after the parent or the parents exercising parental authority and/or his guardian have been involved in the decision process.[14]
>
> If the minor patient is aged between twelve and sixteen years and may be deemed to have a reasonable understanding of his interests, the physician may carry out the patient's request for termination of life or assisted suicide, provided always that the parent or the parents exercising parental authority and/or his guardian agree with the termination of life or the assisted suicide.[15]

Thus, the new law permits twelve to fifteen year-olds to request euthanasia, but requires parental consent in such cases; by contrast, the statute permits sixteen and seventeen year-olds to make such decisions for themselves, though parents must be "involved" in the discussion.

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[14]Id.

[15]Id.

## VII.3 Dutch Practices

To date, two large-scale studies (the "Surveys") have been performed on Dutch assisted suicide and euthanasia practices, one in 1990 and the other in 1995. Both were performed under the auspices of Professor G. van der Wal, of the Free University of Amsterdam, and Professor P.J. van de Maas, of the Institute of Public Health at Erasmus University, Rotterdam. Medical ethicist Margaret Battin has argued that the Surveys demonstrate that practice of assisted suicide and euthanasia are practiced in the Netherlands "virtually abuse-free."[16] Joceyln Downie has suggested that the Surveys show that euthanasia is not widely practiced in the Netherlands.[17] In this section we shall examine whether and to what degree such comforting suppositions can be squared with the data.

The 1990 and 1995 Surveys employed two methods. First, the authors interviewed a random sample of slightly more than 400 physicians, reflecting general practitioners and representatives from five different specialties (cardiology, surgery, internal medicine,

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[16]Margaret Battin, Should We Copy the Dutch? in Euthanasia: The Good of the Patient, The Good of the Society 95, 102 (1992).

[17]Jocelyn Downie, The Contested Lessons of Euthanasia in the Netherlands, 8 Health L.J. 119, 128 (2000) (hereinafter, "Downie, Contested Lessons") (claiming that the notion that euthanasia is widespread "is simply not supported by the data").

pulmonology, and neurology).[18] Second, the Surveys examined a random sample of over 6000 death certificates over the course of a four month period for each year under review (1990 and 1995), followed up by a 24-question questionnaire directed to the physicians identified in each death certificate in the sample under study.[19]

Some of the central findings of the Surveys' physician interviews are summarized in Table 1:

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[18]Paul van der Maas, Gerrit van der Wal, Ilinka Haverkate, et al., Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995, 335 New England Journal of Medicine 1699 (Nov. 28, 1996) (hereinafter, "van der Maas, Euthanasia").

[19]Id.

Table 1
Central Findings of 1990 and 1995 Surveys[20]

| | 1995 | 1990 | % change |
|---|---|---|---|
| Total deaths | 135,675 | 128,786[21] | 5% |
| No. of requests for euthanasia or assisted suicide later in disease | 34,500 | 25,100 | 37% |
| No. of requests for euthanasia or assisted suicide at a particular time | 9,700 | 8,900 | 9% |
| End of Life Practices Performed: | | | |
| Euthanasia | 3,120 | 2,447 | 17.4% |
| as % of all deaths | 2.3% | 1.9% | |
| Assisted Suicide | 542 | 386 | 25% |
| as % of all death | 0.4% | 0.2% | |
| Ending life w/o patient consent | 949 | 1030 | -8% |
| as % of all death | 0.7% | 0.8% | |

As reflected in Table 1, the 1990 Survey found that fully 1.9% of all Dutch deaths (2,447 deaths) were attributable to the practice of euthanasia. Substantially more people died in the Netherlands as a result of euthanasia than HIV, leukemia, or homicide. The Survey found that an additional 0.3% of all deaths -- or some 400 cases -- were the result of physician-

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[20]The figures in this Table are extrapolated from data in van der Maas, Euthanasia.

[21]The Netherlands has a total population of approximately 16 million. Id.

assisted suicide. By 1995, these figures had grown measurably: 2.3% of all deaths nationwide that year were the result of euthanasia (a 17.4% increase) and 0.4% were due to assisted suicide (a 25% increase).

The Surveys also reveal that requests for euthanasia increased dramatically between 1990 and 1995 (prospective requests for euthanasia at a later stage of a disease grew 37% and requests for euthanasia at a particular time rose 9%). The actual incidence of euthanasia and assisted suicide also increased substantially, 17.4% and 25%, respectively. Nor have all of these deaths gone smoothly. Dutch researchers have found that problems with completion arise in 16% of all attempted assisted suicide and 6% of all attempts at euthanasia, and such problems include patients vomiting, waking from drug-induced comas, and living as long as 14 days after the administration of death-inducing medication.[22]

In 1995, the Survey, for the first time, systematically examined the frequency with which physicians euthanize their patients without consent.

As shown in Table 1, the 1995 Survey found that 0.7% of

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[22]J.H. Groenewoud, et al., Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands, 342 New Eng. J. Med. 551 (2000).

all deaths nationwide were the result of unconsented-to killings. Though the 1990 Survey did not seek to study this issue on a systematic basis, the limited study it conducted suggested that non-consensual killings represented 0.8% of deaths nationwide (approximately 1000 deaths). While these data suggest that nonconsensual killings decreased slightly between 1990 and 1995, the Survey authors were cautious to reach such a conclusion, explaining that "chance fluctuation cannot be ruled out as an explanation" for the change between 1990 and 1995, adding that their "1990 interview study did not permit sufficiently reliable estimates of this variable."[23]

Jocelyn Downie has sought to diminish the significance of non-consensual killings, noting that "in 600 of the 1000 cases" of nonconsensual euthanasia in 1990, "something about the patients' wishes was known although explicit consent according to the [Dutch Medical Association's] guidelines had not been given."[24] This interpretation, however, does not address the 1995 finding that 949 persons were killed without their consent. As to the 1990 findings, moreover, in 400

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[23]Downie, Contested Lessons, 8 Health L.J. at 128.

[24]Id. at 132.

cases patient's wishes were not known at all. In the 600 remaining cases, the patient was adjudged by the euthanizing physician to have expressed something less than explicit consent. But these ranged from a "rather vague earlier expression of a wish for euthanasia" as in comments like, "'If I cannot be saved anymore, you must give me something,'" or "'Doctor, please don't let me suffer for too long,'" to more extensive discussions that were "still short of the explicit request" required by Dutch law.[25] In 1995, the New York task force on medical ethics recommended against legalization of assisted suicide in part on the strength of the then-available 1990 Survey data. Referring to the 2,700 reported deaths by assisted suicide and euthanasia in the Netherlands, and the 1000 cases of nonconsensual terminations, the task force reasoned that

> if euthanasia were practiced in a comparable percentage of cases in the United States, voluntary euthanasia would account for about 36,000 deaths each year, and euthanasia without the patient's consent would occur in an additional 16,000 cases. The Task Force members regard this risk as unacceptable. They also believe that the risk of such abuse is neither speculative nor distant, but an inevitable byproduct of the

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[25]Margaret Battin, The Least Worst Death 137 (1994).

> transition from policy to practice in the diverse circumstances in which the practices would be employed.[26]

All of the foregoing statistics and analysis, moreover, arguably understate both the incidence of euthanasia in the Netherlands and the frequency with which Dutch patients are killed without consent. The Dutch Surveys included only affirmative acts of euthanasia in their data on the incidence of mercy killings with and without consent. They did not include omissions or withdrawals of care performed without patient consent and with the intention of killing the patient (which Dutch medical practice itself recognizes as acts of euthanasia).[27] The 1990 Survey sought to count such deaths separately, but the 1995 Survey, surprisingly and without explanation, apparently neglected to do so. The 1990 data revealed that 4,000 deaths were caused that year by the withdrawal or withholding of treatment without explicit patient consent and with the explicit purpose of ending life. The Survey found an additional 4,750 deaths were caused by withdrawing or withholding without explicit consent but "partly with the purpose" of ending life.

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[26]New York Task Force on Life and the Law 134.

[27]Keown, Euthanasia Examined 270.

Combined, these figures represent 8,750 cases where care was discontinued by a doctor who intended to kill the patient, and who acted without the explicit consent of the patient. Such deaths accounted for some 6.78% of all deaths in the Netherlands in 1990.[28] When added to the 1,000 nonconsensual affirmative acts of euthanasia, the total number of intentional killings without patient consent in 1990 was 9,750, or 7.55% of all deaths. Extrapolating to the United States population, this would translate into approximately 173,650 medically accelerated deaths per year without explicit patient consent (based on the approximately 2.3 million deaths that occur in the United States annually).

Nor is it clear that killing is used only in extremis to prevent unbearable suffering. In the 1990 Survey, physicians involved in nonconsensual affirmative killings volunteered that ending pain and suffering motivated them in only 30 percent of the cases. Reasons physicians gave more frequently for terminating life without consent included the absence of prospects for improvement (60 percent), avoidance of "needless prolongation" (33 percent), the relatives'

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[28]See van der Maas, Euthanasia; Keown, Euthanasia Examined 271.

inability to cope (32 percent), and "low quality of life" (31 percent).[29] Studies suggest, too, that Dutch physicians are undertrained in palliative care techniques that might mitigate the perceived need to resort to assisted suicide and euthanasia: a 1987 Dutch Health Council study found that a majority of cancer patients in pain suffered because of their caregivers' lack of expertise in pain management;[30] a 1989 study found that palliative care was "inadequate" in "slightly more than 50% of evaluated cases."[31] Even among Dutch doctors, most of whom support assisted suicide and euthanasia, fully 40% agree with the proposition that "adequate alleviation of pain and/or symptoms and personal care of the dying patient make euthanasia unnecessary."[32]

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[29]See id. See also John Keown, Further Reflections on Euthanasia in The Netherlands in Light of the Remmelink Report and the van der Maas Survey, in Euthanasia, Clinical Practice and the Law 219, 230 (Luke Gormally, ed. 1994) (hereinafter, "Keown, Further Reflections") (discussing 1990 Survey results).

[30]See John Keown, The Law and Practice of Euthanasia in the Netherlands, 108 L.Q.R. 51, 65 (1992).

[31]Kairn L. Dorrepaal, et al., Pain Experience and Pain Management Among Hospitalized Cancer Patients, 63 Cancer 593, 598 (1989).

[32]Keown, EEPP 111; 1990 Survey, table 9.7.

Ultimately, the government panel that reviewed the 1990 Survey results sought to explain and even defend the seemingly large number of non-consensual killings, doing so on the ground that the

> ultimate justification for the intervention is in both cases [i.e., where there is and is not an explicit request for assistance in dying] the patient's unbearable suffering. So, medically speaking, there is little difference between these situations . . . because in both cases patients are involved who suffer terribly. The absence of a special request for the termination of life stems partly from the circumstances that the party in question is not (any longer) able to express his will because he is already in the terminal stage, and partly because the demand for an explicit request is not in order when the treatment of pain and symptoms is intensified. The degrading condition the patient is in confronts the doctor with a case of force majeure. According to the Commission, the intervention by the doctor can easily be regarded as an action that is justified by necessity, just like euthanasia.[33]

Thus, it appears that it is not patient autonomy or choice or even the alleviation of pain that, to the Dutch government at least, stands as the ultimate justification for assisted suicide, but, instead, a physician's assessment of the patient's quality of life as "degrading."

As reflected in Table 2, it also appears that the incidence of non-voluntary euthanasia is closely related to age. The 1995 Survey's death certificate

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[33]Translated in Keown, Further Reflections 229.

study found that younger patients (especially those between 0-49) are far more likely than older persons to be killed without consent:[34]

Table 2
End of Life Decisions in 1995
By Age[35]

| | 0-49 | 50-64 | 65-79 | >80 |
|---|---|---|---|---|
| Total death certificates studied | 661 | 652 | 1792 | 2041 |
| All deaths in the Netherlands | 8% | 12% | 36% | 44% |
| All end-of-life decisions | 6% | 14% | 34% | 46% |
| Ending Life w/o Explicit Request (n=64) | 18% | 16% | 31% | 36% |
| % Ending life w/o Explicit request vs. % of all end-of-life decisions | 300% | 114% | 91% | 78% |

While the young (ages 0-49, including children and infants) represented 6% of all end-of-life cases surveyed in 1995, they represented 18% of all cases found where life was ended without an express request; the young were, thus, vastly overrepresented (300%)

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[34]Such an age-based study was not performed in 1990.

[35]The data in this Table are extrapolated from van der Maas, Euthanasia.

among cases where patients were killed without express consent compared with their population in the pool of all end-of-life cases. Those between 50 and 64 years of age were also overrepresented (114%), representing 14% of all end-of-life cases, but 16% of cases where life was ended without clear consent.

Remarkably, the 1995 Survey found that a significant number of assisted suicides and acts of euthanasia went unreported, even though Dutch professional and legal guidelines have long allowed the practices and, in fact, required reporting to public authorities; state approval of assisted suicide and euthanasia did not, it seems, end the "grey market" for such services. Of 147 physicians in the 1995 survey who reported cases of assisted death, 84 -- or fully 57% -- admitted they had decided not to report at least one other case, and none identified any adverse legal consequence from his or her behavior. Further, of the 2,700 cases of assisted suicide and euthanasia recorded in 1990, only 486 were reported pursuant to Dutch medical guidelines, meaning that 82% of cases were, in effect, "illegally certified by doctors as death by 'natural causes.'"[36]

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[36]Keown, EEPP 113.

As reflected in Table 3, physicians admitted, too, that in their unreported cases of assisted suicide and euthanasia, they were far less likely to consult with colleagues, family members, or ensure an explicit patient request; they likewise admitted that they were far less likely to leave a written record that might to permit subsequent inquiries into their conduct:

Table 3
Characteristics of Reported and Unreported Cases of Euthanasia and Assisted Suicide: 1995[37]

| | Reported Cases (N=68) | Unreported Cases (N=68) |
|---|---|---|
| Patient Request Was - | | |
| Highly Explicit | 100% | 92% |
| "Rather" Explicit | 0% | 8% |
| Written Will present | 73% | 44% |
| Express written report on decision | 36% | 0% |
| Notes in medical record | 84% | 57% |
| No writing | 3% | 43% |
| Discussion with colleagues | 100% | 58% |
| Contact with patient's relatives | 99% | 92% |

When asked about their most recent unreported case, 16 of the 84 responding physicians -- or 19% -- stated that their most recent unreported case involved killing the patient without an explicit request. Physicians stated that they had complied with guidelines requiring them to consult with colleagues 100% of the time in their reported cases, but had respected this requirement only 58% of the time in their unreported cases; they likewise revealed that they left behind no written record of their conduct in

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[37]Id.

just 3% of reported cases, but left no record (again in violation of professional requirements) in 43% of their unreported cases. And fully 60% of general practitioners said they thought the rule requiring them to consult with another colleague before killing a patient was not very important.

John Griffiths has acknowledged that the "present control-regime [in the Netherlands] does not offer effective control,"[38] and that it "is a bit of a paper tiger, in the sense that only a minority of case (and these the least problematic ones) are reported, and that little serious enforcement is undertaken in reported cases that do not meet the legal criteria."[39] In fact, of all the data gathered on Dutch assisted suicide and euthanasia practices, the low reporting rate is the issue that, to Griffiths, "most gives rise to concern."[40] To encourage greater reporting, especially of cases that do not meet current legal criteria, Griffiths, somewhat surprisingly, doesn't argue for greater criminal enforcement, but instead seeks the elimination of criminal penalties associated

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[38]Griffiths, Euthanasia & Law 268.

[39]Id. at 245-46.

[40]Id. at 282.

not just with consensual assisted suicide and euthanasia but also those associated with non-voluntary euthanasia. Echoing and building on the sentiments of the Dutch Commission reviewing (and seeking to justify) the data on non-consensual killings, Griffiths gives us a hint where the Dutch regime might ultimately find itself: routinizing "euthanasia and termination of life without an explicit request [such that they are] handled in the same way [as voluntary requests for assisted suicide and euthanasia]: deemed 'normal medical practice' and subjected to the controls applicable to other behavior of doctors."[41]

Gone here is any linkage between assisted suicide and patient autonomy. A physician would be free to kill his patients, without their consent, and have no reason to fear criminal prosecution -- whatever his reasons or professional competence. Griffiths's proposal seemingly would preclude the criminal prosecution not just of those acting out of motives of mercy, but even mass murderers like Dr. Harold Shipman.[42] Indeed, in Griffiths's regime, only

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[41] Id. 286-87 (emphasis added).

[42] See Department of Health, Harold Shipman's Clinical Practice 1974-1998: A Clinical Audit Commissioned by the Chief Medical Officer (2000) (finding that Shipman, convicted of murdering 15 of his

professional and civil sanctions would be available as remedies if and when doctors kill in the absence of a recognized medical "necessity," or what he calls "normal medical practice." Though Griffiths believes decriminalization of non-voluntary euthanasia would lead to better reporting, he does not consider whether it would lead to additional cases of abusive, coercive, and mistaken killings, as well. Nor does Griffiths fairly make out a case that his proposal would guarantee better self-reporting: doctors who fail to meet the guidelines for "normal" non-voluntary killings (whatever those might be), or who kill in "borderline" cases would avoid reporting their activities for fear of professional and civil penalties which, for doctors, can mean the end of their careers and financial security. Griffiths's proposal, thus, would change the boundaries regarding what is acceptable medical practice (from voluntary to non-voluntary killings) but would not assure that cases outside of the applicable

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patients, had 297 "excess deaths" compared to other similarly situated physicians). See also James Thunder, Quiet Killings in Medical Facilities: Detection & Prevention, 18 Issues in Law & Medicine 211, 213 (2003) (hereinafter, "Thunder, Quiet Killings") (noting that, over the last 25 years, at least 18 American health care workers responsible for approximately 455 "mercy killings" inside medical facilities have been convicted of murder or manslaughter).

boundaries would be reported. And Griffiths himself, somewhat inconsistently with the entire premise for his decriminalization-of-non-voluntary-euthanasia hypothesis, acknowledges that any self-reporting regime, whatever its prescribed boundaries, is "intrinsically ineffective."[43]

## VII.4 Oregon Procedures

Among American jurisdictions, only Oregon has experimented with assisted suicide and, even there, only on a small scale, at least to date. Oregon's law is also, as we noted in Chapter I and shall explore further in Chapter IX, under legal attack. For our purposes in this Chapter, however, the question at hand is how the Oregon experiment has fared so far. Richard Epstein, for one, has hailed Oregon's assisted suicide law as "tightly drafted legislation" and an "all-too-conscientious attempt" to avoid cases of abuse, mistake, and pressure.[44] And certainly the statute is more refined than the medical guidelines long in force in the Netherlands or the recent Dutch statute. But Epstein's enthusiastic endorsement arguably glosses over certain deficiencies in the structure of the

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[43]Compare id. at 292 with id. at 257.

[44]Epstein, Mortal Peril 326-27.

Oregon law and its practice in the field.

To qualify for assistance in dying under the Oregon Death With Dignity Act, a patient must be "[a]n adult who is capable . . . and has been determined by the attending physician and consulting physician to be suffering from a terminal disease," and who has made "a written request for medication for the purpose of ending his or her life."[45]

The term "capable" is defined by statute to mean that, "in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers."[46] A "terminal disease," is defined to mean "an incurable and irreversible disease that . . . will, within reasonable medical judgment, produce death within six months."[47] Written requests for assisted suicide must be witnessed by at least two individuals who, "in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily,

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[45]Oregon Rev. Stat. 127.805 § 2.01(1).

[46]Id. 127.800 § 1.01(3).

[47]Id. 127.800 § 101(12).

and is not being coerced to sign the request."[48]

An attending physician is required, among other things, to "make the initial determination of whether the patient has a terminal disease, is capable, and has made the request voluntarily," and to refer the patient to a consulting physician for confirmation of all three of these findings.[49] If the attending or consulting physician believes that a patient "may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment either physician shall refer the patient to counseling," and no medication to end the patient's life may be prescribed until "the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment."[50]

Once the medical review process is complete, the attending physician may prescribe life-ending

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[48]Id. 127.805 § 202. One of the witnesses may not be related to the patient, stand to benefit under the patient's estate, or be connected to the medical facility where the patient is being treated. Nor can the attending physician serve as a witness. If the patient is a resident in a long-term care facility, one of the witnesses must be an individual designated by the state Department of Human Services. Id.

[49]Id. 127.815 § 3.01.

[50]Id. 127.825 § 3.03.

medications.[51] No less than 15 days must elapse between the patient's first oral request and the writing of a prescription; 48 hours must elapse between the patient's written request and the prescription.[52] Doctors who write death-inducing prescriptions in good faith compliance with the Act's requirements are shielded from criminal, civil, or professional sanction.[53]

Physicians are responsible for maintaining records regarding each act of assisted suicide, including documents reflecting all of the patient's oral and written requests for assistance in dying; the attending and consulting physician's diagnosis, prognosis, and finding that the patient was capable, acting voluntarily, and with full information; and any report regarding any counseling that occurred.[54] The state Department of Human Service is charged with reviewing a sample of these records annually.[55]

Though it perhaps represents a drafting

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[51]Id. 127.815 § 301(1).

[52]Id. 127.850 § 3.08.

[53]Id. 127.855 § 4.01(1).

[54]Id. 127.855 § 3.09.

[55]Id. 127.865 § 3.11.

improvement over the Dutch statute, a great many questions can still be raised about how the Oregon law is written and practiced. It is, for example, entirely unclear from the language of the statute whether "terminal" means that the patient is expected to die within six months assuming she is given medical care or assuming she is not.[56] When surveyed, more than 50% of Oregon physicians have acknowledged that they are not confident they can make a prediction whether a "terminal" patient has more or less than six months to live.[57] In point of fact, putatively terminal patients have received lethal prescriptions in Oregon and waited to use them for as long as 466 days -- over 15 months.[58] And though proponents of the law have argued that Oregon's regime helps dying patients avoid unnecessary pain and suffering, unlike even the Dutch guidelines, Oregon's law in no way conditions access to assisted suicide on the existence of pain of any kind, let alone pain that cannot be fully treated by readily available

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[56]Keown, EEPP 171.

[57]Melinda A. Lee, et al., Legalizing Assisted Suicide: View of Physicians in Oregon, 334 New Eng. J. Med. 310, 334 (1996) (hereinafter, "Lee, Legalized Assisted Suicide").

[58]Oregon Department of Human Services, Fifth Annual Report on Oregon's Death With Dignity Act 21 (2003) (hereinafter, "Oregon, Fifth Annual Report").

medicines.

Because the attending physician under Oregon law is allowed to choose a consulting physician who may be related to the attending doctor or the patient professionally or personally, the consultant is not guaranteed to be free to render a dispassionate judgment (something even Dutch guidelines again purport to mandate). Nor does the Oregon statute require that either physician have any special expertise; trainees can render judgments that an illness is terminal. Thus, while approximately 80% of patients seeking assisted suicide in 2001 suffered from cancer, prescribing physicians were predominately internal medicine and family practitioners (collectively representing 69% of prescribers); oncologists prescribed death-inducing medication in just 25% of assisted suicide cases.[59] Significantly, too, there is no requirement that any of the physicians involved review with the patient or even know about potential alternatives (e.g., hospice, pain killers), or that those with expertise in such areas (e.g., pain management specialists) be brought in to review care

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[59]Oregon Department of Human Services, Fourth Annual Report on Oregon's Death With Dignity Act 10 (2002) (hereinafter, "Oregon, Fourth Annual Report").

options that may alleviate the patient's perceived need for assisted suicide.

While the statute requires the attending and consulting physicians to make a finding that the patient is mentally capable, it does not require any mental health qualifications or expertise of either doctor, again leaving specialized questions -- here the diagnosis and referral of potential psychiatric or psychological disorders -- to individuals without training in the relevant disciplines. And despite evidence suggesting that most suicides are caused in whole or part by clinical depression or mental illness,[60] 28% of Oregon physicians polled have indicated that they do not feel competent to recognize depression.[61] In fact, a recent study of depression in cancer patients found that oncologists accurately detected depression in only 13% of their patients who described themselves as suffering from "moderate to

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[60]See Ch. III.8, supra. See also T. Grisso & P.S. Appelbaum, The MacArthur Treatment Competency Study: III. Abilities of Patients to Consent to Psychiatrict and Medical Treatments, 19 Law & Human Behavior 149-74 (1995).

[61]Lee, Legalized Assisted Suicide, 334 New. Eng. J. of Med. At 313.

severe" levels of depression.[62]

Oregon's statute (again in contrast to Dutch medical guidelines) also does not require the presence of a doctor when the patient commits suicide, and, in 2002, physicians were absent 66% of the time.[63] Accordingly, there is no guarantee that a doctor will assess the patient's mental condition at the time of death -- "capability" is assessed only once, when the prescription is written, on a day that may be weeks or even months (or years) removed from the patient's decision to die. The physician's absence also means that reviewing state authorities do "not have all information about what happened when the patient ingested the medication,"[64] including information about what, if any, complications may arise. And the complications themselves may also go unaddressed. A nationwide survey of U.S. oncologists found that fully 15% of all attempts at physician assisted suicide are

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[62]S.D. Passkik, et al., Oncologists' Recognition of Depression in Their Patients With Cancer, 16 Journal of Clinical Oncology 1594-1600 (1998).

[63]Oregon, Fifth Annual Report 20.

[64]Oregon, Fourth Annual Report at 8. "Other health care providers" (presumably nurses, but this is not clear from the Oregon report) were present in an additional 9% of 2001 cases at 78% percent of cases in 2002. See id.; Oregon, Fifth Annual Report at 20.

unsuccessful.[65] And data from the Netherlands, noted above, is to similar effect.[66] In Oregon in 2002, 38 patients ingested lethal medications and the time to death after ingestion varied widely; one patient lived for 14 hours, another lived for 9 hours, and a third lived for 12 hours.[67] And in at least four cases since 1998, a patient has vomited or expectorated immediately after taking the prescribed mediation, living for as long as 37 hours after ingestion.[68]

For all of the data it has collected on completed suicides within the state, moreover, Oregon relies entirely on written self-reports by participating physicians and it requires the reports only after the patient is dead. Accordingly, Oregon has no way to review individual cases for compliance with its law until after the fact -- viz., after the patient is dead. The Oregon Health Department charged with administering the law has acknowledged that this

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[65]E.J. Emmanuel, et al., The Practice of Euthanasia and Physician-Assisted Suicide in the United States: Adherence to Proposed Safeguards and Effects on Physicians, 220 Journ. of the Amer. Med. Ass'n. 507 (1998).

[66]See Ch. VII.3, supra.

[67]Oregon, Fifth Annual Report 13.

[68]Id. at 21.

statutory arrangement raises "the possibility of physician bias," and means that it "cannot detect or collect data on issues of noncompliance with any accuracy."[69] Indeed, the Oregon law gives the State's Health Department no responsibility to investigate, report, or pursue physicians who kill outside the statute's parameters. Finally, while physicians in Oregon are held to a standard of professional competence in administering all other treatments they provide, under the Oregon assisted suicide statute a novel exception immunizes doctors from civil liability, criminal prosecution, or professional repercussion for any actions taken in assisting a suicide, so long as they do so in "good faith"; thus, there is absolutely no recourse for the patient or family members when the physician exhibits even gross negligence in misdiagnosing the patient as terminal, in misassessing the patient as competent, or in erring in the dosage of death-inducing drugs.[70]

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[69]Oregon, First Year's Experience 9. See also Oregon, Fifth Year's Experience 14 ("our numbers . . . [d]o not include patients and physicians who may act outside the law").

[70]See Kathleen Foley and Herbert Hendin, The Oregon Experiment in The Case Against Assisted Suicide: For the Right to End-of-Life Care 144, 159 (Kathleen Foley and Herbert Hendin, eds. 2002) (hereinafter, "Foley, The Oregon Experiment").

## VII.5 Oregon Practices

According to the self-reported data from Oregon physicians, in the first five years of implementation (1998-2002) a total of 198 lethal prescriptions were written, and the number of prescriptions has increased significantly each year: from 1999 to 2002, the overall number of lethal dosages prescribed rose 76%.[71] Many of these prescriptions appear to have been written, moreover, by a very small handful of activist physicians. In its first year questionnaire, the Oregon Health Department specifically asked physicians whether the patients they helped kill were referred to them by advocacy organizations, such as Compassion in Dying or the Hemlock Society, but the state inexplicably declined to publish the answer. It was later revealed through the media that

> the first fifteen assisted suicide cases reported involved fourteen different doctors. Compassion in Dying, an out-of-state assisted suicide group which moved to Oregon just weeks after the law was implemented . . . claimed 11 of the 14 doctors were theirs. . . . [A]t least one additional case came through the Hemlock Society. So at least 12 of 14, or 86%, of the assisted suicide cases were handled by groups politically active in promoting legalization of assisted suicide. This unsettling

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[71]Oregon, Fifth Annual Report 4.

> fact was the one held back, suggesting to many that OHD had become selective in its silence . . . .[72]

Just as it is inexplicable that the State of Oregon would suppress its first year findings on this matter, so it is equally troubling that it has chosen to drop this question from its subsequent annual surveys.

Of the 198 patients who have received prescriptions for lethal medication, 129 (or 65%) have used them to date.[73] Though these figures provide a small sample, the data do reveal certain correlations, reflected in Table 4:

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[72]N. Gregory Hamilton, Oregon's Culture of Silence at 180-81 in The Case Against Assisted Suicide: For the Right to End-of-Life Care 144, 159 (Kathleen Foley and Herbert Hendin, eds. 2002). See also Foley, The Oregon Experiment.

[73]Id.

Table 4

Oregon Assisted Suicide Demographics: 1998-2002[74]

| Year | '98 | '99 | '00 | '01 | '02 |
|---|---|---|---|---|---|
| Total Deaths | 16 | 27 | 27 | 21 | 38 |
| % change from prior year- | | +41% | 0% | -22% | +81% |
| Median age | 70 | 71 | 69 | 68 | 69 |
| Age range | 25-94 | 31-87 | 51-93 | 51-87 | 39-92 |
| % Male | 50% | 59% | 44% | 38% | 71% |
| % Female | 50% | 41% | 56% | 62% | 29% |
| Married % | 12% | 44% | 67% | 38% | 53% |
| Divorced % | 31% | 30% | 11% | 33% | 24% |
| Widowed % | 31% | 22% | 22% | 24% | 18% |

As shown in Table 4, the number of deaths in 1999 appeared to increase greatly over 1998, though a firm comparison cannot be drawn because the law was not in effect for all of 1998. While the number of deaths in 2001 declined 22% compared to 2000, this represented a difference of just 6 persons. Also, the total number of lethal prescriptions increased in 2001,[75] and many of these prescriptions were apparently filled in 2002, when total deaths increased 81% over 2001, to 38 persons, by far the largest number of deaths in any year since the

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[74]Derived from data in Oregon Health Department annual reports on Oregon's Death With Dignity Act, 1998-2002.

[75]There were 44 prescriptions for lethal doses of medication in 2001, compared to 39 in 2000, 33 in 1999, and 24 in 1998. Oregon, Fourth Annual Report 3.

Oregon law went into effect, and representing 41% more deaths than occurred in the first full year of legalization (1990).

The median age for assisted suicide seems to be hovering around the 70-year mark, though the actual ages of patients taking their lives has varied widely -- including as low as 25 years-old in 1998, 31 years-old in 1999, and 28 years-old in 2002. Surprisingly, no special examination has been made into these suicides by the very young, though it would be useful to have more information about the physical and mental condition of such young persons committing suicide.

There also appears to be a persistent correlation between assisted suicide and divorce. As shown in Table 5, in each year except 2000, divorced persons have represented over 24% of all assisted suicides in Oregon, well in excess of their representation among the population of all deaths due to similar underlying illnesses:

Table 5
Relative Incidence of Assisted Suicide:
Married vs. Divorced Patients: 1999-2002[76]

| | Married | Divorced |
|---|---|---|
| Assisted Suicides: | 47% | 25% |
| Oregon deaths due to similar causes: | 49% | 18% |
| Est. Proportion of Assisted Suicide Deaths Per 10,000 Oregon deaths: | 29.2 | 54.5 |
| Relative Risk | Reference | 1.9 |

As reflected in Table 5, divorced persons constituted 25% of all assisted suicides in 1998 through 2002, but 18% of all deaths in the state of Oregon due to similar underlying maladies as those afflicting the assisted suicide patients. Meanwhile, married persons constituted 47% of all assisted suicides, but 49% of all deaths due to similar illnesses. These data suggest that divorced persons are nearly twice as likely to commit assisted suicide than similarly situated married patients. This persistent correlation between divorce and assisted suicide suggests the possibility that other things besides terminal illness (e.g., social isolation or depression) may drive the decision to seek death.

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[76]Derived from data in Oregon Health Department annual reports on Oregon's Death With Dignity Act, 1998-2002.

Of potential concern as well, data show that physicians are increasingly unlikely to refer their patients for psychiatric or psychological consultation before declaring them competent to make the decision to die, despite the evidence consistently linking suicidal impulses to mental illness.[77] Physicians referred patients in just 13% of cases in 2002 (5 of 38), compared with 14% of cases in 2001 (3 of 21), 19% of cases in 2000 (5 of 27), 37% of cases in 1999 (10 of 27), and 31% of cases in 1998 (5 of 16).[78] Even when evaluations are done, given the fact that so many patients are apparently being shepherded to doctors affiliated with advocacy groups that favor assisted suicide, the possibility exists that "a bias may be introduced into the competency evaluation. On balance the psychiatrists' conclusions may reflect personal values and beliefs more than psychiatric expertise."[79]

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[77]See Chs. III.8, VII.2, supra.

[78]Derived from data in Oregon Health Department annual reports on Oregon's Death With Dignity Act, 1998-2002.

[79]L. Ganzini, et al., Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide 153 Am. J. of Psychiatry 1469, 1474 (1996) (hereinafter, "Ganzini, Attitudes").

Further, physicians in the Netherlands often have longstanding relationships with patients; as a result, they are in some position to assess the patient's "concerns, values, and pressures that may be prompting the . . . request [for assistance in dying]."[80] By contrast, the AMA has opposed the legalization of assisted suicide in part because American physicians, increasingly employees or agents of large corporate health maintenance organizations, lack such long-term relationships with their patients: in the AMA's view, American physicians "rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's [assisted suicide] request."[81] And there is data from Oregon that speaks to this concern. In 2002, the median length of the relationship between patients seeking assisted suicide and the physicians who agreed to help them was 11 weeks, and in some cases was a matter not of weeks, but of days or hours.[82] Prior years vary, but, as reflected in Table 6, are generally in the same range:

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[80]American Medical Association, Council on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 Journ. of the Amer. Med. Ass'n at 2230, 2232.

[81]Id.

[82]Oregon, Fourth Annual Report 17.

Table 6

Duration of Patient-Physician Relationship[83]

(weeks)

| | '98 | '99 | '00 | '01 | '02 | Total |
|---|---|---|---|---|---|---|
| Median | 11 | 22 | 8 | 14 | 11 | 13 |
| Range | 2-540 | 2-816 | 1-851 | 0-500 | 0-379 | 0-851 |

While Oregon reports the duration of the patient-physician relationship, moreover, it has failed to collect any similar data regarding the length, if any, of the relationship between patient and the psychiatrist or psychologist who may be called in to assess competency. Given that such a consultation is entirely optional under the Oregon law, it seems likely that these relationships are extremely short, often just a single visit -- and this is likely so even though a survey of Oregon psychiatrists found that only 6% felt very confident that they could determine whether a patient was competent to commit suicide without a long-term relationship with that patient.[84]

Finally, while loss of autonomy topped the list of reasons proffered by patients seeking assisted suicide (a concern in 85% of cases between 1998 and 2002), many other reasons were also given, as shown in Table 7:

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[83]Derived from data in Oregon Health Department annual reports on Oregon's Death With Dignity Act, 1998-2001.

[84]Ganzini, Attitudes, 153 Am. J. Psychiatry 1469.

Table 7
Reasons Given by Oregon Patients
Seeking Assisted Suicide[85]

| | '98 | '99 | '00 | '01 | '02 | Total |
|---|---|---|---|---|---|---|
| Financial implications of treatment | 0 | 0 | 4% | 6% | 3% | 2% |
| Inadequate Pain Control | 12% | 26% | 30% | 6% | 26% | 21% |
| Burden on family, friends/ caregivers | 12% | 26% | 63% | 24% | 37% | 34% |
| Losing Control of Bodily Functions | 56% | 59% | 78% | 53% | 47% | 63% |
| Decreasing Ability to Participate in Activities that Make Life Enjoyable | 69% | 81% | 78% | 76% | 84% | 77% |
| Losing Autonomy | 75% | 78% | 93% | 94% | 84% | 85% |

Again, these data come from after-the-fact self-reporting performed by the attending physicians, not any more objective source. Even so, they reveal that 21% of cases between 1998 and 2002 were motivated in part by inadequate pain control, which, taken together with the evidence that many Oregon doctors lack sufficient

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[85]Derived from data in Oregon Health Department annual reports on Oregon's Death With Dignity Act, 1998-2001.

training in palliative care, suggest that suicide may have been substituted for adequate care in some cases. In contrast to the official state numbers, moreover, a 1999 survey of Oregon doctors who received requests for assisted suicide revealed that 43% of patients requesting assisted suicide cited pain as an important reason motivating their request; the same survey shows that physicians recommended a palliative care consultation in just 13% of cases.[86] Also, 34% of cases involved patients who were concerned about becoming a "burden" on their family and friends; even more pointedly, 2% of cases were motivated by concerns over the financial implications of continued treatment (this in one of the nation's most affluent states where one would expect financial concerns to be less pressing than in other jurisdictions where assisted suicide might be legalized).

### VII.6 Two Oregon Cases

Kathleen Foley and Herbert Hendin have investigated in detail the case of "Helen" (last name unknown), the first person to obtain assisted suicide under Oregon's regime, and of Kate Cheney, a more recent applicant.[87]

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[86]L. Ganzini, et al., Physician Experiences with the Oregon Death with Dignity Act, 342 New Eng. J. Med. 557 (2000).

[87]See Foley, The Oregon Experiment 146-49, 156-58.

Foley and Hendin's findings offer vivid case studies illustrating some of the questions and concerns I have raised regarding Oregon procedures and practices.

Helen was a breast cancer patient in her mid-80s when the Oregon law went into effect. Helen's regular physician refused to assist in her suicide (for unknown reasons); a second doctor was consulted but also refused, on the ground that Helen was depressed. At that point, Helen's husband called the advocacy group, Compassion in Dying. The medical director of the group spoke with Helen and later explained that Helen sounded "frustrated and [was] crying because she felt powerless."[88] Helen was not, however, bedridden or in great pain, but enjoyed aerobic exercises until two weeks before contacting Compassion in Dying and was still doing housework. The Compassion in Dying medical director referred Helen to a physician who, he assured, would help her. That physician referred Helen to a psychiatrist who met Helen once. A lethal prescription was then supplied.

After Helen died, the prescribing physician was quoted as saying that he regrets that he didn't contact Helen's regular physician and that he had only a "very cursory" discussion with the second doctor Helen

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[88] Id. at 146.

approached: "[h]ad I felt there was a disagreement among the physicians about my patient's eligibility" -- and no doubt there was -- "I would not have written the prescription."[89] The prescribing physician also explained that the thought of Helen dying by lethal medication was "almost too much to bear, and only slightly less difficult was the knowledge that many very reasonable people would consider aiding her death a crime. On the other hand, I found even worse the thought of disappointing this family. If I backed out, they'd feel about me the way they felt about her previous doctor, that I had strung them along, and in a way, insulted them."[90] An Oregonian newspaper reporter who interviewed the family was told that the patient was concerned that further care would threaten her financial assets.[91]

When Kate Cheney, an 85 year-old widow, more recently sought a lethal prescription from a physician, her daughter Erika, a retired nurse, accompanied her. Erika described the doctor as "dismissive" so she and her mother requested and received a referral to another physician in the same health maintenance organization

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[89]Quoted in id. at 149.

[90]Peter Reagan, Helen, 353 Lancet 1265, 1266 (1999).

[91]Foley, The Oregon Experiment at 169.

("HMO") (in this case, Kaiser Permanente). The second doctor arranged for a psychiatric evaluation; the psychiatrist found that Ms. Cheney did not "seem to be explicitly pushing for assisted suicide," and lacked a "very high level of capacity to weigh options about it." The psychiatrist noted that Ms. Cheney accepted his assessment when he presented it, but that the daughter became angry.

The HMO then, apparently at Erika's (not Ms. Cheney's) request, suggested that the family obtain a second psychiatric evaluation, and agreed to pay for it. The second psychologist found that Erika might have been "somewhat coercive," but concluded that Ms. Cheney was competent to make the decision to die. Ms. Cheney thereafter received a lethal prescription and the drugs were placed under the care of Erika. As time went by, Ms. Cheney ate poorly and became weaker and, to afford Erika and her husband a respite, was sent to a nursing home on a temporary basis to regain her strength. On the day she returned home, Ms. Cheney said that something had to be done given her declining health, that she did not want to go into a nursing home again, and she then asked to use the lethal pills in Erika's care. After the daughter consented, Ms. Cheney took the pills and died.

Helen and Kate Cheney's cases raise several questions about Oregon's assisted suicide regime: What is the role of depression, as opposed to terminal illness, actually playing in patient decisions to die in Oregon? Are alternative options, including treatment for depression, being fully presented, and are Oregon doctors knowledgeable about the alternatives that exist? To what extent are family members unduly influencing patient choices and physician evaluations? What would've happened if family members in each case had argued against the request to die and offered care? Should patients be allowed to "shop" around for physicians and psychologists who will find them competent? Do psychologists and physicians have an obligation to do more than a cursory examination? Should they consult the patient's primary care providers and other doctors or psychologists who may have refused prior requests for lethal medication by the patient? Would the HMO have paid for a second opinion if the first psychologist had found Ms. Cheney competent? Do HMOs have a conflict of interest -- assisted suicide is far cheaper than continuing care -- that incentivize them to encourage patients to seek death?

## VII.7 Other Unintended Consequences

If evidence from the Netherlands and Oregon leavs one with less than brimming confidence that assisted suicide can be practiced without the attendant cost of non-consensual killings due to abuse, mistake, and coercion, it still bears discussion whether yet other unintended costs may also attend the normalization of assisted suicide, including the possibility of discrimination against minority populations such as the elderly, African Americans, and Hispanics. When entering hospitals, for example, many elderly Dutch patients have taken to insisting on written contracts assuring against non-voluntary euthanasia.[92] Poll after poll suggests that ethnic minorities in the United States are relatively far more troubled by the prospect of legalized euthanasia and its impact on them. Indeed, Oregon's highly homogenous population (approximately 90% white) perhaps helps explain, in part, why the U.S. legalization campaign took root there first.[93]

The Detroit Free Press has found that while 53 percent of whites sampled in Michigan could envision

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[92]House of Lords Report HL Paper, 21-I of 1993-1994 Session, vol. 1 at 66.

[93]U.S. Bureau of the Census, Statistical Abstract of the United States (2001).

requesting assistance in suicide, only 22 percent of blacks could.[94] A poll in Ohio revealed that, while roughly half those sampled favored legalization of assisted suicide, those most likely to favor the practice were high income, highly educated young adults, and those most likely to oppose the practice were blacks, people 65 and older, and those with low levels of income and education.[95]

Empirical evidence concerning the medical treatment presently provided to minority groups suggests that their relative unease with the legalization of assisted suicide is not irrational. The New England Journal of Medicine has reported that women, blacks, elderly and Hispanic cancer patients are all less likely than similarly situated non-minorities to receive adequate pain-relieving treatment that may help obviate a patient's perceived need to resort to assistance in suicide or euthanasia.[96] Minority cancer patients are fully three

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[94]Joseph P. Shapiro with David Bowermaster, Death on Trial, U.S. News & World Report 31, 39 (Apr. 25, 1994) (hereinafter, "Shapiro, Death on Trial").

[95]See Ohioans Divided on Doctor Assisted Suicide Issue, United Press International, June 28, 1993, BC cycle.

[96]See Charles S. Cleeland, et al., Pain and Its Treatment in Outpatients with Metastatic Cancer, 330 New Eng. J. of Medicine 592, 594 (Mar. 3, 1994).

times less likely than non-minority patients to receive adequate palliative care.[97] Minorities also receive poorer AIDS treatment: only 48 percent of blacks receive medicines designed to slow the progress of AIDS, compared to 63 percent of whites; while 82 percent of whites receive effective treatments for preventing AIDS-related pneumonia, only 58 percent of blacks receive similar attention.[98] African-Americans have higher mortality rates than whites across disease categories, and recent declines in breast cancer mortality rates have been enjoyed only among white, not black, women.[99] Blacks even have fewer physician visits and receive different treatment than whites within the federally funded Medicare and Veteran's Affairs programs.[100] And African-Americans are 3.5 times more likely than whites to have one or more of their limbs amputated, even though diabetes, the most common reason for amputation, is only

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[97]Id.

[98]See Richard D. Moore, et al., Racial Differences in the Use of Drug Therapy for HIV Disease in an Urban Community, 330 New Eng. J. of Medicine 763 (1994).

[99]Patricia King and Leslie Wolf, Lessons for Physician-Assisted Suicide from the African-American Experience in Physician Assisted Suicide: Expanding the Debate 90, 101 (Margaret Battin, Rosamond Rhodes & Anita Silvers, eds. 1998) (hereinafter, "King, The African-American Experience").

[100]Id.

1.7 more common among blacks than whites.[101]

In the events leading up to the consideration of the failed California voter referendum on assisted suicide in 1992, advocates of the measure turned to the American Bar Association ("ABA") for support. The ABA, however, ultimately recommended against legalization and did so specifically on the ground that

> [t]he proposed right to choose aid-in-dying freely and without undue influence is illusory and, indeed, dangerous for the thousands of Americans who have no or inadequate access to health and long-term care services.[102]

The Canadian Medical Association, the British Medical Association, the World Medical Association, and the American Nurses Association have all argued against legalizing euthanasia on similar grounds.

The New York Task Force, too, recommended against legalization in part because it would, in the task force's words, impose severe risks on "the poor, minorities, and those who are least educated and least

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[101]Id.

[102]ABA Commission on Legal Problems of the Elderly, Memorandum in Opposition to Resolution No. 8 on Voluntary Aid in Dying, 8 Issues L. & Med. 117 (1992). "The lack of access to or the financial burdens of health care hardly permit voluntary choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts. Our national health care problem should be our priority -- not endorsement of euthanasia." Id.

empowered";[103] "[o]fficially sanctioning [euthanasia] might also provide an excuse for those wanting to spend less money and effort to treat severely and terminally ill patients, such as patients with Acquired Immunodeficiency Syndrome."[104] Even those task force members who thought euthanasia justified in some instances concluded that, weighing the costs and benefits, continued criminalization would

> curtail[] the autonomy of patients in a very small number of cases when assisted suicide is a compelling and justifiable response, [but would] . . . preserve the autonomy and well-being of many others. It [would] also prevent[] the widespread abuses that would be likely to occur if assisted suicide were legalized.[105]

The State of Michigan established a similar commission to study the assisted suicide issue after Dr. Kevorkian brought attention to the subject there. While the commission was unable to achieve a consensus position, those who concluded that euthanasia should not be legalized stressed the dangers of "social biases."[106] Though "proponents of assisted suicide would . . . point out that the criteria for allowing assisted

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[103]New York Task Force on Life and the Law 125.

[104]Id. at 96.

[105]Id. at 141.

[106]See Michigan Commission on Death & Dying, Final Report (June 8, 1994).

suicide should be blind to the factors of age or disability," commission members argued that

> {t]o suggest that legalizing assisted suicide will not continue to reinforce . . . stereotypes and prejudices against [the] disabl[ed] is to ignore the practicalities of how, and for whom, assisted suicide would be applied.[107]

The British House of Lords Committee on Medical Ethics, after lengthy hearings, reached much the same conclusion, recommending against legalization out of "concern that vulnerable people -- the elderly, lonely, sick or distressed -- would feel pressure, whether real or imagined, to request early death."[108] "We believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life."[109]

Because normalizing assisted suicide and

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[107]Id. at 6-7.

[108]House of Lords Report HL Paper, 21-I of 1993-1994 Session, vol. 1 at 491.

[109]Id. During the brief experiment with legalization in the Northern Territory of Australia, a consultant was commissioned by the government to explain its goals and operation to Aboriginal communities. Despite his initial support for the law, the deep fear Aboriginal communities expressed about the laws implications for them led the consultant to advise the Northern Territory legislature to repeal the statute. See John Finnis, Euthanasia, Morality, and Law, 31 Loyola of Los Angeles L. Rev. 1123, 1144 n. 75 (1998) (quoting unpublished reports on file with author).

euthanasia would represent such a sea change in our end-of-life laws and ethics, it would undoubtedly carry with it additional unintended consequences for medicine, law, and social norms, only some of which can be now predicted or foreseen. Still, we might ask, what glimmers can we make out, if only barely, on the horizon of such a significant change in our law?

One possibility is that, as a cheaper and easier option (killing) becomes available as a legitimate medical response to terminal illness or grave physical suffering, it will create disincentives to the development and dissemination of other more expensive end-of-life options. A 1988 study strongly suggested that physician incompetence and the lack of adequate palliative medicines in the Netherlands may contribute to the number of requests made for assisted suicide and euthanasia in that country: more than 50 percent of Dutch cancer patients surveyed suffered treatable pain unnecessarily, and 56 percent of Dutch physician practitioners were found to be inadequately trained in pain relief techniques.[110] Another study conducted under the auspices of the U.S. Department of Health and Human Services gives reason to fear the same result in other

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[110]See House of Lords Report HL Paper, 21-I of 1993-1994 Session, vol. 1 at 67.

countries:

> [p]atients with cancer often have pain from more than one source, but in up to 90 percent of patients the pain can be controlled by relatively simple means. Nevertheless, undertreatment of cancer pain is common because of clinicians' inadequate knowledge of effective assessment and management practices, negative attitudes of patients and clinicians toward the use of drugs for the relief of pain, and a variety of problems related to reimbursement for effective pain management.[111]

Providing assisted suicide and euthanasia is a cheap means of responding to patients suffering grave pain, less expensive than guaranteeing the care, attention, and pain medication required for some patients to die in comfort. To recognize killing as a valid medical response to patient discomfort may create economic disincentives not only to the development of new palliative treatments, but also to the full dissemination of nursing and hospice care and existing pain suppressants that can prevent suffering and the perceived need for assistance in dying. John Griffiths, while advocating the extension of the Dutch regime to non-voluntary euthanasia, has acknowledged that "there are occasional indications" that economic considerations do play a role in the administration of

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[111]Ada Jacox et al., New Clinical-Practice Guidelines for the Management of Pain in Patients with Cancer, 330 New Eng. J. of Medicine 651 (1994).

assisted suicide in the Netherlands, noting that "some 12% of the doctors and 15% of the prosecuting officials interviewed [in 1995] expect[ed] that drastic budget-cutting in the health-care system could lead to increased pressure on doctors to engage in life-shortening practices."[112] And these findings come in a society where, quite unlike America, virtually everyone is guaranteed medical insurance.[113]

We may see in the case of Ms. Cheney what may, in this respect, be a glimpse of the future for American patients -- even ones with medical insurance. The HMO there was quite willing to pay (at the daughter's urging) for a second opinion after the first psychologist refused to certify Ms. Cheney for death, and it then agreed to allow the assisted suicide to proceed despite the evidence suggesting coercion and patient incompetence; notably, the HMO did not intervene in the same way to offer continued psychiatric counseling or a palliative care consultation. And now the very same HMO is soliciting its doctors to participate in assisted suicide. A Kaiser executive recently e-mailed more than 800 Kaiser

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[112]Griffiths, Euthanasia & Law 304 n.5.

[113]Griffiths, Euthanasia & Law 31 et seq. (describing Dutch health care system).

doctors asking them to "act as Attending Physician under the [assisted suicide] law for YOUR patients" and soliciting doctors "willing to act as "Attending Physician under the law for members who ARE NOT your patients" to contact "Marcia L. Liberson or Robert H. Richardson, MD, KPNW Ethics Services."[114] As one commentator has concluded, "Kaiser is apparently willing to permit its doctors to write lethal prescriptions for patients [within Kaiser's HMO system whom] they have not treated."[115]

What others have left implicit or perhaps chosen to turn a blind eye to, Derek Humphry, co-founder of the Hemlock Society, an assisted suicide advocacy organization, has made explicit, candidly acknowledging that money is an "unspoken argument" in favor of legalization: "the hastened demise of people with only a short time left would free resources," in an amount Humphrey estimates would run into the "hundreds of billions of dollars."[116]

If we normalize assisted suicide and euthanasia,

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[114]Quoted in Byron York, Doctors of Death: Kaiser Solicits Its Doctors to Kill, Guest Comment, National Review Online (Aug. 19, 2002).

[115]Id.

[116]See id.

essentially recognizing them as legitimate forms of medical treatment, we must also consider whether we will, in effect, create a new standard of care, imposing, in essence, a professional duty on physicians to offer to "treat" patients with assisted suicide under certain circumstances, perhaps even opening medical care professionals to suits in negligence by families upset that their relatives have suffered needlessly because the doctor or nurse did not advocate their death. Far-fetched as such a result may seem today, some advocates of legalization are discussing just this possibility.[117]

More modestly, we might also ask, whether legalization would foster a culture in which physicians at least feel freer to disregard patient wishes for what doctors may perceive as futile or unduly expensive care? Certainly such a result would harm, not help, the objective of patient autonomy assisted suicide is intended by some to serve. But it is a possibility

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[117]See, e.g., Frances Kamm, Physician-Assisted Suicide, Euthanasia, and Intending Death in Physician Assisted Suicide: Expanding the Debate 28, 36 (Margaret Battin, Rosamond Rhodes and Anita Silvers, eds. 1998); Patricia Mann, Meanings of Death in Physician Assisted Suicide: Expanding the Debate 11 (Margaret Battin, Rosamond Rhodes and Anita Silvers, eds. 1998) (hereinafter, "Mann, Meanings of Death"); Griffiths, Euthanasia & Law 285-92. See also Ch. X.2 (discussing In re B).

that cannot be considered implausible or remote. John Griffiths has advocated extending the decriminalization of euthanasia in the Netherlands to non-voluntary killings.[118] Of course, Griffiths says that families could seek civil remedies for non-voluntary killings that fail to meet specified medical guidelines. But the costs and energy associated with such lawsuits would be daunting obstacles and, even if one could muster the resources for such a suit, success seems far from guaranteed. Indeed, at least one U.S. court has endorsed the notion that physicians may override a patient's autonomous desire for treatment. In April 1995, a Massachusetts court ruled that a hospital and its doctors need not provide life-sustaining care they deem futile, even if the patient expressly requests it.[119] The case involved an elderly woman, Catherine Gilgunn, who became comatose after suffering irreversible brain damage. Her daughter instructed the hospital that her mother wished everything medically possible should be done for her should she become incompetent. The hospital, however, ignored the daughter's instructions and refused to place Mrs.

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[118]See Ch. VII.3, supra.

[119]See Gina Kolata, Court Ruling Limits Rights of Patients, N.Y. Times, sec. 1, at 6 (Apr. 22, 1995).

Gilgunn on a respirator or provide cardiopulmonary resuscitation. The lawyer defending the hospital provided his forthright assessment of the ruling: the court's "real point," he said, was that, "physicians can't be required to do things they feel would be inappropriate and harmful to the patient" -- regardless of how the patient herself "feels."[120]

Patricia Mann, who, notably, takes no position in the assisted suicide debate, describes in vivid detail some of the cultural consequences that a shift to legalization might entail for the medical profession:

> [M]any doctors will adjust their practices, and gradually their values . . . . Insofar as assisted suicide is a cost-efficient means of death, doctors are . . . likely to be rewarded by their healthcare companies for participating in it. As institutional expectations and rewards increasingly favor assisted suicide, expectations and rewards within the medical profession itself will gradually shift to reflect this. Medical students will learn about assisted suicide as an important patient option from the beginning of their training. We may expect that a growing proportion of doctors will find themselves sympathetic to the practice, and will find themselves comfortable with recommending it to their patients.[121]

But not only will the medical profession, Mann notes, be affected:

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[120]Id.

[121]Mann, Meanings of Death 21.

> Family members may want a loved one to remain alive as long as possible, while also harboring secret desires to be done with this painful process. Many people today are ashamed of such secret desires . . . . But if assisted suicide becomes legal, such desires will cease to be wrongful in such an obvious way. If patients themselves may decide to put an end to this painful process of dying, then it is not blameworthy for relatives of such a patient to inquire whether he or she may be thinking along these lines, and to offer a sympathetic support for the idea. . . . Once assisted suicide ceases to be illegal, its many advantages to busy relatives will become more readily apparent. More than merely an acceptable form of ending, relatives and friends may come to see it as a preferred or praiseworthy form of death.[122]

Nor can Mann's fears be dismissed as fanciful: the former Governor of Colorado, Richard Lamm, for one, has openly and repeatedly issued a challenge to the elderly whom he says have a duty to shuffle off the stage and make room (and save resources for) the young.[123]

And, of course, economic incentives play a role for HMOs and all of society:

> If dying sooner is more cost efficient, their profit-based concerns will make them prefer patients to choose assisted suicide . . . . Economic interests may still seem crass in relation to dying patients, and yet we are already accustomed to recognizing them in the context of treatment, as well as in all other context of daily life. When we legalize assisted suicide, it

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[122] Id. at 21-22.

[123] See Nat Hentoff, A Duty to Die?, Washington Post, at A19 (May 31, 1997).

too becomes a part of daily life.[124]

As Mann notes, "[i]n our society, where almost everyone is pressed for time, and many are pressed for money, individual notions of agency and the fabric of social agency relations may evolve very quickly to reflect [assisted suicides] conveniences and cost efficiency."[125] If anyone should doubt how quickly economic forces can change cultural norms and expectations, Mann asks us to look back to the 1950s and 1960s and compare "how rapidly we have come" to alter our views on women working outside the home, with many today even "consider[ing] it somewhat indulgent and eccentric" for highly educated women to give up professional careers in favor of remaining at home.[126] How can we doubt, as Mann asks, that "our views of dying will change quite radically if and when assisted suicide is legalized"?[127]

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[124]Mann, Meanings of Death at 22.

[125]Id.

[126]Id. at 23.

[127]The unintended consequences of legalization would surely include, as well, the fact that it would leave some set of persons who remain morally and religiously opposed to assisted suicide and euthanasia in a position similar to the one in which abolitionists found themselves in antebellum America, or contemporary abortion and capital punishment opponents find themselves today -- in distress at even passive participation in a regime which facilitates what they believe to be wrong. The social division and unrest associated with such discontent is yet one more cost

## VII.8 Griffiths and Kuhse: Decriminalization As "Costless"?

John Griffiths has sought to press the somewhat counter-intuitive notion that the decriminalization of assisted suicide is an essentially "costless" enterprise: Just because the incidence of assisted suicide is high in the Netherlands, Griffiths submits, doesn't necessarily mean that it "increased after legalization" or that it "is higher in the Netherlands than elsewhere."[128] In fact, Griffiths argues, assisted suicide and euthanasia are practiced on a "widespread, if hidden" basis in the United States at "rates roughly comparable to those in the Netherlands," a "fact" which leads Griffiths to conclude that "[l]egalization of euthanasia, apparently does not lead to an increase even in the rate of euthanasia itself."[129]

Griffiths is surely right to note that the data we have from the Netherlands, like the data from Oregon, only tells us about the incidence of assisted suicide

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that would have to be figured into any comprehensive utilitarian calculus on the assisted suicide question.

[128]Griffiths, Euthanasia & Law 26.

[129]John Griffiths, The Slippery Slope: Are the Dutch Sliding Down or Are They Clambering Up? in Asking to Die: Inside the Dutch Debate About Euthanasia 100 (David C. Thomasma, et al., eds. 1998) (hereinafter, "Griffiths, Slippery Slope"). See also Griffiths, Euthanasia & Law 27 (arguing to same effect).

and euthanasia after they became legally permissible in those jurisdictions, and that we lack much data regarding the rate of voluntary or non-voluntary killings in those jurisdictions before legalization. But Griffiths does nothing to dispel concerns that Dutch and Oregon procedures and practices raise on their own terms (concerns we have outlined on above), and Griffiths goes far beyond noting the limitations of current data to an argument that is itself unwarranted on the evidence.

First, Griffiths's hypothesis, that decriminalization of assisted suicide and euthanasia does not result in any additional cases of those practices, runs directly contrary to the intuitive principle of the Law of Demand. The Law of Demand holds that, other things being equal, the quantity demanded of a good falls when the price of the good rises.[130] One would, thus (and quite sensibly), expect

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[130]N. Greggory Mankiw, Principles of Economics 68 (2d ed. 2001). Theoretically, some goods may violate the Law of Demand ("Giffen goods," so named for economist Robert Giffen); their demand curves slope upward because of an exceptionally large negative income effect which dominates the substitution effect. Thus, some "suggest that potatoes were in fact a Giffen good during the Irish potato famine of the nineteenth century. Potatoes were such a large part of people's diet that when the price rose, it had a large income effect. People responded to their reduced living standards by cutting back on the luxury of meat and

that if the "costs" associated with assisted suicide and euthanasia (e.g., the social stigma and difficulty of finding a willing physician to help when the practices remain illegal) are lowered or eliminated, more, not fewer, people would take advantage of this fact and seek an early death. Consistent with the Law of Demand, one would expect that legalizing assisted suicide and euthanasia (and thus lowering the "price" associated with the practices) would lead to an increase in their frequency. Advocates of legalization usually champion exactly this point, arguing for regularization of assisted suicide precisely because doing so would allow more people to exercise the choice to kill themselves. Griffiths gives us no reason to adopt a contrary, and entirely counter-intuitive, assumption.

Second, while Griffiths asserts that assisted suicide and euthanasia are secretly practiced in the United States on approximately the same scale they are openly practiced in the Netherlands, the only authority he provides for this claim is a citation to the amicus

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buying more of the staple food of potatoes." Id. at 479. Whether any Giffen good has ever been discovered, however, remains a matter of substantial dispute among economists, and Griffiths does not invoke the Giffen good theory in his argument for an assisted suicide exception to the Law of Demand.

brief in Glucksberg written by Ronald Dworkin and other legal scholars, described by its authors as the "Philosophers' Brief"; that legal advocacy piece hardly purported to provide a systematic study of assisted suicide and euthanasia rates in the United States, doing no more than citing other authorities.

And Griffiths' empirical assertion is, in fact, contradicted by the available data -- data which is entirely consistent with what one would expect under the Law of Demand. The 1995 van der Maas survey of Dutch physicians found that 63% of general practitioners and 37% of clinical specialists in the Netherlands (and 53% of all physicians) had performed euthanasia or assisted suicide.[131] Meanwhile, a sample of physicians in Oregon conducted prior to the legalization of assisted suicide in that state found that only 12% had ever received a request for euthanasia or assisted suicide and just 7% had written a lethal prescription at a patient's request[132] -- and, given subsequent vote approval of assisted suicide, one

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[131]van der Maas, Euthanasia Table 2.

[132]van der Maas, Euthanasia. In Washington state, a survey found that 12% of physicians had received requests for physician assisted suicide and 4% had received a request for euthanasia in the prior year; a quarter of these requests were granted. Id.

might have expected these figures to be comparatively high when measured against other American states. In fact, a 1998 nationwide survey of over 1,900 U.S. physicians (conducted by, among others, Dr. Quill) found that, over the entire course of their careers, 11.1% had received a request for euthanasia, 18.3% had received a request for assisted suicide, and approximately 6% had acceded at least one request for either euthanasia or assisted suicide. One of Quill's co-authors remarked that the "most important finding" in this survey was that "[t]his is really not happening very often. . . . It's a rare event."[133] As Professor van der Maas himself has noted, the figures from the United States "are consistently lower than those we found" for Dutch physicians,[134] and all extant data suggests "the proportion of deaths in the United States that involve physician-assisted suicide and euthanasia

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[133]Diane E. Meier, et al., A National Survey of Physician-Assisted Suicide and Euthanasia in the United States, 338 New Eng. J. Med. 1193 (1998); Daniel Q. Haney, 6 Pct. of Physicians in Survey Say They Have Assisted Patient Suicides, Wash. Post., Apr. 23, 1998, at A9 (referring to Meier study and quoting Ezekiel Emmanuel of the National Institutes of Health who has estimated that 3% to 13% of all physicians have "hastened" the death of a patient); Dick L. Willems, et al., Attitudes and Practices Concerning the End of Life: A Comparison Between Physicians from the United States and from the Netherlands, 160 Archives Internal Med. 63 (2000).

[134]van der Maas, Euthanasia.

is likely to be small."[135] The American Geriatrics Society has also argued that the widespread practice of assisted suicide and euthanasia "seems unlikely. Three-quarter of all deaths happen in institutions where a regularized endeavor would require the collusion of a large number of persons."[136]

Third, even supposing, counterfactually, that the rates of voluntary assisted suicide and euthanasia in the United States (where the practices are generally illegal) and the Netherlands (where the practices are allowed) are presently comparable, it would be error to leap to the conclusion that legalization in the United States would therefore be a "costless" enterprise. It would be equally consistent with the facts to suppose that different countries have different baseline (pre-legalization) rates of assisted suicide and euthanasia because of cultural phenomena and that, consistent with the Law of Demand, legalizing voluntary assisted suicide and euthanasia (and thus reducing the "price"

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[135]Paul van der Maas and Linda L. Emmanuel, Factual Findings in Factual Findings in Regulating How We Die: the Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide 151 (Lina L. Emmanuel, ed. 1997). See also Keown EEPP at 61-62 (discussing British and American evidence).

[136]Brief of the Amici Curiae the American Geriatrics Society, in Glucksberg.

associated with the practices) would lead to an increase in the frequency of the practices when compared with existing baseline, pre-legalization rates in any given country.

In a variation of Griffiths' hypothesis, Helga Kuhse argues that empirical data undermine any suggestion that "the rate at which doctors intentionally end patients' lives without an explicit request is higher in a country where voluntary euthanasia is practiced open . . . than in a comparable country which prohibits the practice"; simply put, in her view, "laws prohibiting the intentional termination of life . . . do not prevent doctors from intentionally ending the lives of their patients" without consent.[137]

As with Griffiths' theory, however, the foundation on which Kuhse seeks to builds her argument is not free from question. Kuhse argues that the rates of non-voluntary killings in her home country of Australia, where assisted suicide is now illegal, are higher than in the Netherlands, and, therefore, that legalization is likely to reduce (or at least not increase) the

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[137]Helga Kuhse, From Intention to Consent: Learning from Experience with Euthanasia in Physician Assisted Suicide: Expanding the Debate 263 (Margaret Battin, Rosamond Rhodes & Anita Silvers, eds. 1998) (hereinafter, "Kuhse, Expanding the Debate").

total number of cases of non-consensual killings. But, again, the fact that non-voluntary killings in Australia may already be high when compared with the Netherlands doesn't mean that the problem of non-consensual killings won't be exacerbated in Australia if voluntary assisted suicide and euthanasia are legalized there. Kuhse's empirical claim is equally consistent with the supposition that Australia simply starts from a different (higher) baseline of non-consensual killings and that, as voluntary assisted suicide and euthanasia become more common, so too will non-consensual killings due to abuse, mistake, and coercion.

Similarly, Kuhse's thesis -- like Griffiths's -- is in tension with the Law of Demand. As and when non-consensual killings become more acceptable -- as they surely have in the Netherlands, where the government has sought to justify them as "necessary" and others, such as John Griffiths, have urged their complete decriminalization -- one would expect the number of such cases to increase, not remain constant as Kuhse seems to suppose. While an exception to the Law of Demand is not inconceivable, a theory that depends on such an exception would require considerable proof.

The empirical data which Kuhse cites, like her theory itself, are open to question. Kuhse's data come from a postal survey of physicians that Kuhse conducted together with Peter Singer. Singer, now DeCamp Professor at Princeton University's Center for Human Values is, like Kuhse, a well known exponent of legalizing assisted suicide and we shall examine many of his views in subsequent chapters. Kuhse and Singer's survey was limited to Australian doctors and makes no claims or findings regarding the practice of assisted suicide in America. Their most fundamental finding was that voluntary euthanasia and assisted suicide collectively represent approximately 1.8% of all deaths in Australia.[138] By comparison, however, voluntary euthanasia and assisted suicide accounted for 2.1% of all deaths in the Netherlands in 1990, and 2.7% of all deaths in 1995.[139] This data, standing alone is, thus, hardly consistent with the thesis that legalization does not result in more killings -- suggesting that euthanasia and physician assisted suicide were 50% more common in the Netherlands in 1995 than in Australia in 1996 (and confirming what one

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[138] Id.

[139] See Ch. VII.3, supra.

would expect given the Law of Demand).

Kuhse and Singer, perhaps unsurprisingly, seek to emphasize other findings from their survey. By way of example, Kuhse claims that passive (i.e., by omission) non-voluntary euthanasia is more common in Australia than the Netherlands, despite its greater acceptability in the Netherlands.[140] But at least some of the data on which Kuhse and Singer base this conclusion do not seem to bear out such their assertion. For example, Kuhse and Singer claim that 22.5% of all deaths in Australia were the result of omissions of care without "explicit" patient consent, and seek to contrast this figure with Dutch experience, noting that all decisions to omit treatment, consensual and non-consensual, accounted for 13.3% of deaths in the Netherlands in 1995.[141] After unearthing data buried in a table, however, one finds

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[140]The Kuhse-Singer study was poorly designed to identify true cases of passive euthanasia. Participants were asked whether they had withheld or withdrawn treatment with the "explicit intention of not prolonging life or of hastening death." Kuhse, Australian Medical Practice. But this question obviously risks conflating different things; physician assisted suicide and euthanasia, as we have discussed, involve actions where an intent to end life is present. An intention "not to prolong life," is unclear and not necessarily the same thing at all, arguably embracing decisions where no intent to end life is present at all, but simply an intent to avoid burdensome or futile care.

[141]Australian Medical Practice.

that included within the critical 22.5% figure of supposedly non-consensual killings is a very large number of cases (21% of all omission cases) where patient-physician discussions, if any, are unknown, because the participating physicians simply did not provide any information in the write-in postal survey.[142] The analogous non-report rate in the Netherlands was much lower (5%).[143] This large difference could, perhaps, be attributed to the fact that Khuse's survey depended on voluntarily mailed-in results, whereas the van der Maas Survey relied on in-person interviews and studies of mandatory death certifications filed with the state; accordingly, it would have been relatively easy (and understandable) for doctors in the Australia survey to bypass questions about what, if any, private (and privileged) doctor-patient discussions they may have had.

In any event, an apples to apples comparison of non-voluntary euthanasia by omission, avoiding non-report cases, seems to undermine Kuhse's and Singer's thesis. According to Kuhse and Singer, 28.6% of all

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[142]See Australian Medical Practice Box 3 (reporting that in 62 of 289 surveys regarding omissions of care, doctors simply didn't report their discussions, if any, with patients).

[143]van der Maas, Euthanasia Table 4.

deaths in Australia are the result of omissions of care with or without consent. Of that universe, only 27% occurred without some indication, explicit or less than explicit, of patient consent; thus, total deaths by omission of care without any indication of patient consent amounted to 7.72% of all deaths in Australia. From the van der Maas Survey, by comparison, we know that omissions of care accounted for about 20.2% of all deaths in the Netherlands in 1995.[144] And we know that 51% of these cases involved no physician-patient discussion at all -- nearly double the same applicable percentage for Australia.[145] Accordingly, approximately 10.3% of patients in the Netherlands -- or 33% more persons than in Australia -- appear to have died as a result of omissions of care without any indicia of consent.[146]

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[144]van der Maas, Euthanasia Table 1.

[145]van der Maas, Euthanasia Table 4.

[146]Kuhse and Singer suggest that non-voluntary active euthanasia is also more pervasive in Australia than in the Netherlands -- representing fully 3.5% of all deaths, compared with 0.8% and 0.7% of deaths in the Netherlands in 1990 and 1995, respectively. While this, if reliable, is an apparently significant finding, the authors do not draw much attention to the fact that Australian doctors are apparently more likely to have some discussion with the patient before killing them: 65% who killed without "explicit" consent reported that the patient either expressed a wish for the procedure, or at least discussed the action, compared with 52% of similarly situated Dutch doctors.

Relatedly, Robert Manne, of Australia's LaTrobe University has questioned Kuhse's and Singer's finding that 64.8% of all deaths in Australia are the result of some medical decision, formally labeled as a "medical decision concerning the end of life" (or "MDELs").[147] By comparison, Dutch data shows that MDELs occur in approximately 40% of all deaths.[148] This considerable disparity has led Manne to ask: "As about 30 per cent of deaths in Australia must be, as in Holland, sudden or acute where MDELs could not take place, what [the authors] are effectively claiming is that while in Holland an MDEL takes place in a little over one-half of non-acute deaths, in Australia a medical decision concerning the end of life takes place in almost every case. . . . To my mind this finding calls into question the scientific rigour of the whole study."[149]

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See Kuhse, Australian Medical Practice Table 3; van der Maas, Euthanasia Table 4.

[147]Id. Table 5.

[148]Id.

[149]Robert Manne, Research and Ye Shall Find, Bioethics Research Notes 9(1) (Southern Cross Bioethics Institute, March 1997). A Belgian study also showed that all MDELs accounted for 39.3% of deaths, a figure in line with findings in the Netherlands, and only a fraction of the findings Kuhse and Singer reported in Australia. See Luc Deliens, et al., End-of-Life Decisions in Medical Practice in Flanders, Belgium: A Nationwide Survey, 256 Lancet 1806 (2000) (hereinafter, "Deliens, Belgium: A Nationwide Survey"). The Belgian

Finally, even if Griffiths and Kuhse could convincingly prove their counter-intuitive hypotheses that decriminalization does not encourage more cases of voluntary and non-voluntary assisted suicide and euthanasia, that would not necessarily make decriminalization the appropriate or most efficient response. "By parity of reasoning," the U.S. Justice Department has noted in its opinion declaring that the prescription of lethal drugs for assisted suicide in Oregon contravenes the federal Controlled Substances Act, "if it could be shown that physicians violated traditional medical canons of ethics more often than is usually supposed, e.g., by engaging in sexual relations with their patients or disclosing patient confidence, it would follow that the evidence of such deviations overturned the professional standards prohibiting such misconduct."[150] As this passage suggests, evidence about the pervasiveness of "clandestine" practice of assisted suicide and euthanasia and the existence of non-

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study did suggest that patients actively killed without consent represented 3.2% of all deaths, approximating the result found in Australia, but this again included cases where some discussion with the patient took place. Focusing on cases where no discussion took place, the figure dropped to 1.9%. See id.

[150]Memorandum for the Attorney General, 17 Issues L. & Med. 269.

voluntary killings under current law may be wielded by partisans on both sides of the debate -- constituting to some a reason for greater vigilance and enforcement rather than for abolishing altogether criminal penalties for voluntary euthanasia; certainly, the contemporary debate over the status of illicit drugs illustrates this point, with politicians and the public on both sides agreeing that drug usage occurs on a large scale, but disagreeing utterly on whether to step up enforcement measures or repeal possession laws. And, of course, we have seen how the argument has so far played out in America: the recent activities of Dr. Kevorkian and his followers have induced state legislatures across the country, along with Congress and the U.S. Attorney General, to take steps aimed aid at enhancing, not watering down, the enforcement of laws against assisted suicide.[151]

One might seek to respond that legalization would at least allow the state to oversee and regulate the practice of assisted suicide and euthanasia, ensuring that safeguards are respected by bringing the practices

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[151]See also Keown, EEPP 63; James Thunder, Quiet Killings, 18 Issues in Law & Medicine 213 (Spring 2003) (arguing that the existence of clandestine killings is a reason for enhancing existing laws and enforcement efforts, not legalization).

out of the closet and into the light of day. But the evidence from the Netherlands and Oregon does not offer great comfort that decriminalization will result in zealous regulatory reporting or enforcement: again, over 57% of Dutch doctors have admitted that, despite the acceptability of assisted suicide and euthanasia in the Netherlands, they have deliberately failed to report cases of such practices -- and these cases disproportionately involve illegal killings without consent from the patient or consultation with professional colleagues.[152] Even John Griffiths has acknowledged that the present control-regime in the Netherlands "is a bit of a paper tiger."[153] Indeed, as we have seen, the only solution Griffiths offers for the severe reporting problem in the Netherlands is to "reform" the Dutch regime by decriminalizing non-consensual homicide -- an alternative that may well make enhanced enforcement of existing law look preferable by comparison to some utilitarians.

## VII.9 How to "Balance" The Costs and Benefits of Legalization?

To this point, I have sought to suggest that

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[152]See Ch. VII.3, supra.

[153]Griffiths, Euthanasia & Law 245-46. See also Keown, EEPP 63.

legalization, even if narrowly limited to the terminally ill or gravely suffering, is not necessarily a "costless" enterprise. It is important, however, to emphasize what I have not done: I have not proven that the costs we might associate with legalization outweigh the benefit of permitting people who really wish to kill themselves the liberty of doing so. I have not even shown that the costs and benefits of normalization are in equilibrium. All I have done or sought to do, to this point, is to question whether application of a utilitarian calculus would inexorably lead to the conclusion that legalization represents the best solution for the greatest number of persons. And this raises the next question remains: how to balance the competing costs and benefits in a definitive utilitarian calculation? Accepting that legalization may bring with it unintended and unwanted consequences, as well as real benefits, the utilitarian must somehow "sum up" these competing costs and benefits. But how?

Utilitarians do not, of course, uniformly line up in favor of legalizing assisted suicide or euthanasia. In the 1950s, Glanville Williams wrote The Sanctity of Life and the Criminal Law, the classic utilitarian case for euthanasia, but, soon afterward, Yale Kamisar

published an article arguing for the opposite conclusion applying the same utilitarian methodology.[154] The most interesting feature of the Williams-Kamisar debate, however, is not that two utilitarians disagree. Nor is it in trying to determine who offered the more complete or accurate utilitarian calculation. Instead, the interesting question raised by the debate they began (which has continued ever since) is whether -- even if one could definitively identify <u>all</u> of the positive and negative consequences associated with assisted suicide or euthanasia -- one could then rationally and objectively weigh those consequences to ascertain the "correct" result? On a purely utilitarian account, how can we compare, for instance, the interest the rational adult seeking death has in dying with the danger of mistakenly killing persons without their consent?

Such questions suggest, I think, a fundamental problem besetting <u>both</u> Williams's and Kamisar's projects: the absence of any agreed scale on which the utilitarian can weigh or compare radically different competing values. Endeavoring to weigh the interest

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[154]Yale Kamisar, <u>Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation</u>, 42 Minn. L. Rev. 969 (1958).

the rational adult has in choosing death against the interest the incompetent elderly widow has in avoiding being killed by a greedy guardian and heir is metaphysically impossible without reference to some extrinsic, agreed upon moral rule or code. It is seemingly as senseless an enterprise as trying to compare the virtues of apples to those of oranges, senseless "in the way that it is senseless to try to sum up the quantity of the size of this page, the quantity of the number six, and the quantity of the mass of this book."[155]

Margaret Battin appears to identify the incommensurability problem underlying utilitarian arguments against assisted suicide and euthanasia, acknowledging that

> [t]he wedge argument against euthanasia [i.e. the fact that allowing voluntary euthanasia may lead to acceptance of nonvoluntary euthanasia] usually takes the form of an appeal to the welfare rights of those who would become victims of later, unjustified practices. Usually, however, when the conclusion is offered that euthanasia therefore ought not be permitted, no account is taken of the welfare or rights of those who are to be denied the benefits of this practice. Hence, even if the causal claims advanced in the wedge argument are true . . . they still do not establish the conclusion. Rather, the argument sets up a conflict. Either we ignore the welfare and

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[155]John Finnis, Natural Law and Natural Rights 115 (1980) (hereinafter, "Finnis, Natural Law"). See also Joseph Raz, Morality of Freedom, ch. 13.

> abridge the rights of persons for whom euthanasia would clearly be morally permissible in order to protect those who would be the victims of corrupt euthanasia practices, or we ignore the potential victims in order to extend mercy and respect for autonomy to those who are the current victims of euthanasia prohibitions.[156]

Though she seemingly identifies the incommensurability problem -- viz. that utilitarian reasoning merely "sets up a conflict" between competing goods -- Battin claims to see a way out:

> To protect those who might wrongly be killed or allowed to die might seem a stronger obligation than to satisfy the wishes of those who desire release from pain, analogous perhaps to the principle in law that "better ten guilty men go free than one be unjustly convicted." However, the situation is not in fact analogous and does not favor protecting those who might be wrongly killed. To let ten guilty men go free in the interests of protecting one innocent man is not to impose harm on the ten guilty men. But to require the person who chooses to die to stay alive in order to protect those who might unwillingly be killed sometime in the future is to impose an extreme harm -- intolerable suffering -- on that person, which he or she must bear for the sake of others. Furthermore, since, as I have argued, the question of which is worse, suffering or death is person-relative, we have no independent, objective basis for protecting the class of persons who might be killed at the expense of those who would suffer intolerable pain; perhaps our protecting ought to be done the other way around.[157]

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[156]Margaret Battin, The Least Worst Death 119 (emphasis added) (1994).

[157]Id.

In this latter passage, Battin intimates that the conflict between competing autonomy concerns can be resolved -- and perhaps resolved in favor of allowing euthanasia ("perhaps our protecting ought to be done the other way around"). Battin begins, however, by acknowledging that the "ten guilty men" maxim, frequently cited as an ideal of our justice system, seems to cut against her position. Battin responds by suggesting that the maxim is not properly applicable in, or analogous to, the assisted suicide and euthanasia issue. She suggests that society's traditional willingness to protect the one innocent man even at the expense of letting ten guilty men go free is based, at least in part, on the fact that doing so imposes no "harm" on the guilty men, while, by contrast, preventing persons from seeking assistance in dying does impose real harms on them.

The point of the "ten guilty men" maxim, however, is not that we protect innocent human life against the risk of mistaken or wrongful killings only when it imposes no harm on the guilty, but rather that society protects the innocent individual life against such risks even when it means accepting harms to the guilty men's potential future innocent victims and to the

innocent victims of those emboldened by the state's leniency. The maxim is, thus, an apparent affirmation of the school of moral theory teaching against intentionally harming human life that we might associate with Aristotle or Aquinas and discussed in Chapter IV (and to which we shall return in Chapter IX); any attempt to apply the maxim in the consensual homicide context would surely result in the conclusion that it is wrong to risk killing one innocent person even if it means accepting the fact that other innocent persons may be forced to endure unwanted pain and suffering.

Other utilitarians seeking a way around the incommensurability problem sometimes seem to resort to the principle of double effect, arguing that the undesirable consequences associated with permitting assisted suicide and euthanasia (e.g., deaths caused by abuse, mistake, and pressure) may be discounted because they are unintended; in legalizing assisted suicide, society intends only to permit free autonomous choice and end unwanted suffering. Joel Feinberg, for one, argues that we should

> consider reasonable mistakes in a legalized voluntary euthanasia scheme to be 'the inevitable by-products' of efforts to deliver human beings, at their own requests, from intolerable suffering,

> or from elaborate and expensive prolongations of a body's functioning in the permanent absence of any person to animate that body.[158]

Glanville Williams similarly suggests that the fact that killings would occur due to abuse, mistake, or pressure is relatively unremarkable: "[i]t may be allowed that mistakes are always possible, but this is so in any of the affairs of life."[159] But Williams's apparent reliance on double effect doctrine in this context -- distinguishing between "mistakes" or other unintended consequences associated with legalization, and those consequences that are intended -- is at odds with his attack on the principle elsewhere.[160] And it is fundamentally a recognition that utilitarianism cannot by itself solve the assisted suicide question. In suggesting that intended consequences are more important than unintended ones, Feinberg and Williams are forced to step outside a purely utilitarian analysis aimed at maximizing pleasurable or social

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[158]Joel Feinberg, Freedom and Fulfillment 273-74 (1995).

[159]Williams, The Sanctity of Life 283.

[160]See Williams, Criminal Law 37 (rejecting notion that punishment is justified on the theory that society's intent is not to harm offenders through incarceration but to prevent crime, and arguing that, even though offenders are harmed, "the utilitarian opinion" holds that such harm is outweighed by preventing graver evils from occurring to future victims).

welfare-maximizing consequences to endorse a separate, independent moral theory for ranking or scoring different kinds of consequences that is foreign to a strictly utilitarian account.[161]

## VII.10 Conclusion

In this Chapter, I have sought to show that the utilitarian case for assisted suicide and euthanasia is not altogether free from doubt. To be sure, benefits would flow from legalization, including the possibility that some persons would be able to end painful suffering. I do not seek to discount such benefits or seek to suggest that they are "outweighed" by attendant costs. Instead, I have sought only to show that legalization may also entail costs and, thus, that the utilitarian interested in selecting the legal rule that serves the greatest-good-for-the-greatest-number is

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[161]Even allowing their resort to ranking consequences based on the intent behind them, Feinberg's and Williams's argument raises the question whether a state that chooses legalization, with the intent to permit freely chosen deaths (at the expense of killings due to abuse, mistake, and pressure), is preferable, by reference to some moral principle, to a state that chooses to make assisted suicide illegal, with the intent of protecting innocent life against non-consensual killings due to abuse, mistake and pressure (at the expense of keeping some people alive who wish to die). Simply put, simply referencing intent is not enough: Feinberg and Williams must still explain to us why a regime that intends to permit assisted suicide is to be preferred to one that intends to protect innocent life, a question to which I shall return in Chapter IX.

presented with a non-trivial choice.

Worries about the costs attendant to legalization have, in fact, persuaded many authorities to retain laws against assisted suicide. The Canadian Supreme Court declined to find a right to assisted suicide precisely because, in its judgment, "the concerns about abuse that have been expressed and the great difficulty in creating appropriate safeguards to prevent these" make it impossible to say "that the blanket prohibiting on assisted suicide is arbitrary or unfair, or that it is not reflective of fundamental values at play in our society."[162] The British House of Lords also recommended against legalization, in part, because "it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused."[163] Justice Souter of the United States Supreme Court, too, declined to find a constitutional right to assisted suicide, at least for now, because, in his view, "[t]he case for the slippery slope is fairly made out here

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[162]Rodriquez, [1993] 3 S.C.R. at 608.

[163]House of Lords Report HL Paper, 21-I of 1993-1994 Session, para. 238.

. . . because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not."[164] Such judgments, I submit, cannot be ruled out as unreasonable on the available evidence.

In the end, moreover, I submit, the utilitarian focus on competing costs and benefits -- such as the interest in allowing patients to exercise their autonomy versus the interest in preventing the non-consensual killing of innocent persons -- may help sharpen our thinking about the policy choice we face, but it provides us with no way to weigh or compare such radically different, and ultimately incommensurate, interests. A utilitarian approach to the assisted suicide question may help clarify the consequences of legalization or non-legalization, but it cannot, I submit, definitively resolve the debate.

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[164]521 U.S. at 702, 785.

# CHAPTER VIII

## POSNER AND EPSTEIN: SOME LEADING UTILITARIAN AND LIBERTARIAN ARGUMENTS FOR ASSISTED SUICIDE

### VIII.1 Introduction

In recent years, two of America's most respected legal thinkers, Richard Posner and Richard Epstein, have published books arguing for the legalization of assisted suicide. Posner introduced Aging and Old Age in 1995, and Epstein followed in 1999 with Mortal Peril.

Posner argued for legalization primarily on practical, or utilitarian grounds. The benefits associated with legalization, he claimed, outweigh any attendant costs. Legalization would, in this sense, be the "efficient" legal response. Epstein's argument, meanwhile, was equally characteristic of his libertarian body of work: in deference to the harm principle, he argued that government should leave people to make their own decisions.

These authors exemplify some of the arguments developed in two preceding chapters and, thus, provide us with test cases: Do the points I have suggested with respect to autonomy- and utilitarian-based theories of assisted suicide and euthanasia withstand their thoughtful writings?

Ultimately, I believe they do. The empirical benefits Posner claims will flow from legalization are open to question, and Posner's utilitarian calculus founders on the incommensurability problem. Eventually, Posner himself offers an alternative argument; joining Epstein, Posner suggests that persons should be left to decide for themselves whether to seek assisted suicide because no harm befalls any third party. Yet faithful adherence to libertarian theory tends not merely toward legalizing assisted suicide for the terminally ill, but also toward legalization of assisted suicide, euthanasia, and consensual homicide for all competent adults, regardless of their physical condition or reasons for action.

## VIII.2 Posner's Utilitarian Case for Assisted Suicide

Posner argues for legalization of assisted suicide primarily on the basis that it would lead to fewer, not more, suicides.[1] Without assisted suicide as a viable legal option, the argument runs, people frightened of oncoming disability associated with terminal illness are forced either to kill themselves while they still can or face the prospect of losing self-control. If assisted suicide is legalized, people will not feel compelled to kill themselves early, for they will be comforted with the knowledge that assistance in dying will be available even after they become physically incapacitated:

> If the only choice is suicide now and suffering later, individuals will frequently choose suicide now. If the choice is suicide now or suicide at no greater cost later, they will choose suicide later because there is always a chance that they are mistaken in believing that continued life will impose unbearable suffering or incapacity on them. They would give up that chance by committing suicide now. The possibility of physician-assisted suicide enables them to wait until they have more information before deciding whether to live or die.[2]

Posner's claim that the primary benefit of legalization accrues to elderly persons faced with the

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[1]Posner, Aging and Old Age 243-53.

[2]Id. at 247-48.

prospect of oncoming disability is in some apparent tension with his simultaneous assertion that "some of the strongest cases of rational suicide" do not involve the elderly at all, but "people who face an indefinite lifetime of paralysis, severe pain, or other terrible disability."[3] One here thinks not of the aged patient facing a terminal illness, but the young quadriplegic with years to live. The primary empirical benefit Posner claims for legalization (fewer and older suicides), thus, seemingly has little to do with what he identifies as the most compelling cases for assisted suicide: young persons who suffer neither from a terminal illness nor unendurable pain. Posner's hypothesis also rests on the supposition that people frequently use suicide as a rationally calculated means of escaping future and oncoming disabilities. But Posner presents no evidence for this (rather counterintuitive) supposition. Indeed, most evidence suggests that suicides committed by relatively younger persons are associated with depression and mental illness.[4] And by far the highest rates of suicide in the United States today belong not to younger or

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[3] Id. at 237.

[4] See Ch. III.8, supra.

middle-aged adults supposedly fearful about future illness and disability, but to the very elderly (75+ years) -- 45.2 deaths per one hundred thousand (100,000) for men and 5.2 deaths per one hundred thousand for women, compared with national averages of 18.7 and 4.4 respectively -- thus suggesting that one of the benefits Posner seeks to achieve through legalization (later suicides) seems to have been accomplished already.[5]

While the foregoing indicates some tension between Posner's thesis and his stated goal, and while it raises the question whether there really is a problem with relatively younger persons killing themselves rather than face the prospect of future illness and pain, none of this directly addresses the specific empirical data that Posner offers in support of his fewer-and-later-suicides hypothesis. We turn to that data now.

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[5]See World Heath Organization, Suicide Rates (per 100,000), by gender and age, USA, 1998 <http://www.who.int/mental_health/documents/suicide/unitstate.pdf> (site visited April 15, 2002).

*Posner's Argument from U.S. Data*

The first piece of evidence Posner presents in support of his fewer-and-later-suicide hypothesis is a regression analysis testing the relationship between suicide rates and the status of state law on assisted suicide:

> The question whether allowing physician-assisted suicide in cases of physical incapacity would increase or reduce the suicide rate can be studied empirically. Table 10.1 regresses state suicide rates in the United States on state per capita income, the percentage of the state's population that is black (blacks have much lower suicide rates than whites), and a dummy variable that takes as a value of 1 if a state has a law criminalizing physician-assisted suicide and 0 otherwise.

Table 10.1 Regression of Suicide Rate on Assisted Suicide Law and Other Variables (t-statistics in parentheses)

| Per Capita Income | Percentage Black | Assisted Suicide Law | R2 |
|---|---|---|---|
| -.0005 | -.1287 | -.7601 | .31 |
| (-3.388) | (-2.999) | (-0.951) | |

The coefficients of the income and percentage-black variables are negative and highly significant statistically, and these two variables explain a good deal of the variance across states in the suicide rate. The coefficient of the law variable is also negative, implying that states that forbid physician-assisted suicide do have lower suicide rates than states that permit it. But it is not statistically significant, although perhaps only because most suicides are not committed by terminally or otherwise desperately ill people and thus do not come within the scope

of the hypothesis I am trying to test. Although these results do not suggest that repealing an assisted-suicide law is a sound method of reducing a state's suicide rate, they cast at least some doubt on the hypothesis, which I have been questioning despite its intuitive appeal, that making suicide easier is likely to lead to more suicides.[6]

Posner here states that he finds no statistically significant relationship between assisted suicide laws and the rate of suicide, yet he proceeds to argue that the data lend support to his hypothesis anyway: "Although these results do not suggest that repealing an assisted-suicide law is a sound method of reducing a state's suicide rate, they cast at least some doubt on the hypothesis . . . that making suicide easier is likely to lead to more suicides." But Posner's findings are simply not helpful to his thesis. Before a regression's findings are deemed sufficiently reliable for an economist to offer them in evidence in any legal setting, we typically require a 95% confidence level (a t-statistic of 1.96).[7] Sometimes, a

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[6]Posner, Aging and Old Age 250-51.

[7]E.g., FTC v. Swedish Match, 131 F. Supp. 2d 151, 161 (D.D.C. 2000) (rejecting use of an 85% confidence level); Moultrie v. Martin, 690 F.2d 1078, 1083 (4th Cir. 1982) ("[s]tatisticians usually use 95% . . . confidence levels"); Procter & Gamble Co. v. Chesebrough-Pond's, Inc., 588 F. Supp. 1082, 1088 (S.D.N.Y.)(a 95% confidence level is sufficient to be considered statistically significant).

90% confidence (with t-statistic of 1.645) will do. Posner's t-statistic for assisted suicide laws is less than 1 (0.951), suggesting a possibility of sampling error of approximately 40%.

Making matters worse, Posner reveals that his data regarding the status of state assisted suicide laws are drawn from a single footnote in a student-written law review note:

> Data on assisted suicide laws are from Julia Pugliese, *Don't Ask - Don't Tell: The Secret Practice of Physician Assisted Suicide*, 44 Hastings L. Journal 1291, 1295 n. 20 (1993).[8]

That student note, however, merely declared that "most states" ban assisted suicide by statute and proceeded to cite a great many state laws as <u>examples</u> to support that claim.[9] When constructing his regression, Posner apparently (mis)inferred that the remaining, unlisted states do not have statutes banning the practice. In fact, at least 10 states not listed by the student Note have statutes banning assisted suicide.[10] Posner's

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[8]Posner, <u>Aging and Old Age</u> 250 n.34.

[9]Julia Pugliese, Note, <u>Don't Ask - Don't Tell: The Secret Practice of Physician-Assisted Suicide</u>, 44 Hastings L.J. 1291, 1295 (1993).

[10]States which, although not mentioned in Pugliese's note, do have statutes banning assisted suicide include Georgia (Ga. Code § 16-5-5,"Offering to assist in the commission of suicide; criminal penalties"); Illinois (720 Ill. Comp. Stat. 5/12-31 (2001), "Inducement to Commit Suicide"); Iowa (Iowa

"dummy variable" column, thus, actually runs counter to available evidence.

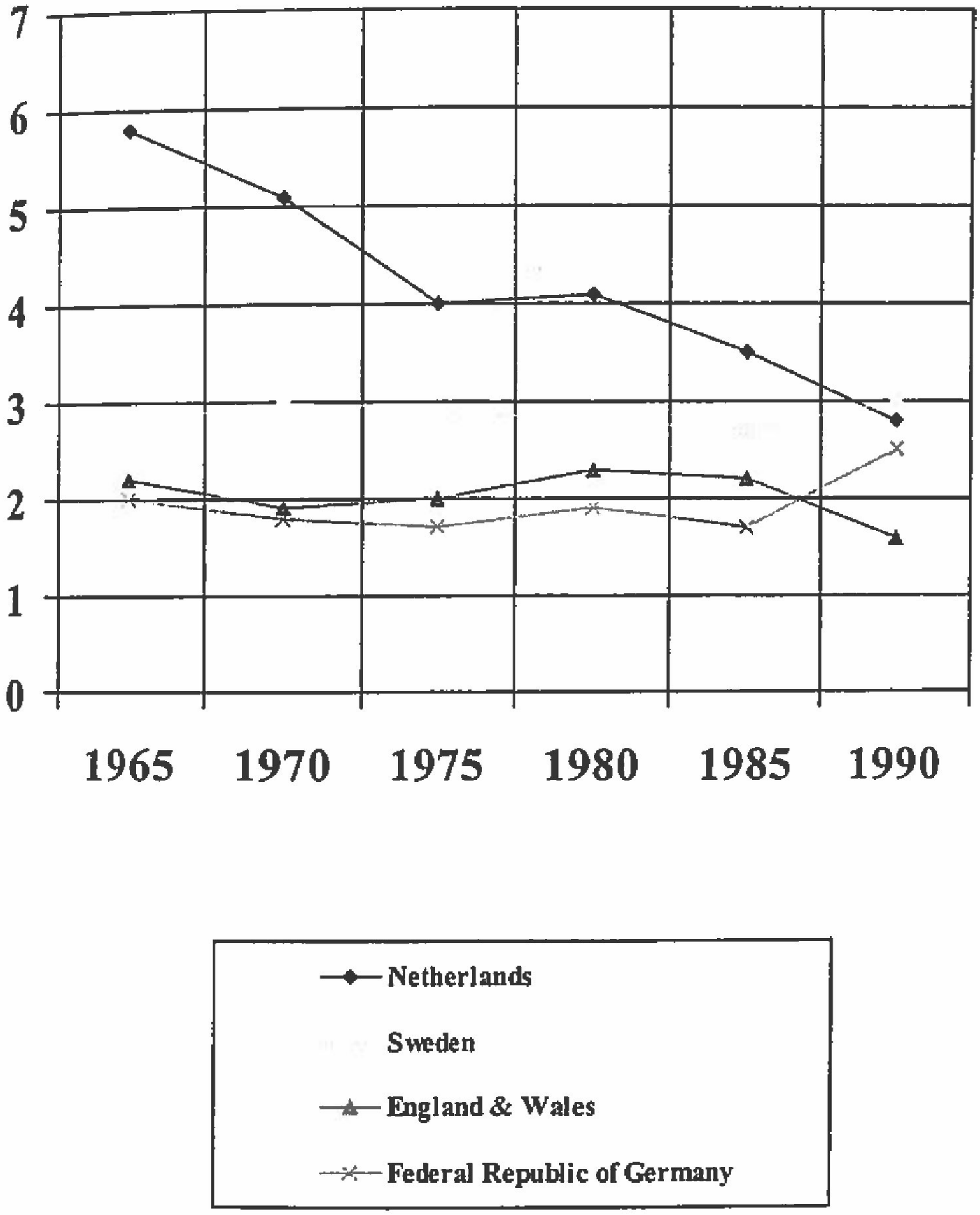
*Posner's Argument from Dutch Data*

Though lacking meaningful support for his thesis based on American data, Posner also seeks to rest his argument on data from the Netherlands. Posner posits that the rate of elderly suicide was "very high in the Netherlands before euthanasia became common in the early 1970s and has fallen since, both absolutely and relatively" compared to other Western European countries, and Posner points to data reproduced here in Graph 1:

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Code § 707A.2 (2000), "Assisting Suicide"); Kentucky (Ky. Rev. Stat. § 216.302 (Michie 2001), "Causing a Suicide - Assisting in a Suicide"); Louisiana (La. Rev. Stat. § 14:32.12)(West 2001), "Criminal Assistance to Suicide"); Maryland (Md. Code 1957 Art. 27 § 416 (2001), "Crimes and Punishments"); North Dakota (N.D. Cent. Code § 12.1-16-04 (2001), "Assisting the Commission of Suicide"); Rhode Island (R.I. Gen. Laws § 11-60 (2001), "Assisted Suicide"); South Carolina (S.C. Code 1976, Art. § 11. § 16-3-1090 (Law Co-op. 2001), "Assisted Suicide; Penalties; Injunctive Relief"); Tennessee (Tenn. Code § 39-13-216 (2001), "Assisted Suicide"). Still other states not on Pugliese's list condemn assisted suicide as a matter of common law. See, e.g., Michigan v. Kevorkian, 527 N.W.2d 714 (Mich. 1994) (permitting prosecution of Kevorkian under common law before Michigan enacted a statute banning assisted suicide).

Graph 1
Suicide Rate of Elderly Dutch Males as a Multiple of the Total Dutch Male Suicide Rate 1965-1990[11]




[11]See Posner, Aging and Old Age 253.

Posner asserts that the legalization of assisted suicide caused the drop in the Dutch male suicide rate between 1965 and 1990, yet he makes no effort to consider and rule out the statistical significance of other potential causal factors for the phenomenon he observes in the data.[12] There are, moreover, ample reasons to question Posner's untested causal claim. First, it is difficult to attribute all of the decline in elderly male suicide rates between 1965 and 1990 to the legalization of assisted suicide, as Posner asserts. Though assisted suicide was surely practiced earlier in the Netherlands and attitudes were evolving, assisted suicide became legally permissible only with a decision by the Dutch Supreme Court in 1984 recognizing a limited "necessity" defense to homicide charges for physicians who kill the terminally ill.[13] The fact that the male suicide rate, as depicted Graph 1, declined so profoundly between 1970 and 1984 -- before the key judicial decision -- suggests that other factors besides legalization may be responsible for significantly reducing the incidence of suicide. Since the Dutch effectively legalized assisted suicide in

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[12]Cf. Daubert v. Merrell Dow Pharms. Co., Inc., 509 U.S. 579 (1993).

[13]See Ch. VII.2, supra.

1984, moreover, Graph 1 reveals that the rate of Dutch male suicides has followed roughly the same trajectory as the rate of male suicides in England and Wales, where assisted suicide remains unlawful, again casting further doubt on whether one can attribute the decline between 1984 and the present to any factor unique to the Netherlands.

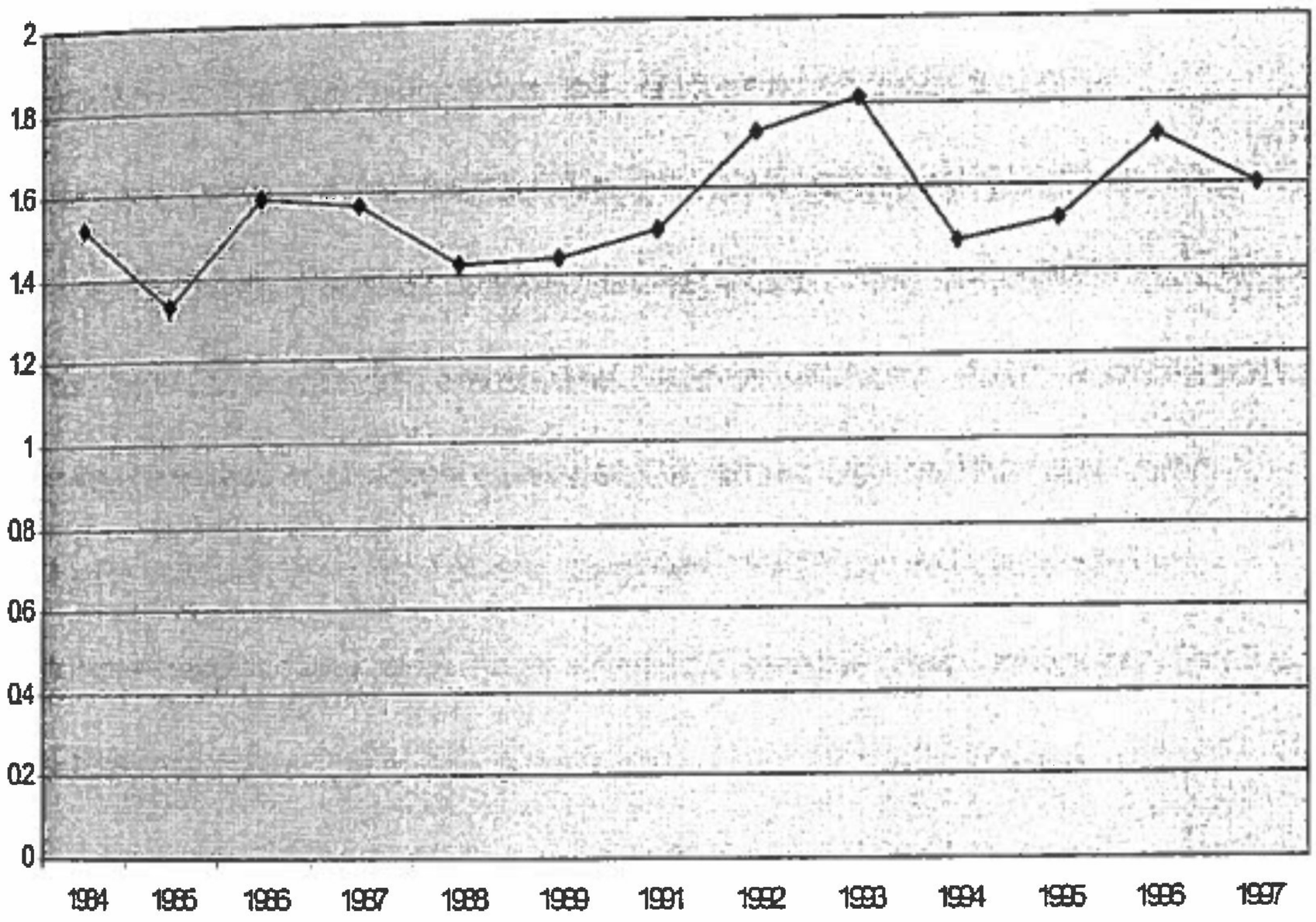
Second, Posner notably rests his argument on suicide data for men. He relegates to a footnote any mention of -- equally available -- data for women. And an examination of the data for Dutch women offers little support to his causation argument. As reflected in Graph 2, the rate of elderly female Dutch suicides has not declined since de facto legalization in 1984:[14]

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[14]Posner, Aging and Old Age 252 n.39.

Graph 2

Suicide Rate of Elderly Women as a Multiple of the Total Female Suicide Rate, 1984-1997[15]

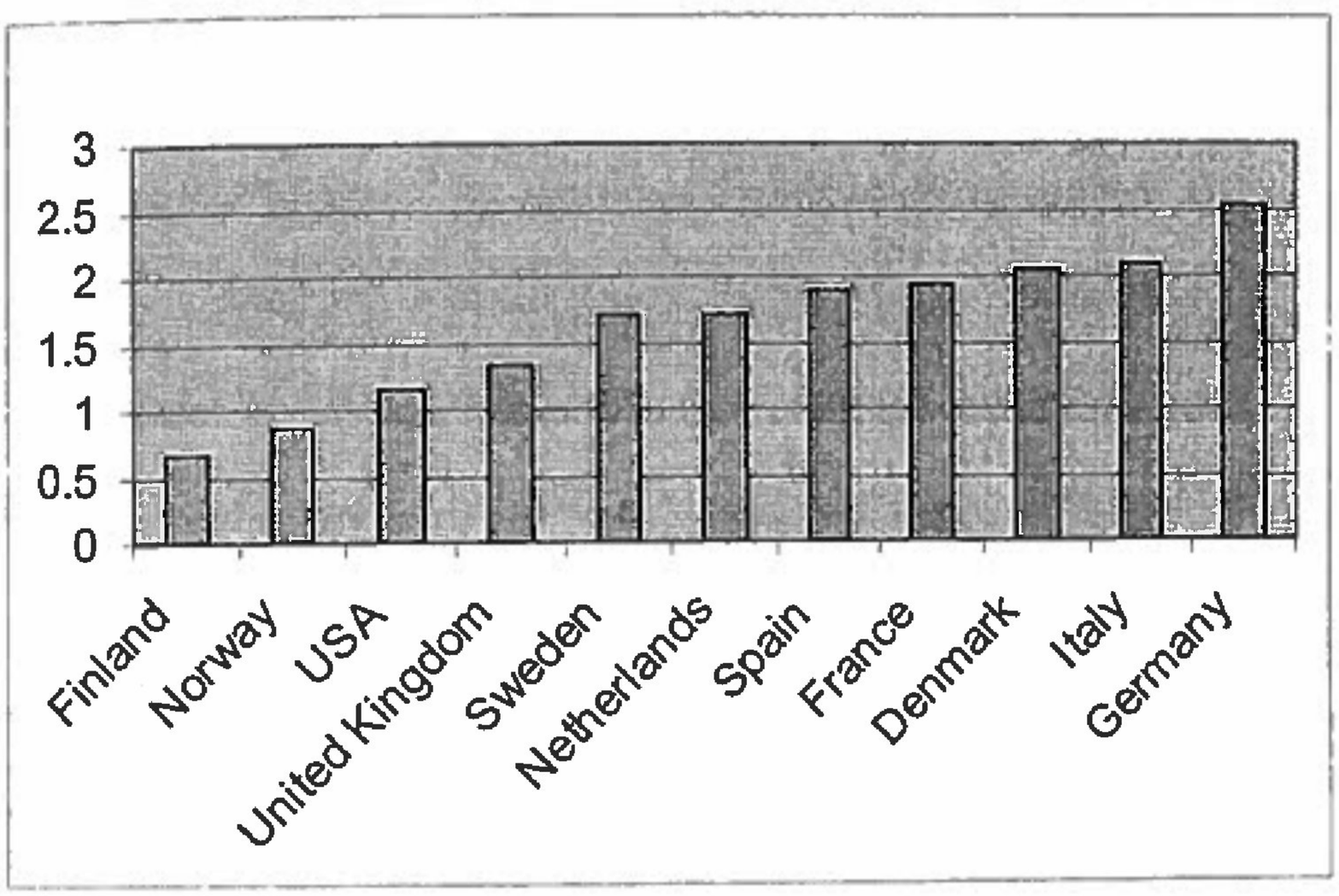



[15]See Appendix B for data and calculations underlying this graph.

Third, World Health Organization data depicted in Graphs 3 and 4 show that, after nearly two decades of de facto legalization, the rate of elderly Dutch suicides remains comparable to the rate of elderly suicides in many other countries where assisted suicide remains unlawful. In fact, the rate of elderly suicides as a proportion of all suicides in the Netherlands continues to be significantly higher than the rate of such suicides in either the United States or United Kingdom. Perhaps the most one can say about the Netherlands' experience is that decades ago the elderly suicide rate was out of kilter with other Western countries and in recent years has merely fallen in line:

Graph 3

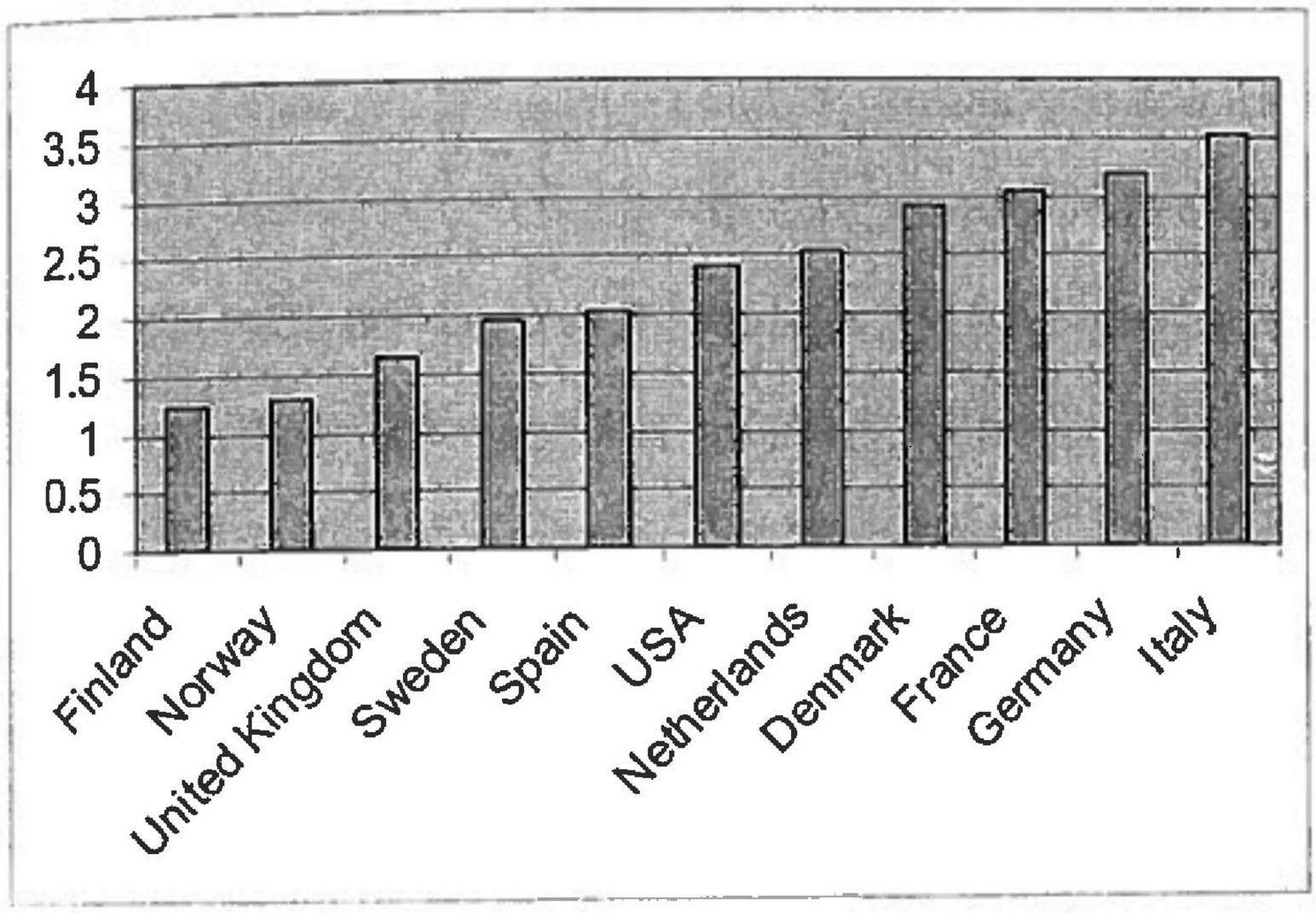
Suicide Rate of Elderly Women As a Multiple of the Total Female Suicide Rate[16]




[16]These results are computed from data available in World Health Organization reports for each country. The data and calculations underlying this graph can be found in Appendix B.

Graph 4

Suicide Rate of Elderly Men As a Multiple of the Total Male Suicide Rate[17]




[17]Id.

Fourth, an even more fundamental problem seems to inhere in Posner's analysis of Dutch data. While Posner focuses on the rate of elderly Dutch suicides over time as compared to that country's overall suicide rate, such a comparison tells us only the relative percentage of suicides committed by elderly persons. Even if the overall rate of elderly suicides relative to all suicides had dropped, such a finding would shed little light on Posner's thesis that legalization of assisted suicide will result in younger and healthier persons committing suicide less frequently.

If Posner's hypothesis that fewer younger and healthier persons commit suicide when assisted suicide is legally tolerated were true, one might expect to find that the overall number of Dutch suicides -- which includes those committed by younger, healthier persons -- declined after 1984, when assisted suicide was effectively legalized. Posner, however, does not address that question, nor would doing so appear to aid his argument. The overall suicide rate in the Netherlands is nearly double what it was 50 years ago -- 9.8 deaths per 100,000 persons in 1995 versus 5.5 per 100,000 persons in 1950.[18] Since 1980 the Dutch suicide

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[18] Id.

rate has consistently hovered somewhere in the range of 9.7 and 11.3 deaths per 100,000 persons.[19] In essence, the Dutch have seemingly been unable to effect meaningful decreases in the overall suicide rate despite de facto legalization of assisted suicide in 1984.

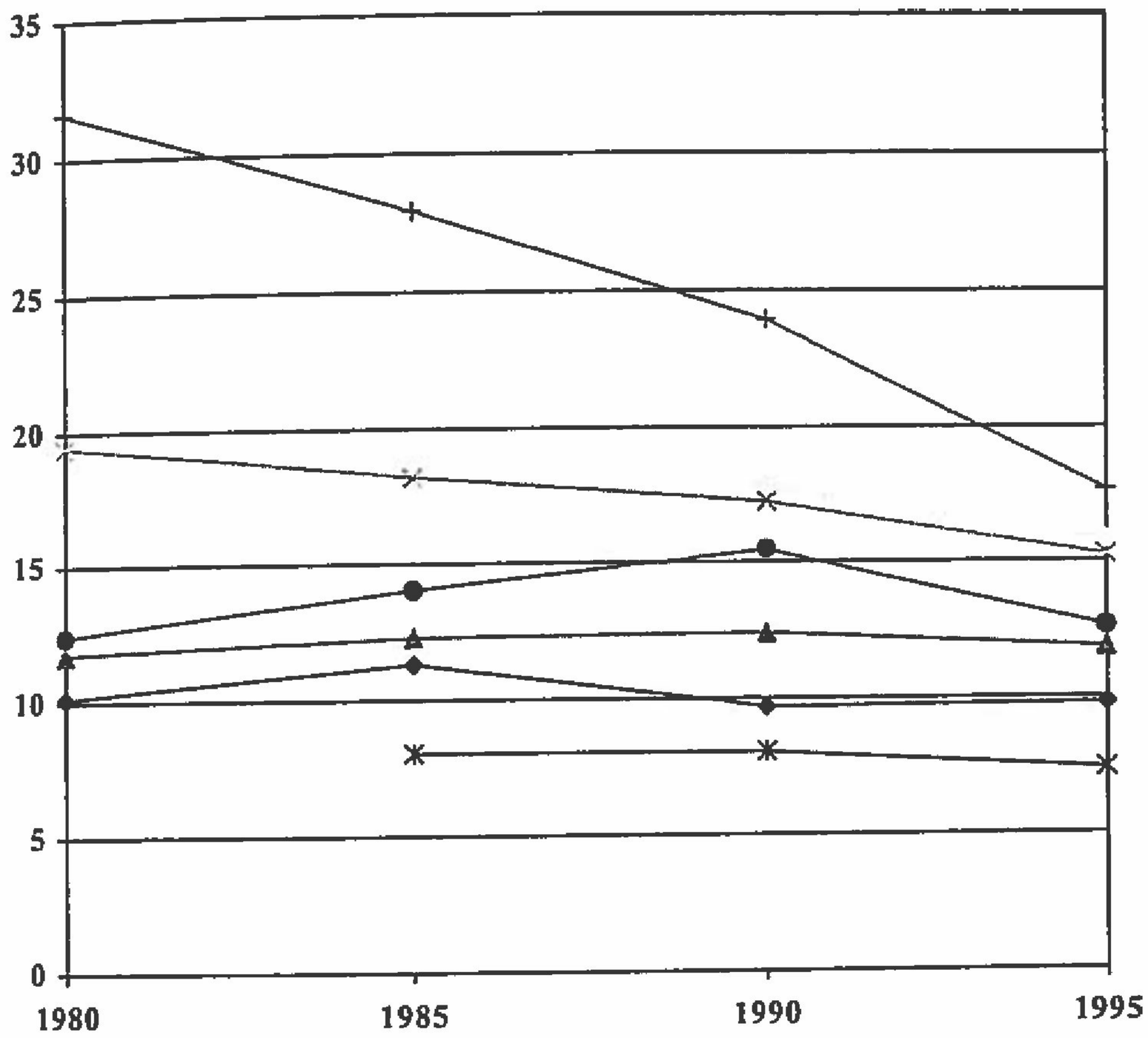
One might seek to suggest that the Dutch have been unusually successful in at least keeping the suicide rate from growing over the last twenty years. But the data does not bear out that theory either: as reflected in Graph 5, the overall incidence of suicide in many other countries where assisted suicide remains unlawful (including the United States, the United Kingdom, and Norway) has remained equally steady. Meanwhile, at least some other Northern European countries, such as Denmark and Sweden, where assisted suicide remains unlawful, have cut their suicide rates significantly during the same period (albeit from higher starting points):

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[19]See World Health Organization Statistics, Suicide Rates-Netherlands <http://www.who.int/mental_health/Topic_Suicide/suicide1.html> (site visited Jan. 11, 2002).

Graph 5

Suicide Rate Per 100,000 Deaths[20]




[20]These results are computed from data available in World Health Organization reports for each country. The data and calculations underlying this graph can be found in Appendix B.

Finally, and perhaps most remarkably, Posner's thesis -- much like the theories offered by John Griffiths and Helga Kuhse that we explored in Chapter VII -- appears to be in tension with the Law of Demand, suggesting as it does that legalization of assisted suicide would result in fewer, rather than more, deaths.[21] Unlike Griffiths, however, Posner recognizes the inconsistency between his argument for assisted suicide and the Law of Demand and openly argues for an exception to the rule. He suggests that lowering the "price" of assisted suicide (by legalizing it) would reduce the incidence of unassisted suicide, and he sees no reason to suppose that this reduction would be fully offset by the increased demand for assisted suicide:

> It may be objected that my entire analysis violates the economist's Law of Demand; that lowering the price of a good or service - here, suicide - must increase rather than reduce the demand for it. This is not the correct way to frame the issue. We have two goods, not one: unassisted suicide, and physician-assisted suicide. They are substitutes, so lowering the price of the second (by legalizing it) will reduce the demand for the first, and nothing in economics teaches that this reduction must be fully offset by the increased demand for the second good. A razor blade that retains its sharpness for ten shaves is a substitute for one that retains it for only one shave, but if the former takes over the market the total number of razor blades produced

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[21] See Ch. VII.8, supra (discussing and defining the Law of Demand).

> and sold will decline even if the longer-lasting blade is no more expensive than the other blade.[22]

Essentially, Posner supposes that demand will simply shift from unassisted suicide to assisted suicide/euthanasia and that no additional demand will be generated from the latter's legalization. But Posner offers no evidence that assisted suicide is a one-for-one substitute for suicide, and data shows that the Dutch suicide rate has not changed substantially since assisted suicide was effectively legalized in 1984.[23] At the same time, though we do not have pre-1984 data for assisted suicide and euthanasia, we know that assisted suicide and euthanasia are leading causes of death: more deaths now result from those practices combined than from than many other significant causes (e.g., HIV, leukemia, or homicide): in 1995, the Dutch recorded 3,120 acts of euthanasia, 542 assisted suicides, and 949 affirmative killings without patient consent, for a total of 5,111 deaths, or 3.76% of all deaths in the Netherlands that year.[24]

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[22]Posner, Aging and Old Age 249-50.

[23]See Graph 7, supra, and Appendix B (suicides per 100,000 deaths in the Netherlands: 10.1 in 1980; 11.3 in 1985; 9.7 in 1990; 9.8 in 1995).

[24]See Graph 1. The Dutch also record thousands of cases where patients are intentionally killed by omission without their consent, including some 8,750,

Posner's exception-to-the-Law-of-Demand hypothesis runs not only against the grain of the available evidence, his hypothetical analogy lacks explanatory value in the "market" for end-of-life services. In Posner's hypothetical, unassisted suicide is like a disposable, single-use razor blade. With the introduction of a re-usable, ten-shave razor, which Posner likens to assisted suicide, the total sales of razor blades decline. But Posner's analysis says nothing about total consumer demand for the service rendered by both products (i.e., the total number of shaves) in his hypothetical market. Nor, in fact, is there reason to suppose that the advent of a new razor would lead consumers to wish to shave less often. (If anything, one could imagine reasons why the advent of re-usable disposable razors would lead consumers to shave more often).

Likewise, there is no reason to suppose that the introduction of assisted suicide would reduce total consumer demand for end-of-life services. The only reason Posner supposes for the decline in razor sales in his hypothetical market has nothing to do with a reduction in consumer demand for shaves, but with an

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or 6.78% of all deaths, in 1990 (1995 data was not studied). See Ch. VII.3, supra.

innovation (the re-usable razor) that permits manufacturers to satisfy a constant (or even growing) consumer demand for shaves with a smaller supply. Translating to the suicide market, Posner's imaginary razor market gives us no reason to think that overall demand in the overall suicide/assisted suicide market will decline, and, unlike a ten-shave razor that is capable of satisfying higher demand with a smaller supply, the "new product" he promotes, assisted suicide is, like the original product (suicide), good for only one use per customer.

Rather than analogizing to a ten-shave razor, perhaps a more accurate analogy might be between razors with equal useful lives for the consumer. The disposable single-use razor blade (like unassisted suicide) has been available to consumers for years, but it is not terribly comfortable to use. Eventually, the razor merchants devised the "Sensitive Skin" single-use razor, which sports a "moisturizing strip." Like assisted suicide, this new razor has the same basic use as the original disposable, but it also contains an added feature that certain consumers find more comfortable and, thus, purchase. One expects the introduction of such a product to lead to an increase

in overall sales of disposable razors; indeed, this is precisely why manufacturers introduce line extensions of this sort and business scholars develop complex models for evaluating how to use line extensions to maximize consumer demand and profits.[25] So, too, as progressively easier and less stigmatizing options to suicide become available, first assisted suicide and then euthanasia, the overall use of "end of life services" can be expected to increase. Posner offers little evidence that this particular arena of human activity presents any exception to the Law of Demand, and his analogy to a hypothetical razor market does not prove the point on its own terms.[26]

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[25]E.g., R.D. McBride & S.F. Zufryden, An Integer Approach to the Optimal Product Line Selection Problem, Marketing Science 126 (1988); P.E. Green & A.M Krieger, Models and Heuristics for Product Line Selection, 4 Marketing Science 1 (1985); Kamalini & Ramdas, A Cross Functional Approach to Evaluating Multiple Line Extensions for Assembled Products, 47 Management Science vol. 1 (2001).

[26]Posner seeks to supplement his empirical case for legalization by positing that terminally ill persons will find comfort in knowing that they can choose to die on demand even if they never use the option. Living will become more bearable, the argument runs, knowing that death is easily available. See Posner, Aging and Old Age 239-40. But Posner makes no attempt to quantify how many people would find an unrealized option to obtain assisted suicide to be valuable, how valuable they would find it, or how the psychic benefit of a never-used option compares against the harms that may attend the regularized practice of assisted suicide -- both actual (e.g., people killed without their consent as a result of accident or abuse) and psychic

## *Posner's Analysis of the Costs Associated With Assisted Suicide*

The purpose of any utilitarian project like Posner's is to weigh the competing costs and benefits of alternatives to determine which, on balance, produces the "best" or "most efficient" result. While Posner focuses intently on possible benefits associated with legalization, he admits that his argument for legalization can be considered only "tentative" because he does not even attempt to enumerate or consider the costs associated with legalization.[27]

That said, Posner indirectly acknowledges the reality and potential "cost" that some patients will be killed by physicians, family members or others without their consent as a result of human error, and he does so with a colorful anecdote about his grandfather. Physicians told Posner's grandfather, then in his forties, that he had a fatal kidney disease but might manage to live a year or two if he gave up meat. Posner's grandfather refused to give up meat, lived to 85, and died of an unrelated ailment. "Like other

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(e.g., people who are frightened that they might be killed without consent even if they are never so killed).

[27] Id. at 244. Some such costs are discussed in Chapter VII, supra.

professionals," Posner explains, "doctors sometimes speak with greater confidence than the facts warrant."[28] Posner apparently overlooks that in the very regime he advocates, his grandfather would have been a prime candidate for an early (mistaken) act of euthanasia.

Posner identifies yet another potential cost associated with legalization. If, as Posner hypothesizes, fewer people will decide to kill themselves and those who do decide to kill themselves will do so later, medical costs will also rise. People who decide not to end their life early will incur substantial additional costs as a result of their decision as they become sicker. In our society, many of these costs are borne by third parties and not the individual patient. We cannot, Posner tells us, "disregard [such] tangible costs borne by people who through their taxes, health-insurance premiums, or doctors' bills are forced to pay other people's medical expenses."[29] Though he stops short of saying so explicitly, Posner here seems to suggest that we might not want to legalize assisted suicide and provide people with the benefit of knowing they can die when

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[28]Posner, Aging and Old Age 245.

[29]Id. at 244.

they wish, because it is cheaper for society to have some of them (as Posner posits they now do) commit suicide at a younger age.

### *The Incommensurability Problem in Posner's Work*

Posner himself hints at the incommensurability problem confronting his utilitarian argument for assisted suicide when he acknowledges that medical costs may be borne by the public if assisted suicide is legalized. Fearful of these costs, Posner backs away from his argument for legalization, and submits that it would be "difficult to say whether allowing physician-assisted suicide would be cost-justified."[30] Posner, at least here, sees real costs and benefits on both sides of the ledger and admits that he is not sure how the "balance" should be struck. But even if we could estimate with accuracy the increased medical costs Posner identifies, how are we as a society to measure the benefit of fewer and later suicides against increased medical costs to be borne by the public through increased taxes or health insurance premiums?

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[30]Id.

In the end, Posner seems to admit the inability of a purely utilitarian calculus to resolve this dilemma, and he resorts to the harm principle -- or what he calls "Mill's approach"[31] -- to resolve the problem. According to Posner, "Mill's approach" holds that each person must be afforded the right to exercise self-control "[o]ver himself, over his own body and mind," and that the state may coerce an individual to take actions against his or her will only to "prevent harm to others."[32] Assuming that assisted suicide is a purely self-regarding (or, more precisely, harmless-to-others) activity, Posner argues that "Mill's approach" "enables us to exclude (as a strictly economic or utilitarian analysis would not) the disutility"[33] associated with legalization, thus vindicating the right to assisted suicide and euthanasia regardless of the real, negative side-effects that would attend the regularization of such practices.

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[31]Id.

[32]John Stuart Mill, On Liberty 9 (E. Rappaport, ed. 1978).

[33]Posner, Aging and Old Age 244 (emphasis added).

## VIII.3 Posner and Epstein's Libertarian Case for Assisted Suicide

Posner migrates away from utilitarian arguments for assisted suicide toward a libertarian claim. Richard Epstein, meanwhile, makes no such migration. Epstein, like Posner in his final defense of assisted suicide, argues that respect for the harm principle dictates legalization of assisted suicide for the terminally ill, whatever the "costs" and "benefits" may be.

While Posner and Epstein generally confine themselves to discussing a potential right for the terminally ill, much of their reasoning, inspired by Mill's harm principle, tends toward a right open to all competent adults. Posner, again, argues that "the strongest cases of rational suicide" in his mind do not involve persons with a terminal illness suffering incurable pain, but people who confront "an <u>indefinite lifetime</u> of paralysis . . . or other terrible disability."[34] Posner adds, too, that his "conception of the appropriate scope of legal regulation" is based upon the harm principle, and thus rests on the premise that "the only voluntary activities of [any] competent adult[] with which government can properly interfere

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[34]Posner, <u>Aging and Old Age</u> 237 (emphasis added).

are those that impose tangible harms."[35] This principle is in no way conditioned upon the physical condition or capabilities of the competent adult.

Followed to the logical end, Posner's libertarian principle would seem to tend toward, if not require, the legalization not only of assisted suicide and euthanasia, but any act of consensual homicide. Sadomasochist killings, mass suicide pacts (e.g., Marshall Applewhite and his 38 followers who killed themselves in San Diego in 1997 to transport themselves to a spaceship that they believed trailed behind the Hale-Bopp comet), duels, and the sale of one's life (not to mention the use of now illicit drugs, prostitution or the sale of one's organs) are no more foreign to the version of the harm principle he posits than assisted suicide for the terminally ill. Certainly none of these other acts are any less voluntary or self-regarding than assisted suicide or euthanasia.

Posner does not address these potential corollaries of his Millian argument for assisted suicide and, in fact, he sometimes seems to resist them. Posner insists, for example, that freely agreed

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[35] Id. at 238.

upon suicide contracts are "beyond the gravitational field of American morality" and their enforcement is "unthinkable."[36] But what is "unthinkable" about enforcing freely entered contracts to a libertarian? Posner suggests it is unthinkable that suicide contracts

> would be enforced and a person dragged to his death against his will because he had signed a contract and was now deemed incompetent to repudiate it, or even that it would be enforced by the forfeiture of a bond or by some other monetary sanction.[37]

But contracts of any kind are rarely subject to judicial decree requiring specific performance, so the specter of dragging someone around to enforce an assisted suicide contract is something of a red herring. Posner's apparent willingness to abandon even merely <u>financial</u> consequences for repudiating a contract that is voluntarily agreed and harmless to third persons, however, is telling. It suggests that Posner is willing to deny ordinary judicial enforcement to private, consensual, and considered decisions by competent adults simply because they are, in Posner's words, "immoral," "unthinkable," and violate "immovable intuitions concerning the priority of human beings,"

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[36]<u>Id.</u> at 257.

[37]<u>Id.</u>

not the ordinary bases for rule-making for a libertarian.[38]

Epstein takes a somewhat different approach in his argument for assisted suicide. He contends that the libertarian ideal requires legalization where assistance in dying is "necessary."[39] But when is this? Certainly Epstein believes the terminally ill qualify. But his formula for determining necessity does not actually rest on the presence of a physical ailment. Instead, Epstein indicates that he would allow euthanasia whenever a "rational agent could prefer death to life."[40]

This formulation, in turn, raises the question <u>when</u> a person could rationally choose death over life. In some places, Epstein suggests that we can and should limit the availability of assisted suicide and euthanasia to persons suffering from a terminal illness because it comports with "our" "prior estimates of rationality":[41]

> In political theory, the rational reconstruction of consent has to do all the heavy intellectual

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[38]<u>Id.</u>

[39]Epstein, <u>Mortal Peril</u> 305.

[40]<u>Id.</u>

[41]<u>Id.</u> at 304.

> work because no observed transactions can be found in some state of nature to provide individuated evidence . . . . The background norms of rational behavior . . . assume a [very strong] role within the framework when the question is whether killing another individual is so contrary to that person's self-interest that the per se bar should be maintained in the face of individuated evidence on consent that cuts the other way. Clearly, this categorical approach sets out the correct rule in many cases: if a person of normal health and disposition were deliberately killed by another person, the background judgments are so strong that individuated evidence would be excluded. We do not believe the scenario in which that deal makes sense to the deceased individual. . . . The background position can no longer be that consent is impossible to have; rather it is that consent is so unlikely that to introduce evidence in individual cases produces more error than ignoring that evidence altogether. This rule seems perfectly sensible given the massive amount of feigned or improperly procured evidence that could be presented, especially when the decendent is no longer around to explain his side. However, there are limits to this approach. The standard prescription should not be made in the same fashion for individuals hurt in boxing matches, which are often heavily regulated by the state. In these cases, the prospects of fame and fortune could explain why someone takes the risk of death. . . . When the focus is solely on the subset of cases involved with end-of-life conditions, the background conditions change, and so too our prior estimates of rationality. . . . In this context, taking one's own life begins to make sense, . . . [and] the prohibition on all killings in the criminal law should not be retained in the context of terminal illness.[42]

Though it is not entirely clear from this passage, Epstein seems to suggest that laws banning assisted suicide should be retained for healthy persons while

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[42] Id. at 304-05.

they should be abrogated for terminally ill persons because such an arrangement would roughly comport with the choice most of us, in a "state of nature" or behind a veil of ignorance about our eventual status in society, would make.

This argument itself reintroduces the possibility, suggested in Chapter VI, that persons in Epstein's "state of nature" might prefer an absolute ban against assisted suicide -- not one limited just to healthy persons -- because the consequences of mistake, abuse, or coercion (i.e., death) would be so profound and the incidence of such problems would be sufficiently frequent. To Raz, autonomy requires a sufficiency of options to avoid the problem of the Man in the Pit; it does not mean that the state may never rule out any options or avenues for self-creation. To Feinberg and Mill, even purely consensual practices such as dueling and slavery contracts can be ruled out without offending liberty, precisely because of the substantial risks that the practices pose to nonconsenting persons as a result of mistake, neglect, and abuse. At the very least, Epstein owes us a reasoned explanation why assisted suicide does not present a similar case.

Ultimately, after attempting incomplete defenses

of a right to assisted suicide and euthanasia limited to the terminally ill and suffering, Epstein suggests that the practices should always be a matter of unrestrained individual choice. While he says that the background norm should be that assisted suicide should be permitted only when a person is suffering pain,

Epstein admits that

> it is one thing to reject a categorical position [against assisted suicide], and quite another to develop an alternative position. Thus the next question on the agenda asks just how much pain and despair are needed to justify active euthanasia in an individual case. That question is one of degree. Its uniqueness and subjectivity cries out for individual choice and thus precludes collective power in the absence of independent evidence of physician or family abuse in hastening or securing death.[43]

Thus, on the one hand, Epstein relies on "estimations" of rationality to argue for retaining laws against assisted suicide for "healthy" persons but, on the other hand, he contends that only individuals, according to their own unique and subjective standards, may determine for themselves whether they are "healthy" or not, thereby essentially creating an exception that seems to swallow the rule. If the individual may, without collective supervision, decide how much pain or despair is too much to endure, what is the point of

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[43] Id. at 305 (emphasis added).

defending a rule against assisted suicide for "healthy" persons in the first place? Nearly every act of assisted suicide could be justified under such a rule: the mentally depressed Ms. B from the Chabot case would be as free to obtain assistance in dying as any terminally ill patient suffering from physical pain. We appear to wind up, then, in much the same place whether we follow Epstein's more circuitous path or Posner's more-or-less upfront path of defending a right open to all competent adult persons.

# CHAPTER IX

# HUMAN LIFE AS A BASIC GOOD NOT TO BE INTENTIONALLY DESTROYED

## IX.1 Introduction

We have so far considered arguments for assisted suicide and euthanasia based on history, fairness, neutrality, the harm principle, and utilitarianism. We have found that, if the harm and neutrality principles support any assisted suicide right, they tend toward (if not require) a right open to all competent adults; that arguments from history and fairness seem not to compel such a right at all; and that arguments from utilitarianism are indecisive.

In this Chapter, I seek to lay the groundwork for a new argument, one that has been largely overlooked in contemporary American debate over assisted suicide. It is an argument, based on secular moral theory, that human life is fundamentally and inherently valuable, and that the intentional taking of human life by private persons is always wrong. To be clear from the

outset, I do not seek to address publicly authorized forms of killing -- in war, for example, or in the criminal justice system.[1] Some adherents to the view that human life is an inherent and fundamental good argue that war can be waged and capital punishment can be practiced consistently with the norm against private intentional killing; others disagree.[2] But inherent in any version of the view of human life we will examine is, I shall suggest, an exceptionless secular norm against the intentional taking of human life by private persons that, if accepted, would preclude the legalization of assisted suicide or euthanasia -- and would do so despite any contrary demands of a utilitarian analysis or personal autonomy theory. In

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[1]See, e.g., Joseph Boyle, Sanctity of Life and Suicide: Tensions and Developments Within Common Morality 221, in Suicide and Euthanasia (Baruch Brody, ed. 1989) (hereinafter, "Boyle, Sanctity of Life and Suicide"); Aquinas, ST Part II of the Second Part, Q. 64, a. 2-6 (arguing that a murderer loses his human dignity by engaging in criminal activity).

[2]See, e.g., John Finnis, Joseph Boyle and Germain Grisez, Nuclear Deterrence, Morality and Realism (1987). One of the authors thought that capital punishment is consistent with this norm, though he subsequently changed his view: see John Finnis, Aquinas 282, 293 (1998). Nor do I seek here to engage the abortion debate. Abortion is ruled out by the inviolability of life principle I intend to set forth if, but only if, a fetus is considered a human life. It is precisely that question, however, over which the Supreme Court in Roe divided, with the majority holding that a fetus is not a "person" for purposes of constitutional law. See Ch. V.3, supra.

what follows, I begin my argument seeking to establish the proposition that there are certain irreducible human goods (and evils); I then proceed to suggest that there is a moral imperative not to do intentional harm to such goods.

## IX.2 The Inviolability of Human Life

The existence of basic goods, and the moral imperative to respect them, has been suggested by Aristotle,[3] argued by Aquinas,[4] and defended by contemporary natural law thinkers.[5] A basic human good is one that is understood and felt as intrinsically worthwhile. It is an end that is a <u>reason</u>, in and of itself, for action and choice and decision. Its value need not -- and cannot -- be deduced by reference to some prior premises; instead, its truth is self-evident (<u>per se nota</u>, to Aquinas).[6] Our understanding of such basic goods comes not from logical constructs, or religious belief, but from experience. Neither are

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[3]<u>See</u> Ch. III.2, <u>supra</u>; Aristotle, <u>Ethics</u> § 1107a9-17.

[4]<u>See</u> Ch. III.3, <u>supra</u>.

[5]<u>See</u>, <u>e.g.</u>, John Finnis, <u>Moral Absolutes: Tradition, Revision and Truth</u> 1-30 (1991); Finnis, <u>Natural Law</u> chs. 3-5; Robert George, <u>Recent Criticisms of Natural Law Theory</u>, 55 U. Chi. L. Rev. 1371 (1988) (hereinafter, "George, <u>Recent Criticisms</u>").

[6]Aquinas, <u>ST</u> Part I of the Second Part, Q. 94, a. 2.

basic human goods idealized Platonic forms that are unrealizable in daily life, but are, instead, reasoned practically from human experience. Thus, in the Nicomachean Ethics, Aristotle tried to identify basic human goods (and evils), arguing from life's experience and observations of human nature, not from logical premises or by reference to some unreal world or hypothetical construct; no logical truth about what "is" can be used to derive this collection of "oughts."[7] As Aristotle explained, there are some actions and emotions whose very names "directly connote depravity," and

> are evils in themselves. In their case, then, it is impossible to act rightly; one is always wrong. Nor does acting rightly or wrongly in such cases depend upon circumstances -- whether a man commits adultery with the right woman or at the right time or in the right way, because to do anything of that kind is simply wrong.[8]

Aquinas self-consciously picked up and developed Aristotle's adultery analogy. In the mouth of an objector he put the following interpretation of Aristotle:

> But as the Commentator on the Ethics says, a morally good man commits adultery with the tyrant's wife, so that the tyrant may be killed and the country liberated. Therefore adultery is

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[7]Finnis, Natural Law 36-42, 62, 101-03.

[8]Aristotle, Ethics § 1107a9-17.

not intrinsically wrong.[9]

To which, Aquinas flatly replied: "The Commentator is not to be followed on this matter; for one may not commit adultery for any good."[10] For Aquinas, independent, discrete and "diverse virtues" exist ranging widely from "loyalty to family and country, gratitude to benefactors, and so on."[11]

As basic reasons for action, basic goods are not instrumental or useful merely for the purpose of achieving some other end. By definition, they are ends in and of themselves, fulfilling in their own right. In claiming something as a basic good, one is claiming it as something good in and of itself, as something in which an indefinite number of persons can participate in any number of ways.[12]

Nor is the notion of basic rights and wrongs the province of moral philosophers; we hear defenses of moral absolutes -- categorical rights and wrongs -- from our parents and teachers (and radio talk show hosts) all the time. Our very political philosophy, as

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[9]Thomas Aquinas, De Malo, q.15, a. I, arg. 5[4].

[10]Id.

[11]Aquinas, ST Part I of the Second Part, q. 60 a. 3.

[12]See George, Making Men Moral 12-14.

embodied in the Declaration of Independence, rests on the assertion that there are "self-evident" truths.[13] While it is surely true that much of life is spent on instrumental pursuits -- e.g., seeking money or clothes or food so that we may enjoy or use them -- the notion of the intrinsically valuable is not foreign either: often we honor family and art and nature and friends often not for their instrumental value in satisfying our desires or needs, but simply out of respect for their own innate value.

Human life's status as an intrinsic, not merely instrumental, good is suggested in part by the fact that people everyday and in countless ways do something to protect human life (one's own or another's) without thinking about any good beyond life itself. The recognition of life as a basic good is

> as various as the crafty struggle and prayer of a man overboard seeking to stay afloat until his ship turns back for him; the teamwork of surgeons and the whole network of supporting staff, ancillary services, medical schools, etc.; road safety laws and programmes; famine relief expeditions; farming and rearing and fishing; food

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[13]To say that a good is self-evident is not, of course, to say that everyone will recognize it as such. In our Declaration of Independence, we hold the rights to life, liberty, and the pursuit of happiness to be self-evident; not every society has (or does). See George, Recent Criticisms, 55 U. Chi. L. Rev. at 1410-12.

> marketing; the resuscitation of suicides; watching out as one steps off the kerb.[14]

All of these are indicia that human life has value not just instrumentally, but also intrinsically. So, too, is the fact that some family, friends, and medical workers often choose to provide years of loving care to persons who exist only physically, comatose or semicomatose, even linked to respirators and feeding tubes; members of religious orders and hospice organizations choose to devote their adult lives caring for such persons precisely because they <u>are</u> human persons, not because doing so instrumentally advances some other hidden objective. This is not to say that all persons would always make a similar choice, but the fact that some people have made such a choice is <u>some</u> evidence that life itself is a basic good.

Perhaps the most profound indicium of the innate value of human life, however, lies in our respect for the idea of human equality. The Fourteenth Amendment to the U.S. Constitution guarantees equal protection of the laws to all persons; this guarantee is replicated in Article 14 of the European Convention and in the constitutions and declarations of rights of many other countries. Our social and political commitment to

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[14]Finnis, <u>Natural Law</u> 86.

human equality is grounded on, and an expression of, the belief that all persons innately have dignity and are worthy of respect -- entirely without regard to their perceived worth based on some instrumental scale of usefulness or merit. We treat people as worthy of equal respect because of their status as human beings, without regard to their looks, their gender, race, creed, or other incidental traits -- because, in the words of the Declaration of Independence, we hold it as "self-evident" that "all men [and women] are created equal" and enjoy "certain unalienable Rights," and "that among these are Life."[15]

If one were to start from a radically different premise, assuming not that human life is an innate good, but that different human lives bear different value depending on their instrumental worth to society or other persons, a critical rationale for equal protection itself withers, if not drops away. Why treat people as if they are equal if, in fact, we really don't believe that they are equal? As the House of Lords Select Committee on Medical Ethics put it in its report rejecting the legalization of euthanasia, the belief that human life is inherently valuable and

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[15]Declaration of Independence ¶ 2.

worthy of protection "is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal."[16]

The case of Regina v. Dudley and Stephens helps to illustrate this relationship between the innate value of all human life and the promise of human equality. There, two shipwrecked men faced with impending starvation ate their cabin boy and, when later rescued and charged with murder, pleaded that the intentional killing was "necessary."[17] In essence, they argued that the life of the cabin boy could be treated as violable because of its instrumental value in keeping them alive. The Court, however, rejected this plea, and did so precisely because it saw all human lives as worthy of equal dignity and respect and any alternative rule as morally unacceptable; if we reject the notion that all human life is equally and innately valuable, and instead bears only instrumental value, the Court asked, "By what measure is the comparative value of lives to be measured? Is it to be strength, or intellect, or what?"[18] If life bears only instrumental value and may

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[16] House of Lords Report, HL Paper, 21-I of 1993-1994 Session, para. 237.

[17] 14 Q.B.D. 271 (1884).

[18] Id.

be extinguished whenever "necessary" for other ends and purposes, the Court reasoned, "It is plain that the principle leaves to him who is to profit by it to determine the necessity which will justify him in deliberately taking another's life to save his own. In this case, the weakest, the youngest, the most unresisting, was chosen."[19]

In United States v. Holmes, the Court similarly rejected the claim of "necessity" by ship's first mate who had ordered thrown overboard 18 passengers in a grossly overcrowded lifeboat. The Court ruled that, if decisions had to be made about whom to kill intentionally, they can only be made by lot because "[i]n no other way than this or some like way are those having equal rights put on equal footing, and in no other way is it possible to guard against partiality and oppression, violence and conflict," that might arise if some persons are permitted to sit in judgement on the value of other persons' lives.[20]

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[19]Id.

[20]26 F. Cas. 360, 1 Wall Jr. 1 (C.C.E.D. Pa. 1842). Sentencing defendants in cases like Dudley and Holmes may, of course, pose a different and difficult task, and courts have recognized the need for some leniency. In Dudley, the Court imposed a death sentence that was later commuted by the Crown to six months' imprisonment. Holmes was initially sentenced to six months imprisonment, though the punishment was later

The notion of equal and intrinsic human dignity is not, of course, universally accepted. Some, even within our society, reject the premise, embodied in the Declaration of Independence, that all human beings are intrinsically and equally valuable, asserting instead that human life has value only insofar as, and to the extent that, a person can do projects and activities that have value to them. Judge Posner, for one, candidly expresses this sentiment when he writes that "[r]espect for human life must have something to do with perceptions of the value, not wholly metaphysical, of that life. . . . The better the quality of lives, the greater the perceived value of preserving them."[21]

A similar distinction is made, if more subtly, by

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remitted.

Benjamin Cardozo later vigorously defended the result in Holmes: "Where two or more are overtaken by common disaster, there is no right on the part of one to save the lives of some by the [intentional] killing of another. There is no rule of human jettison." Benjamin Cardozo, Life and Literature 113 (1930). And states have codified Holmes's teaching. See, e.g., Wis. Stat. Ann. tit. 45, § 939 ("Pressure of natural physical forces which causes the actor reasonably to believe that his act is the only means of preventing imminent public disaster, or imminent death or great bodily harm to himself or another and which causes him so to act, is a defense to the prosecution for any crime based on that act except that if the prosecution is for murder the degree of the crime is reduced to manslaughter."); Ky. Rev. Stat. Ann. ch. 500, § 500.410; Mo. Ann. Stat. tit. 38, § 563.026.

[21]Posner, Aging and Old Age 241.

Ronald Dworkin. Dworkin first speaks of human life being intrinsically valuable, even sacred, and rejects the view that nothing is valuable absent instrumental value.[22] Dworkin proceeds, however, to suggest that one reasonable (if not exclusive) "interpretation" of the value of human life is the "liberal view" that the importance of human life "depends on the intrinsic importance of human creative investment" in it -- namely, that human life is inviolable because (and only to the extent) that it is "created . . . by personal choice, training commitment and decision."[23] In short, the value of human life to Dworkin turns on the ability of persons to express themselves autonomously. Thus, Dworkin takes the view, as we discussed in Chapter VI, that the life of the person suffering from Alzheimer, while once capable of self-expression and self-creation, has lost its value -- such a person is, in Dworkin's idiom, "no longer capable of the acts or attachments that can give [life] value. Value cannot be poured into a life from the outside; it must be generated by the person whose life it is, and this is

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[22]Dworkin, Life's Dominion 69.

[23]Id. at 93.

no longer possible for him."[24]

But if one's valuable human-ness (and thus legal inviolability) turns on one's currently exercisable abilities for self-creation and self-expression, what specific traits and qualities must one exhibit? And how developed must they be before one qualifies for equal protection under the law? Dworkin tells us the Alzheimer patient does not meet his criteria. How about those with low IQs? The mentally handicapped? The autistic? Stroke victims? Infants? The variations between persons, even those suffering from the same species of disability, are subtle and nearly endless, and any attempt to draw lines between different sorts of lives based on their current capacity for self-creation seems almost inevitably to become more or less an arbitrary and subjective enterprise. This arbitrariness is illustrated, too, by the competing opinions and views of Ronald Dworkin, Richard Posner, Richard Epstein, and Peter Singer, all of whom otherwise agree that life's value is instrumental, not innate.

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[24]Id. at 230.

While Dworkin posits that it would be acceptable to kill Alzheimer's patients to accord with their prior, autonomously expressed wishes, even though they now resist, Posner, after denying that human life is anything more than an instrumental good, declares that infanticide is immoral and "not up for reconsideration,"[25] arguing that it violates "intuitions" that "precede and inform, rather than follow" from philosophical analysis.[26] Epstein, meanwhile, waffles on the infanticide question, asking whether patients have the duty to undertake ordinary surgery to preserve the life of a Down's syndrome child and answering that "after some misgivings perhaps, [the answer should be] an emphatic yes. But, if for some reason, the parents have no duty to keep the child alive, active euthanasia is probably preferable to the slow starvation of a helpless infant."[27] Peter Singer does no such waffling, noting that infants are not currently capable of autonomous self-creation and, thus, as we shall explore in more detail shortly, concluding that there is nothing wrong with

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[25]Posner, Aging and Old Age 256-57.

[26]Id. at 257.

[27]Epstein, Mortal Peril 323.

infanticide. Yet, while endorsing the murder of young children, Singer suggests that we must extend a right to life to adult animals because, in his view, they have a higher capacity for self-awareness that merits absolute protection. And this, somewhat circuitously, takes us back to Dworkin: no doubt the abilities for self-creation of many of the animals Singer wishes to protect from being killed are less developed than those of many human adult Alzheimer patients Dworkin would have us kill.

Simply put, while Dworkin, Posner, Epstein, and Singer agree that human life is only valuable when accompanied by certain instrumental capacities for self-creation, they differ markedly on <u>which</u> human lives possess those capabilities and thus are valuable. And their various and competing theories on which-humans-count-as-full-persons provide only a few examples. American history is replete with arguments for applying eugenics[28] and sterilization[29] to this or

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[28]<u>See</u>, <u>e.g.</u>, F. Kennedy, <u>The Problem of Social Control of the Congenital Defective</u>, 99 Am. J. Psych. 13-16 (1942). <u>See also</u> <u>The Right to Kill</u>, Time, Nov. 18, 1935, at 53-54 (Nobel Prize winner at the Rockefeller Institute urging that "sentimental prejudice . . . not obstruct the quiet and painless disposition of incurable . . . and hopeless lunatics"); D. McKim, <u>Heredity and Human Progress</u> 189,193 (1900)(New York physician advocating the e limination of severely handicapped children, including "idiots,"

that group on the ground that such human beings lack this or that arbitrary prerequisite of full "personhood."

While a certain amount of arbitrariness may be inevitable in making many policy decisions -- say, how much to spend on guns versus butter this year? should the vote be extended to 18 or 21 year-olds? -- the arbitrariness inherent in efforts to draw lines between persons who are and are not sufficiently capable of living an "autonomous" life so as to be inviolable under law is unacceptable, especially given that the

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most "imbeciles, and the greater number of epileptics, for society's protection, via a "gentle, painless death" by the inhalation of carbonic gas); R.H. Gross, et al., Early Management and Decision-Making for the Treatment of Myelomeningocele, 72 Pediatrics 450, 456 (1983) (reporting on the results of selection of handicapped newborns for treatment between 1977 and 1982 at Oklahoma University Health Sciences Center that babies were provided -- or denied -- treatment based on such factors as their ambulatory potential, according to a "formula that also factored in the "contribution anticipated from his home and family and society").

[29]See Buck v. Bell, Superintendent of the Virginia Colony for Epileptics and Feeble Minded, 274 U.S. 200, 207 (1927) ("It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind."). The sentiment in Buck is all the more unfortunate for the fact that it post-dates and stands in such stark contrast to the more enlightened recognition in Meyer v. Nebraska, 262 U.S. 390 (1923) that "'putting away . . . the offspring of the inferior, or of the better when they chance to be deformed' [would] do . . . violence to both the letter and spirit of the Constitution." Id. at 401-02.

consequence of a mistaken classification -- unequal treatment in matters of life and death -- is so profound. American courts closely scrutinize and strike down virtually any legal distinction made between persons on the basis of race, gender, or age when education and other rudimentary government services are at stake. Given this, it would be seriously incongruous to permit states to use distinctions based on one's capacity for "autonomous self-creation" as a ground for enforcing a much greater form discrimination -- namely, for determining who is and is not effectively treated as fully human and entitled to the full panoply of human protections. It is, as the Linacre Centre submitted to the House of Lords committee considering the assisted suicide question, "incompatible with . . . justice that we should determine who are [and are not] the subjects of justice by arbitrary choice."[30]

Assuming that we come to accept human life as a basic, non-instrumental good, important questions still remain: what ought we do to do respect it? Can we ever take any action that harms life? If so, when?

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[30]Linacre Centre Submission, reprinted in Euthanasia, Clinical Practice and the Law 124 (Luke Gormally, ed. 1994).

Such questions lead us back to the distinction between intended and unintended actions that I argued for in Chapter IV. It is, I suggested, a basic feature of our world that we do not live like the Man in the Pit, but with many and varied options for living "good lives." As a result of this fact, I argued that we simply cannot avoid making worthwhile and upright choices about how to live that exclude or harm other valuable ends or goods. And such choices -- those made in pursuit and affirmation of one good -- do not necessarily imply any disrespect for the value of other goods that are not chosen, even when they are incidentally harmed. Thus, to recall some examples, the soldier who accepts an assignment leading to certain death does not <u>deny</u> the innate goodness of human life; rather, his sacrificial choice only <u>affirms</u> the existence of other worthwhile ends. A parent who chooses to devote herself primarily to raising children <u>affirms</u> the goodness and importance of family; she in no way implies any <u>rejection</u> of the inherent value in other ways of life (such as devoting oneself, say, to the homeless or hungry). To say that something is a basic or innate good simply cannot mean that persons may <u>never</u> do harm to it in any fashion, even as an

unintended side-effect. Accordingly, to defend human life as a basic good, or innately valuable, we need not say that human life must be never be harmed under any circumstances, or that human life is the most important object of human action that must be preserved in some absolute, vitalistic fashion.[31]

By contrast, as I argued in Chapter IV, one thing we can do is control our intended actions. Quite unlike unintended side-effects, our freely willed choices are entirely and uniquely within our control. It is a basic feature of the belief in the freedom of human will that our deliberate decisions about how to live in a world with so many varied options define who we are and what our particular lives are about.[32] Quite unlike unintended side-effects, too, intentional decisions to harm someone or something do evince a denial that the objects of our actions possess innate value. Should we deliberately run down the child darting into the street for sport or intentionally kill grandpa for the insurance money or shoot a hostage to make a political point, we would be making a willed denial that these objects of our actions hold innate

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[31]See Keown, EEPP 41.

[32]See Morrisette, 342 U.S. at 250; Ch. IV.3.

value or are worthy of respect simply by virtue of their being. Such actions would demonstrate, instead, a judgment or decision that the objects of our actions contain value to us only as <u>instruments</u> of our pleasure or pique, as means to an end. To harm something intentionally is, simply, to deny that it contains inherent, rather than merely instrumental, value. Accordingly, if, as I have argued, human life does indeed qualify as a basic good, this means that we can and should avoid actions <u>intended</u> to do it harm -- actions which necessarily evince a denial of life's innate worth and suggest that its value depends instead only on its transient instrumental usefulness. And this, of course, rules out assisted suicide and euthanasia. For, unlike the right to refuse treatment or the administration of palliative care, acts of assisted suicide and euthanasia, by their very definition in law and moral theory, involve a willed decision to terminate or help terminate human life. Those who commit such acts do not harm human life merely by accident or as a side-effect of pursuing other worthwhile ends, but instead deny that human life is worthy of respect by virtue of its inherent value, as opposed to its instrumental use as a means to an

end.[33]

## IX.3 Some Objections

The neutralist or libertarian may object that the inviolability of human life principle I have sketched evinces an illegitimate disregard for liberty: consenting adults should be permitted to do as they wish without state interference. Of course, as we saw in Chapters VI and VIII, faithful adherence to the neutrality or harm principle tends to lead toward, if not dictate, results -- such as the legalization of consensual homicide, prostitution, the use of illicit drugs -- that even some advocates of the harm and neutrality principles have tended to suppress or

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[33]To say that human life is a basic good would also tend to rule out sadomasochism and other acts that, even when consensual, likewise represent intentional choices to harm human life.

Kant, often claimed by contemporary adherents to the neutrality and harm principles as one of their own, seemed to eschew these principles in his teachings on suicide, at least as a matter of ethics, arguing that "[h]e who contemplates suicide should ask himself whether his action can be consistent with the idea of humanity as an end in itself. If he destroys himself in order to escape from painful circumstances, he uses a person merely as a mean to maintain a tolerable condition up to the end of life. But a man is not a thing, that is to say, something which can be used merely as means, but must in all his actions be always considered as an end in himself." Immanuel Kant, Fundamental Principles of the Metaphysics of Morals, second section, para. 9 (Thomas Kingsmill Abbott, trans. 1949).

ignore. But for those who openly defend such conduct, how do we answer their principled objection that treating human life as inviolable infringes unduly on human liberty? After all, the rule I am advocating would suppress liberty -- if only to the extent of taking actions intentionally aimed at ending life.

This question takes us back to the issues we discussed in Chapter VI. As noted there, Raz posited three preconditions for human liberty: sufficient leisure and means to make choices (the Hounded Woman); sufficient options to choose among (the Man in the Pit); and an absence of coercion. Recognizing a rule against intentional assaults on human life does not implicate Raz's first precondition at all. As to the second, a neutralist may argue that, for human autonomy to flourish, the state must remain neutral among all competing conceptions of a good life (and death). To this, however, I would respond that ruling out assisted suicide and euthanasia (or sadomasochism, dueling, or consensual homicide contracts), while surely non-neutral, does not remotely leave us in a world with insufficient options for individual self-creation. Recognizing a rule against the intentional taking of human life hardly means that we are left like Raz's Man

in the Pit with no meaningful choices to make.

While laws against assisted suicide plainly restrict some choice, they need, consistent with the inviolability of life principle, restrict only a very limited arena of human actions -- those intended to help kill. Indeed, the strict mens rea limitation inherent in most American laws banning assisted suicide serves, as we discussed in Chapter IV, an important liberty-preserving function in the arena of secondary liability, preventing the state from "sweep[ing] within the drag-net of conspiracy all those who have been associated in any degree whatever," with the principal, and restricting judicial attention to those who "in some sense promote[d] [the] venture himself, ma[d]e it his own, ha[d] a stake in its outcome."[34] The inviolability of life principle, thus, does not suggest that the government should criminalize or regulate every act where life is foreseeably taken, but rather ensures that prosecutions will be rare and government

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[34]United States v. Falcone, 109 F.2d 579, 581 (2d Cir.), aff'd without passing on the issue, 311 U.S. 205 (1940). See also Ch. IV, supra. Thus, while Timothy Quill has criticized intent as a difficult standard to establish in individual cases, it is a difficult standard to establish by design, and a standard that helped Quill himself avoid prosecution for his role in providing sleeping aids to a patient who used them to kill herself. See Chs. I & IV.7, supra.

oversight judicious. The principle, accordingly, cannot -- and should not -- be confused with a wooden, vitalistic demand that every effort be made to keep all persons alive under all circumstances -- a demand that would itself entail serious injustices.

Indeed, in vivid contrast to a vitalistic approach, the inviolability of life principle would permit patients ample room and liberty to accept and reject care of all kinds -- even when death is foreseen as an inevitable result. The inviolability of life principle does nothing to rule out categorically the use of high doses of palliatives for patients in pain or the rejection of respirators for those whose lives depend on them. Patients may, as discussed in Chapter IV, reject any sort of care because they are tired of invasive treatment, wish to be left alone, are unwilling to impose further burdens on their families, or simply want to leave the hospital and go home. None of these everyday (albeit defining) choices (or countless others like them) need involve an intent to die, even when death is foreseen. Indeed, such free and autonomous decisions deserve respect and they are in no way inconsistent with the view that human life is a fundamental good.

Medical professionals, likewise, can administer pain relief and other forms of medical treatment even when they foresee death as likely, even inevitable, without running afoul of the inviolability of life principle. They can, as well, respect and give effect to patient requests to discontinue life-sustaining care even when they consider the requests unreasonable or wrong, so long as they do not intend to help kill. Of course, this is not to say that difficult cases do not arise for doctors and nurses. We considered in Chapter IV the patient who seeks to discontinue treatment with a manifest intent to die (say, to get insurance proceeds now for his family), and we asked whether a doctor could discontinue treatment on the ground that he does not intend to help the patient kill himself, but is simply willing to discontinue services when they are no longer wanted and allow the patient/client to go his way.[35] The inviolability of life principle I have sketched, focused as it is on human intention and willful self-definition, cannot categorically preclude the doctor from discontinuing care in such circumstances: the doctor may know the patient intends do die, but does not intentionally help the patient

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[35]See Ch. IV.6, supra.

kill himself, seeking only, instead, to fulfill a responsibility to cease providing his professional services when they are no longer wanted.[36] The inviolability of life principle, thus, allows us to chart what John Keown would call a "middle way"[37] between the extremes of treating life as a mere instrumental good and treating it as something that we must preserve at any cost, affording, in the process, significant liberty to patient and doctor alike to discontinue or apply treatment even in circumstances where death is foreseen as a certainty -- and precluding any reasonable suggestion, I think, that patient or doctor is left in a position remotely akin to Raz's Man in the Pit.

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[36]To say that the inviolability of life principle would not absolutely forbid the doctor from discontinuing care is, of course, a limited claim and other arguments may be brought to bear. For example, as noted in Chapter IV, a doctor convinced that the patient seeking to discontinue care intends to die is legally privileged to intercede to prevent suicide, though, of course, this legal privilege imposes no duty on the physician to act. Also, jurisdictions are free to legislate more broadly than the inviolability of life principle I have outlined would require. As we saw in Chapter IV, a very few American states treat the crime of assisted suicide as embracing not just the intentional assistance of persons who are seeking death, but also the knowing assistance of such persons. Again, however, such positive laws go beyond what the inviolability of life principle I have outlined would mandate.

[37]Keown, EEPP 235.

Raz's third and final precondition for the flourishing of human liberty and autonomy involves the absence of coercion. Precluding assaults on human life, one might argue, represents "coercion" in the sense that certain consensual activities are forbidden. As we saw in Chapter VI, Raz argues that coercion of any consensual adult human activity undermines liberty and autonomy in two ways -- first, it evinces "an attitude of disrespect for the coerced individual"; second, coercion is often "indiscriminate . . . [and offers] no practical way of ensuring that the coercion will restrict the victims' choice of repugnant options but will not interfere with their other choices."[38]

I would respond to Raz's concerns, as Robert George does, by suggesting that a law ruling out a "bad choice" does not necessarily evince disrespect for the chooser, but for the choice he or she made; after all, parents punish children who make bad choices not because they disdain them, but because they love them and do not wish to see them make bad decisions.[39] In addition to this, an absolute rule against intentionally taking human lives cannot, I think, be

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[38]Raz, The Morality of Freedom 418-19; see also Ch. VI.4, supra.

[39]See George, Making Men Moral 185-86.

viewed legitimately as "indiscriminate" coercion disruptive of human liberty because the prohibition against the intentional taking of human life also serves to protect against the coercive, mistaken, and abusive taking of human life and, thus, serves as a guardian of human liberty and equality. In Chapters VI and VIII, we saw that even notable harm principle advocates deny the premise that every law criminally banning consensual practices constitutes an impermissible encroachment on human liberty. For example, Feinberg and Mill argue for absolute bans against dueling and slavery contracts, contending that such a result is consistent with, and critical to the protection of, human liberty because of the dangers dueling and slavery contracts pose for the liberty of non-consenting persons as a result of their mistaken, neglectful, or abusive practice.

A harm principle or neutralist's right to consensual homicide open to all adults poses risks to human liberty of similar gravity to those posed by dueling, and risks of perhaps even greater gravity than

those posed by slavery contracts,[40] and there is thus no reason to assume that a rule against the intentional taking of human life represents an unreasonable restriction on human liberty. Though a law banning assisted suicide surely will result in the suppression of some consensual conduct, that simply is not, even for such defenders of human liberty as Feinberg and Mill, a conclusive reason against its adoption. The avoidance of the evil of unjust abusive use of the liberty may still be appropriate (and perhaps even generally required of a just state) notwithstanding the side-effect that the liberty of some consenting persons may be suppressed.

In a different vein, one can imagine that the practically minded lawyer might question whether, whatever the principled concerns a harm or neutrality principle advocate might have, the law already permits the use of deadly force with the intention to kill by private persons in at least some extreme contexts where self-defense or necessity compels it, thereby calling into question the application of the inviolability of

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[40]While the primary risk associated with a wrongful slavery contract may be unwanted enslavement, the risk of a wrongful act of assisted suicide is an unwanted death.

life principle, at least at a doctrinal level. But, is this really so?

The use of deadly force in self-defense is, to be precise, legally permitted in most American jurisdictions only when one "reasonably believes" that such force is necessary to protect against an imminent threat of unlawful force.[41] Thus, if the defendant can show that he acted with an actual, honest intention of protecting himself, a court will uphold his claim of self-defense; if, however, the defendant did not reasonably believe that he needed to use deadly force to stop an aggression, his act will be treated as murder or manslaughter.[42] Simply put, it is a requisite element to a claim of self-defense that the defendant acted with the intention of stopping an unwarranted aggression. Not only is an intention of this kind required, there is no need for a person to act in self-defense with any intent to kill. Even when one uses deadly force foreseeing the assailant's certain death, one may intend only that the aggression stop. Aquinas, for one, justified acts of private self-defense

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[41]See Model Penal Code § 2.04.

[42]See, e.g., Model Penal Code § 2.04; State v. Kelly, 478 A.2d 364 (N.J. 1984); Commonwealth v. Ross, 416 A.2d 1092 (Pa. 1979).

specifically on this basis.[43]

Admittedly, the American law of self-defense does not directly interest itself in the case where someone who "reasonably believes" that she is in imminent danger of death and intends to use force to save herself also uses the occasion to satisfy some further intention of seeing the assailant dead. But, just as with the right to refuse, the state is interested in ensuring that exactly what was done can be done uprightly -- i.e., without an intent to kill -- asking whether a person under the circumstances faced by the defendant would have felt reasonably compelled to use lethal force to save himself from imminent death. As the Chief Justice acknowledged in Quill, there is a difference between those acts that can be performed without any intent to kill (e.g., the right to refuse treatment, self-defense) and those that can only be performed with the unlawful intent to kill (e.g., assisting suicide, euthanasia). And, like the right to refuse, acts in self-defense indubitably can be done without any intent to kill. The law has, moreover, developed doctrinal nuances that do much to weed out and protect against the most typical situations where a

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[43]See Ch. III.3, supra.

further intention to kill might arise. A claim of self-defense is not allowed, for example, where one provokes the assailant's use of force or where one could have avoided the use of deadly force simply by retreating. Thus, the battered wife who lies in wait with a gun for her returning husband in order to provoke him into rage, or who refuses to leave the house when she could have easily done so instead of shooting him, cannot escape punishment for her husband's death.[44]

Perhaps more so than self-defense doctrine, the law of necessity, if broadly interpreted to belong in the law of intentional homicide, could run the risk of providing legal authority for killings inconsistent with principle that human life is inviolable. Indeed, necessity doctrine is precisely the legal theory the Dutch government has employed to justify acts of non-consensual assisted suicide and euthanasia.[45] And, as we saw from Dudley and Stephens, once we open the door to excusing or justifying the intentional taking of life as "necessary," we introduce the real possibility that the lives of some persons (very possibly the

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[44]See, e.g., Model Penal Code § 3.04(b)(i) & (ii).

[45]See Ch. VII.2, supra.

weakest and most vulnerable among us) may be deemed less "valuable," and receive less protection from the law, than others.[46]

While many common law courts in America and England have resisted the use of necessity doctrine to justify intentional killings (as Dudley and Stephens and Holmes illustrate), many have called for the use of necessity doctrine to justify or excuse acts of intentional homicide. Though we shall explore another example in the next Chapter, for our purposes here it suffices to consider a hypothetical offered by the drafters of the Model Penal Code. While "recognizing that the sanctity of life has a supreme place in the hierarchy of values" and much contrary precedent, the Model Penal Code's authors have argued for the introduction of necessity doctrine into the law of intentional homicide,[47] suggesting that the case for necessity doctrine is illustrated by (among other examples) the case of a hypothetical mountaineer, "roped to a companion who has fallen over a precipice,

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[46]See Ch. IX.2, supra.

[47]See Model Penal Code, § 3.02, cmt. 3.

who holds on as long as possible but eventually cuts the rope."[48] Such life-taking acts, the Model Penal Code drafters argue, are justified as necessary reactions to extreme circumstances.[49]

This sort of example, however, seems unpersuasive on its own terms. Morally, the hypothetical mountaineer intends only to save himself and in no way wish to do any harm (let alone kill) others. The mountaineer may <u>foresee</u> that his actions will cause harm, but he does not <u>intend</u> any such thing. The mountaineer would (quite unlike Dr. Kevorkian with his clients) prefer that everyone would live. The Model Penal Code's hypothetical defendant simply need not resort to claims of "necessity" to defend his actions. Doctrinally, too, the Model Penal Code's example can be defended at law without resort to a necessity defense. The mountaineer cuts the rope not with the intent of killing anyone, but out of self-defense in response to an imminent threat posed by the man at the end of the rope. In fact, the only significant difference between the case of the mountaineer, on the one hand, and the

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[48]<u>Id.</u>

[49]<u>See also</u> Ch. X.3, <u>infra</u> (discussing invocation of necessity doctrine by Lord Justice Brooke in a recent case before the English Court of Appeal).

classic case of self-defense or defense-of-others, on the other hand, involves the nature of the threat. In the usual case of self-defense, a menacing aggressor points a gun and threatens to kill; in the case of the mountaineer, the man at the end of the rope poses the same deadly threat, though he does so blamelessly -- the man at the end of the rope is, for lack of a better term, an "innocent aggressor."

The common law of self-defense and defense-of-others, and even the Model Penal Code itself, however, fully anticipate and cover such cases. A successful claim of self-defense or defense-of-others formally requires proof that the threatened force faced by the claimant of the defense is "unlawful,"[50] but that term is really a misnomer because an "unlawful" force includes <u>any</u> force that (i) is employed without the consent of the person against whom it is directed, and (ii) is not affirmatively privileged at law.[51] Thus, the mountaineer, even though confronted with threats in no way intended by the man at the end of the rope, is free to take actions to defend himself and others, without resort to necessity doctrine, because the force

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[50]<u>Id.</u> § 3.04.

[51]<u>See id.</u> § 3.11(i) & cmt. 1.

he faces is not one he agreed to and is not privileged at law. The law is emphatic on this score:

> It [is] immaterial that other elements of culpability, e.g., intent or negligence, are absent. Whatever may be thought in tort, it cannot be regarded as a crime to safeguard an innocent person, whether the actor or another, against threatened death or injury that is unprivileged, even though the source of the threat is free from fault.[52]

And there are good reasons for this rule: if the law were otherwise, requiring the threat faced to be intentional, it would have been impossible for dangerously threatened persons to defend themselves or others at common law against attacks by, for example, the mentally insane, minors, or other incompetent persons -- persons who are, by definition, unable to commit criminal or intentionally tortious acts, though clearly capable of imposing real threats.[53]

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[52] Id.

[53] Sanford Kadish has queried whether the first mate's decision in Holmes to throw overboard excess passengers, like the moutaineer's decision to cut the rope, could have been argued as a case of self-defense. Sanford Kadish, et al., Criminal Law and Its Processes 921 n.32 (5th ed. 1989). And perhaps it could have been: whereas the intent to kill (at least as a means) is manifest and undeniable in Dudley, the first mate in Holmes did not kill his passengers but apparently ordered them overboard. Accordingly, it is possible that he may not have wanted to see them dead, but hoped to see them survive in the water until a rescue ship arrived. Of course, as with any claim of self-defense, a detailed appreciation of the facts is necessary. For example, did the first mate wait until the last

In suggesting that the case for necessity in the common law of <u>intentional</u> homicide faces contrary common law authority and seems incomplete in the face of the principle of double effect and the availability of other defenses, I do not mean to foreclose the possibility that the doctrine might have a legitimate role in the law of <u>non-intentional</u> homicide; certainly such a role would not necessarily conflict with the inviolability of life principle which categorically rules out (only) <u>intentional</u> acts against the basic good of human life.

## IX.4 Peter Singer's Infanticide Thesis

While we have discussed potential criticisms of the inviolability of life principle from libertarianism and legal doctrine, perhaps the most aggressive and notorious contemporary challenge to the inviolability of life principle I suggest comes from Peter Singer in his argument for infanticide. It is, accordingly, worth pausing here to unpack and consider his

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possible second (like the mountaineer) before ordering his passengers overboard? Did he provide them whatever assistance was available to make their survival more likely? Ultimately, for our purposes, however, whether <u>Holmes</u> might have been argued as a case of self-defense does nothing to advance (and even further undercuts) the case for necessity doctrine in the law of intentional homicide.

provocative argument in detail.

Infanticide is, of course, nothing new. In earlier times, nothing could be done for many infants with genetic defects and children were left to die, as with the children left on mountainsides by ancient Spartans. What may be new, or at least new to our society, is the notion that infants who can be helped, and perhaps even perfectly healthy children, may be left to die or affirmatively killed, a position Peter Singer openly advocates. Nor can Singer's views of infanticide be fairly labeled as outside the "mainstream." His books are published by mainline academic publishers, he is a professor of bioethics at Princeton, and the New England Journal of Medicine has praised Singer as having "a larger popular readership than any professional philosopher since Bertrand Russell, and more success in effecting changes in acceptable behavior."[54]

Singer encourages us to "put aside feelings based on the small, helpless, and -- sometimes -- cute appearance of human infants."[55] If we shelve such

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[54]Peter Singer, Practical Ethics ii (1993) (hereinafter, "Singer, Practical Ethics"); Singer, Rethinking rear cover.

[55]Singer, Practical Ethics 170.

"emotionally moving but strictly irrelevant aspects of killing the baby," he argues, "we can see that the grounds for not killing persons do not apply to newborn infants."[56] Having disposed of "emotional" claims, Singer begins his analysis by endorsing utilitarian reasoning and explaining that, from what he calls the "classic or indirect utilitarian" perspective, the primary reason for a rule against murder is to ensure that our own lives and happiness are protected. Such reasons, he submits, simply "do not apply" to the murder of infants because

> no one capable of understanding what is happening when a newborn baby is killed could feel threatened by a policy that gave less protection to the newborn than to adults. In this respect, Bentham was right to describe infanticide as "of a nature not to give the slightest inquietude to the most timid imagination." Once we are old enough to comprehend the policy, we are too old to be threatened by it.[57]

Singer also identifies what he calls the "preference utilitarian" perspective, according to which "an action contrary to the preference of any being is, unless this preference is outweighed by contrary preferences, wrong. Killing a person who prefers to continue living is therefore wrong, other

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[56]Id.

[57]Id. at 171.

things being equal."[58] But newborn babies "cannot see themselves as beings who might or might not have a future, and so cannot have a desire to continue living."[59] Finally, from the viewpoint of the moral theory of personal autonomy, Singer argues that "a newborn baby is not an autonomous being, capable of making choices, and so to kill a newborn baby cannot violate the principle of respect for autonomy."[60]

In Singer's account, one's existence as a "member of the species Homo sapiens" is

> not relevant to the wrongness of killing; it is, rather, characteristics like rationality, autonomy, and self-consciousness that make a difference. Infants lack these characteristics. Killing them, therefore, cannot be equated with killing normal human beings, or any other self-conscious beings.[61]

Simply put, on Singer's account, it is wrong to kill those who are aware of the pleasures of living, thereby reducing the overall (utilitarian) balance of societal happiness. But it is not necessarily wrong to kill "conscious beings" (e.g., infants) who do not (yet)

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[58]Id. at 94.

[59]Id. at 171. For analogous views, see, e.g., Jeffrey Reiman, Abortion and the Ways We Value Human Life (1999) (hereinafter, "Reiman, Abortion").

[60]Id.

[61]Id. at 182.

possess sufficient self-awareness to value pleasure.

Singer's argument highlights an interesting feature about utilitarianism, one suggested in Chapter VII: it is an imperfect guarantor of a right to life -- or any other good perceived to be a moral absolute or human right, such as those enumerated in the Declaration of Independence and similar charters. Life is a good worthy of protection if, and only to the extent, that it is perceived to maximize happiness. On a strictly utilitarian account, nothing can lay claim to status as a right or moral or political absolute, a good in and of itself; any "right" is valuable and worthy of respect only if, and to the extent, it is instrumentally helpful in delivering pleasurable consequences and preventing painful ones.

Singer also offers insight into some of the more extreme potential consequences of autonomy theory discussed in Chapter VI. Infants do not enjoy the most basic precondition for autonomy we identified -- they do not have the ability to comprehend the means required to realize their goals; they are in no sense the authors of their lives capable of using their faculties to plan and make choices.[62] Accordingly, to

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[62]See Ch. VI.2, supra.

the extent that autonomy is considered a precondition for possessing human rights, and Singer certainly sees it that way, a human infant surely must matter very little. Singer's argument, in this respect, is but a modest extension of the argument advanced by Ronald Dworkin that we should ignore the (demented) pleas of the contented Alzheimer patient to live and instead abide by her prior (rational/autonomous) request to be killed when dementia sets in. Human life, at both ends of its spectrum where capacity for autonomy may be at its lowest ebb, is of little account in theories where rights depend on the presently exercisable capacity for autonomous self-creation.

While Singer limits his discussion of the acceptability of infanticide to the context of "deformed" children, it ought not go unnoticed that the autonomy rationale he offers does not appear to rest in any way on the physical condition of the infant. A healthy baby is no more capable of Singer's self-awareness than one with Down's syndrome or spina bifida. Singer himself stops short of openly admitting as much, but he does come close: Singer contends that his argument "is not meant to suggest that someone who goes around randomly killing babies is morally on a par

with a woman who has an abortion" and that "[w]e should certainly put strict conditions on permissible infanticide," but then proceeds to concede that "these restrictions might owe more to the effects of infanticide on others than to the intrinsic wrongness of killing an infant."[63] Singer, thus, seems worried not about the life of the infant, but only the consequential loss of pleasure by others "who love and cherish the child."[64] Of course, when parents do not want the child, there is no such consequential loss to worry about, and Singer himself admits that, under his view, "infanticide can . . . be equated with abortion when those closest to the child do not want it to live."[65] Infanticide is primarily justified, then, on the basis of lack of parental interest, not on the basis of the child's health or "deformities." A healthy child who is unwanted seems therefore as much a candidate for infanticide as an unhealthy one.

Singer frankly admits, too, that part of the calculation that goes into determining parental interest revolves around "replaceability." A child

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[63]Singer, Practical Ethics 173 (emphasis added).

[64]Id. See also Reiman, Abortion.

[65]Singer, Practical Ethics 173.

with a condition like Down's syndrome or hemophilia might give parents less overall pleasure than a child without such conditions and, so, parents should be free to choose to kill such children. While "neither haemophilia nor Down's syndrome is so crippling as to make life not worth living from the inner perspective of the person with the condition," and "their lives, like those of small children, can be joyful,"[66] an infant with no self-awareness appears to have no claim against being replaced:

> I cannot see how one could defend the view that fetuses [also non-self-conscious beings] may be "replaced" before birth, but newborn infants may not be.[67]

But what about parents who might find more pleasure from blond-haired, blue-eyed babies than brunettes with brown-eyes, or from boys rather than girls? Singer's reasoning would appear to license parents to cull their infant children to achieve any such desired traits (at least before the children become "self-conscious," an age left Singer leaves undefined).[68]

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[66]Id. at 187.

[67]Id. at 188.

[68]Perhaps somewhat surprisingly, given his views, Singer includes a substantial afterword in Practical Ethics expressing shock at having been identified by some Germans, while on a speaking tour in their

Singer dismisses the view I have been defending in this Chapter, that human life is intrinsically valuable, on the ground that it is an anachronistic product of "early and mediaeval Christian writers"[69] whose "doctrines are no longer generally accepted."[70] But, while the inviolability of life position undoubtedly has religious connections, Singer nowhere considers the possibility that (as I have sought to suggest) the position is entirely defensible on secular grounds. Even Ronald Dworkin, who appears to agree with Singer's argument in certain other respects, acknowledges that "there is a secular as well as a religious interpretation of the idea that human life is sacred. Atheists, too, may feel instinctively that assisted suicide and euthanasia are problematic because human life has intrinsic value."[71] It is also somewhat remarkable that Singer dismisses the inviolability of life position on the ground that it is the product of

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country, with the eugenics ideology of National Socialism. Id. at 337-59. See also Nat Hentoff, Doctor Death: A Newborn Is Not a Person, Village Voice (Feb. 23-29, 2000) (comparing Singer's position that it is acceptable to kill innocent persons intentionally with Nazi ideology).

[69]Id. at 173.

[70]Id. at 89.

[71]Dworkin, Life's Dominion 195.

doctrines that assertedly are no longer "generally accepted" when the alternative he offers is not exactly dominant in popular culture. And curiously, Singer himself at points appears to veer away from strict utilitarianism to argue for the absolute rule that there is "special value" or "claim to protection" in the life of persons.[72] Singer would, of course, define the term "person" to include only autonomous, choosing, rational beings.[73] But, interestingly, Singer actually endorses a rule protecting the "special value" of (autonomous) persons absolutely, thus appearing to take issue with the inviolability of life principle at the end of the day only insofar as it relies on what Singer calls a "species boundary," protecting all human beings as a class regardless whether particular individuals enjoy self-awareness and consciousness.

Singer asserts that relying on species membership as a basis for rights and privileges is the moral equivalent of "racism" against animals:

> The biological facts upon which the boundary of our species is drawn do not have moral significance. To give preference to the life of a being simply because that being is a member of our species would put us in the same position as

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[72]Singer, Practical Ethics 117.

[73]Id. at 89-90.

> racists who give preference to those who are members of their race.[74]

The alternative to the human-animal boundary that Singer offers, however, tends only to confirm the defensibility of the "species" boundary he criticizes. While human infants are not worthy of a right to live, Singer submits, adult chimpanzees, dogs, and cats are "rational and self-conscious beings, aware of themselves as distinct entities with a past and a future";[75] even with their comparatively modest inherent capacities for self-fulfillment and autonomy, these animals are, in Singer's special language, "non-human persons" deserving of legal protection and a right to live. As Singer puts it, "[s]ome members of other species are persons [and thus enjoy a right to life]: some members of our own species are not."[76] And Singer warns that,

> if dogs and cats qualify as persons, the mammals we use for food cannot be far behind. We think of dogs as being more like people than pigs; but pigs are highly intelligent animals and if we kept pigs as pets and reared dogs for food, we would probably reverse our order of preference. Are we

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[74]Id. at 88.

[75]Id. at 110-11.

[76]Id. at 117.

turning persons into bacon?[77]

It is no exaggeration to say that Singer would leave parents free to kill human children capable, with time and nurturing, of autonomous flourishing in ways radically different from any animal, while, at the same time, he would have us acknowledge a right to life for all (adult) pigs.

While it is difficult to discern anything akin to what is ordinarily understood as racism in the traditional human-animal distinction, Singer's alternative -- granting the "right" to life only to those beings, human and animal, who manage to run the gauntlet of infancy and achieve the status of "rational and self-conscious beings" in adulthood, all as a result simply of being lucky enough to be the offspring of parents who chose not to kill them -- is a prime example of what some would label "agism,"[78] and what I might suggest is further evidence of the inherent arbitrariness of instrumentalist accounts of human

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[77]Id. at 119.

[78]Singer quotes an anti-infanticide activist, Nuala Scarisbrick, as having described his position as meaning that "[an] unwanted [infant] is . . . guilty of a capital offense." Singer responds candidly that "Nuala Scarisbrick was not so far off the mark." Singer, Rethinking 128-29.

value.[79] In fact, under Singer's logic, it would seem to be perfectly acceptable for humans to kill not only their own young, but also young animals -- to eat spring lamb but not grown sheep, veal but not steak. Though Singer does not discuss this apparent consequence of his analysis, the reader is left to wonder whether Singer, a well-known animal-rights activist and author, would really want to so limit his defense of animal lives, even if he sees little basis for protecting infant human beings.

Like his fellow utilitarian Posner, Singer ultimately seems to endorse, in part, something akin to the inviolability of life principle, suggesting that certain lives must be protected, regardless of their instrumental worth. But, where Posner appears to find the lives of young human beings inviolable, Singer would limit his argument for the inviolability of life to adult humans and animals (i.e., "rational," and "self-conscious" beings). Yet, Singer -- like Posner -- never supplies a complete account of why the lives of only some arbitrary subset of persons, rather than all, should be held inviolable and fully equal, or why his understanding of "personhood" -- embracing only adult

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[79]See Ch. IX.2, supra.

persons, but also adult animals -- is superior to traditional understandings defined by reference to a "species boundary."[80]

Further, Singer seems to mistake the inviolability of life's affirmative assertion that all human life has intrinsic and equal dignity for the negative claim that no other forms of life have intrinsic moral significance worthy of protection. A secular inviolability of life principle may not <u>mandate</u> the notion that animals have a right to life, but neither does it rule out such a position; and it certainly is consistent with the traditional view that certain ways of treating animals are morally <u>wrong</u> (even if the animal has no <u>right</u> not to be so treated). To make the argument that human lives are entitled to special and differential protection and respect is not to say that animals may be treated poorly or cruelly, but simply to say that it is not always and categorically wrong to take an animal's life intentionally.

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[80]Singer's <u>actions</u>, as opposed to his <u>writings</u>, appear to support the traditional "species-based" understanding of personhood. It has been reported that Singer has hired, at considerable expense, health care workers to provide comfort and dignity for his mother, who suffers from Alzheimer's disease and is no longer able to remember or recognize others and who, thus, may not qualify as a "person" to him. Peter Berkowitz, <u>The Utilitarian Horrors of Peter Singer: Other People's Mothers</u>, The New Republic (Jan. 10, 2000).

## IX.5 The Future of the Oregon Experiment? Oregon v. Aschcroft

I began this Chapter by suggesting that there are certain, irreducible human goods, and that human life itself is among these. From that premise, I then argued that intentional acts against human life, at least by private persons, are categorically wrong and that, on this view, assisted suicide and euthanasia -- acts which, by definition, involve acts intended to end human life -- should be ruled out. After offering this conclusion, I turned to examine and address certain prominent objections to the views I have advanced.

Having gone this far, we might take a step further and ask how the inviolability of life principle might apply in, and contribute to, related legal disputes beyond the specific question whether or not to recognize a new right to assisted suicide or euthanasia. No doubt one of the most important dispute surrounding assisted suicide in America today concerns the Bush Administration's challenge to the ability of Oregon doctors to prescribe federally controlled medicines to induce assisted suicide. This challenge, as we saw in Chapter I, resulted in a victory for Oregon in the trial, but is now pending on appeal

before the Ninth Circuit. What, we might ask, can the inviolability of life contribute to that important statutory dispute?

The case focuses on the potential application of the Controlled Substances Act ("CSA").[81] Passed in 1970 and amended in 1984, the CSA creates a comprehensive scheme for the regulation of drugs, and was enacted in part because of the congressional finding that "federal control of the intrastate incidents of the traffic in controlled substances is essential to the effective control of the interstate incidents of such traffic."[82] The CSA establishes certain categories, or schedules, of substances, and restricts access to them based on their perceived safety for use. Pursuant to the CSA, the Attorney General is entitled to promulgate rules and regulations "relating to the registration and control of the . . . distribution and dispensing of controlled substances."[83] When the CSA became effective in 1970, the Attorney General issued just such a regulation stating, among other things, that prescriptions of controlled substances must be issued

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[81]21 U.S.C. § 801, et seq.

[82]Id. § 801(6).

[83]Id. § 821.

only for "legitimate medical purposes."[84]

After Oregon's assisted suicide legislation went into effect in 1997, it soon became clear that doctors in the state intended to prescribe federally regulated medicines to kill their patients. The federal Drug Enforcement Administration ("DEA") responded by issuing an interpretive ruling informing doctors that the prescription of regulated substances to assist suicides does not constitute a "legitimate medical purpose" under the CSA and the regulations the DEA promulgated after the CSA's passage in 1970. The DEA, however, was quickly overruled by then-U.S. Attorney General Janet Reno of the Clinton Administration. Reno ruled that doctors who prescribed federally controlled substances in aid of a suicide would be subject to legal sanction under the CSA if they issue such a prescription in a state that does not authorize the practice of assisted suicide, but that doctors would receive no punishment if they issue a lethal prescription in a state where the practice is permitted (i.e., Oregon). The upshot of Reno's ruling was to abdicate federal authority under the CSA in favor of the states, allowing state-by-state definitions of what is, and is not, a

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[84]21 C.F.R. § 1306.04(a).

"legitimate medical purpose" for federally controlled substances.

In November 2001, John Ashcroft, Attorney General for the then-fledgling Bush Administration, issued a 23-page rule, reviewing the case law history of assisted suicide, professional medical views, and the statutory structure of the CSA; reversed Reno's ruling; and reinstated the original DEA position.[85] Ashcroft was careful to note, however, that his ruling did not preclude states from experimenting with "methods of assisting in suicides in which [a] . . . physician does not dispense a controlled substance" because such methods would "entail[] no violation of the CSA."[86]

The State of Oregon responded with a law suit, seeking a declaratory judgment that Ashcroft's interpretation of the CSA was wrong. The trial court sided with Oregon,[87] and the U.S. Justice Department appealed to the Ninth Circuit, where the matter is currently pending. The central legal question

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[85]17 Issues L. & Med. 269 (quoting, inter alia, Neil M. Gorsuch, The Right to Assisted Suicide and Euthanasia, 23 Harv. J. Law & Pub. Policy 599 (2000)).

[86]17 Issues L. & Med. at 272-73.

[87]Oregon v. Ashcroft, 192 F. Supp. 2d 1077 (D. Ore. 2002).

confronting the court[88] is whether the plain meaning of the term "legitimate medical practice" excludes assisted suicide,[89] or, in the event the term is held to be ambiguous, whether the Attorney General's construction of the term as excluding the practice is a "reasonable" one. To qualify as a "reasonable" interpretation under this second test, it is settled law that the Attorney General's interpretation need not be the only possible one, or even the most logical one, and should be rejected only if plainly erroneous.[90]

The Attorney General's interpretation of

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[88]Preliminary and subsequent issues also confront the court, including whether the trial court erred by declining to transfer the case to the court of appeals in the first instance, whether the State of Oregon has standing to sue, and whether the Justice Department has exceeded its powers of interstate regulation under the Commerce Clause of the U.S. Constitution. All of these are important doctrinal questions. For our purposes here, however, I am focused on what light the inviolability of life principle might shed on the central merits question before the court.

[89]See, e.g., FDIC v. Meyer, 510 U.S. 471, 476 (1994) (statutory terms should, in the first instance, be given their plain and ordinary meaning).

[90]See, e.g., Auer v. Robbins, 519 U.S. 452, 461 (1997) (courts must uphold an agency's interpretation of its own rules unless it is "plainly erroneous or inconsistent with the regulation") (internal quotation marks omitted); United States v. Mead Corp., 533 U.S. 218, 228 (2001) (agency's interpretation of a statute it is entrusted to administer is entitled to a "fair measure of deference"); Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944) (deference due to an agency's interpretation of its statute is particularly due where there is "thoroughness evident in its consideration").

"legitimate medical practice" as excluding the intentional taking of human life is, I believe, consistent with the plain meaning of the term, and certainly must at least qualify as a "reasonable" interpretation of it. As we saw in Chapter III, no American state, save Oregon, endorses assisted suicide, and the bulk of states (including many that have recently considered or reconsidered the issue) treat assisted suicide not as a "legitimate" practice, but rather as a criminally punishable act. The AMA and the nursing profession, too, we have seen, refuse to endorse the practice as a part of legitimate medical practice. And the U.S. Supreme Court in two separate decisions, Cruzan and Glucksberg, has held that the government has a rational and meaningful interest in enforcing a policy expressive of the inviolability of life, or what it called an "unqualified interest in the preservation of human life."[91] Indeed, Glucksberg expressly found that laws banning assisted suicide "reflect[] and reinforce[] [the] policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal

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[91]Cruzan, 497 U.S. at 282; quoted in Gluckberg, 521 U.S. at 728.

impulses should be interpreted and treated the same way as anyone else's."[92] The Supreme Court in Cruzan likewise found that "a State may properly decline to make judgments about the 'quality of life' that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life."[93] It would be incongruous, given such facts and law, to suggest that Congress, legislating in 1970 and 1984, plainly endorsed assisted suicide as a "legitimate medical practice," or that the Attorney General's interpretation of that operative term is an unreasonable one.

Permitting each state, meanwhile, to define "legitimate medical purposes" would eviscerate the federal regulation of drugs and effectively nullify much of the CSA. What would be the purpose of the federal government declaring that certain drugs, such as morphine or hallucinogens or marijuana, can be prescribed only for "legitimate medical purposes," if every state could then pass laws defining for itself what qualifies as a "legitimate medical purpose"? States could simply declare that treating "anxiety" or

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[92]Glucksberg, 521 U.S. at 732.

[93]487 U.S. at 282.

"mood disorders" is a "legitimate medical purpose" for such drugs; federal drug control would soon give way to a patchwork of idiosyncratic views, making trafficking in currently regulated substances difficult to control and encouraging those states willing to participate in a race to the bottom of seeing who can become the best haven for tourist drug-seekers. Nor is this eventuality conjectural. In 1996, California voters (in one of the state's famous voter referenda) legalized the use of marijuana for "medical purposes" and promptly an array of "clubs" and "cooperatives" sprang up in which marijuana was readily available for recreational use.[94] It was precisely to avoid such

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[94]According to the Drug Enforcement Agency, the notion that medical marijuana was used for "seriously ill patients is misleading." A survey conducted by advocates of the medical marijuana experiment showed, among other things, that 40% of medical marijuana was used for "chronic pain," and 15% was used for "mood disorders." The DEA indicates that there was "no state regulation or standard of the cultivation and/or distribution [of] medical marijuana. California [left] the establishment of any guidelines to local jurisdictions, which . . . widely var[ied]. For example, Marin County allow[ed] up to six mature plants, and/or a half-pound dried marijuana. Its neighbor, Sonoma County permit[ted] possession of three pounds of marijuana, and allow[ed] cultivation [of] up to 99 plants, and physicians [could] recommend more for 'exceptional patients.'" As a result, "[l]ocal and state law enforcement counterparts [could not] distinguish between illegal marijuana . . . [and that which qualified] as medical exemptions. Many self-designated medical marijuana growers [were] in fact, growing marijuana for illegal, 'recreational' use," and "high-level traffickers . . . posing as 'care givers'

results that Congress enacted the CSA with the legislative finding that federal control of intrastate distribution of drugs is "essential to the effective control" of interstate drug trafficking.[95] In 2001, the U.S. Supreme Court accepted and enforced this congressional purpose, rejecting California's argument that its view of appropriate medical purposes trumped the federal uniformity that the CSA was designed to achieve.[96]

Reading the CSA to permit the use of drugs with the intent to kill would not only be difficult to square with the inviolability of life principle and the congressional purpose of uniformity in the regulation of medicines, it would undermine the guarantee of human equality -- a frequent result, I have suggested, when the inviolability of life principle is breached. If assisted suicide should be held to qualify as a "legitimate medical practice," the question will very

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[were] able to sell illegal drugs with impunity." See Drug Enforcement Agency, California Medical Marijuana Information, <http://www.usdoj.gov/dea/ongoing/calimarijuana.html> (site visited Dec. 10, 2003).

[95]21 U.S.C. § 801(6).

[96]See United States v. Oakland Cannibas Buyers' Cooperative, 532 U.S. 483 (2001). Note, however, that the Court declined to pass on the question whether the CSA itself exceeds Congress's power under the Commerce Clause to regulate intra-state activities.

quickly become for whom? and under what circumstances? Will it be a "legitimate medical practice" to kill the old, disabled, and terminally ill, but not the young and healthy? The Attorney General's interpretive regulation reinforces the inviolability and equality of all human lives, without reference to their perceived quality, treating the suicidal impulses of all persons the same way. The alternative interpretation pressed by Oregon, meanwhile, would permit the intentional taking of some lives and thereby lead to discrimination between previously equal persons.

Oregon has argued that it is "rational" to distinguish between the terminally ill and the non-terminally ill, and its law therefore constitutional, on the ground that preventing suicides among the terminally ill "may simply mean prolonging suffering for a person who has no hope of a significant natural life ahead [and thus the state has] a valid public policy to allow choice based on principles of autonomy and self-determination."[97]

In the first place, however, it is far from clear that Oregon's scheme should be examined for mere

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[97]Lee v. Oregon, 891 F. Supp. 1429, 1434 (D. Or. 1995), overruled on other grounds, 107 F.3d 1382 (9th Cir. 1997).

rationality. Laws employing certain "suspect" classifications, such as those based on race and national origin, or impinging upon fundamental rights, receive "strict scrutiny" in equal protection challenges[98]; classifications based on grounds such as gender are reviewed sometimes under strict scrutiny and other times under an intermediate level of scrutiny requiring evidence that the classification is substantially related to an important state interest.[99] Legal discriminations based on physical health (terminally ill versus everyone else), especially when they implicate how much protection an individual's (fundamental right to) life will receive, may well qualify for heightened review.[100] Even when courts do apply a rational basis review, moreover, if the state law at issue (as here) discriminates against a particular group of persons in a manner suggesting that they possess a less valuable form of living (past cases have involved the mentally disabled, unconventional families, homosexuals, individuals having sexual relations out of wedlock), such laws are often

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[98]E.g., Strauder v. West Virginia, 100 U.S. 303 (1879); Yick Wo v. Hopkins, 118 U.S. 356 (1886).

[99]E.g., Craig v. Boren, 429 U.S. 190.

[100]See also Ch. IX.2, supra.

subjected to a particularly searching form of rational basis review -- and this is so even where the potential effects of the discrimination are far less severe than here (where mistaken killings are at issue).[101]

In any event, whatever the rubric employed to review Oregon's discrimination between terminally ill and healthy persons, a serious argument can be made that it fails to pass muster. As we saw in Chapter VII, the class of the "terminally ill" is discernible only in hindsight: patients in Oregon have waited a year or more after their "terminal" diagnoses to make use of their prescriptions, and physicians have admitted that they cannot be sure of their own "terminal" diagnoses; as Judge Noonan observed,

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[101] See, e.g., Lawrence, 123 S. Ct. at 2485 (O'Connor, J., concurring in the judgment) (arguing that anti-sodomy laws based on belief that homosexuality is "devia[nt]" should be struck down on equal protection grounds); Romer v. Evans, 517 U.S. 620 (1996) (disallowing state statute seeking to deny benefits to homosexuals); Department of Agriculture v. Moreno, 413 U.S. 528 (1973) (striking down food stamp law that precluded households containing an individual unrelated to any other members of the household from receiving food stamps on the ground that it discriminated against "hippies"); Eisenstadt, 405 U.S. 438 (overturning legal distinction in access to contraceptives between married and unmarried persons); Cleburne v. Cleburne Living Center, 473 U.S. 432, 440 (1982) (rejecting law that required homes for the mentally disabled to obtain a special use permit when other residences, like fraternities and apartment buildings, did not have to obtain such a permit).

definitions of terminal illness are "inherently unstable."[102] Why, we might ask, is it rational to rest distinctions with the effect of life or death decisions on such guesswork? Even more fundamentally, what reason is there for treating the lives of those who are diagnosed as having less than six months to live as any different from any number of other groups of persons who may wish to die -- such as the patient suffering irremediable pain, the quadraplegic, Singer's Down's syndrome infant, or Dworkin's happy and incompetent Alzheimer's patient? Why single out the "terminally ill"?

Oregon responds that keeping terminally ill persons alive simply "prolong[s] suffering." Yet, as we have seen, suffering simply is not a prerequisite for assisted suicide under Oregon's statutory regime (departing in this respect even from Dutch law). Oregon also invokes themes of patient "autonomy" in defense of its assisted suicide statute. But the goal of patient autonomy is recognized by Oregon as a sufficient reason to permit assisted suicide only for one group, and it is adjudged an insufficient reason to allow any number of other groups to obtain assistance

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[102] Compassion in Dying, 49 F.3d at 590.

in dying. Oregon's law thus vindicates the autonomy of only some persons, and not others, who wish to die, and the state has offered no rational explanation for this difference. Neither, I have suggested, is the inability of Oregon to draw such a rational line an accident. For reasons we discussed in Section 2 of this Chapter, any line we might draw among human beings for purposes of determining who must live and who may die must ultimately be an arbitrary one.

Finally, not only does Oregon's law draw an arbitrary distinction between equal human persons, it operates in a fashion that does not even rationally serve its putative purpose,[103] as can be illustrated by another case involving Oregon's assisted suicide regime. When Oregon's law was first enacted, a group of disabled persons, physicians, and other concerned citizens brought a legal challenge seeking a declaration that Oregon's law violated federal equal protection guarantees, and a federal trial court in Lee v. Oregon[104] sustained their challenge. The trial

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[103]To pass muster in a rational basis equal protection review, not only must the state pursue a rational and valid purpose, the statutory scheme employed must itself be rationally related to the state's asserted interest. Cleburne, 473 U.S. 432

[104]891 F. Supp. 1429 (D. Or. 1995).

court's decision was later reversed by the Ninth Circuit, but only on standing and ripeness grounds; the appellate panel declined to reach the merits of the trial court's equal protection holding on the ground that, because the individual plaintiffs before it were not in imminent danger of being killed as a result of constitutional defects in Oregon's law that they alleged, their claims were premature.[105] The court of appeals, thus, did not foreclose the possibility that properly situated plaintiffs may have standing to challenge Oregon's law or that the trial court's analysis might correctly apply in such a case. And that analysis is relevant here to the question how we should interpret "legitimate medical practice" under the CSA.

As a prefatory matter, however, it must be noted that the trial court in Lee unfortunately failed to consider the point (just discussed) that Oregon's law lacks even a rational basis for distinguishing between terminal and non-terminal persons, or the possibility (also explored above) that a heightened standard of review very well might apply.[106] But the court in Lee

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[105]Lee v. Oregon, 107 F.3d 1382 (9th Cir. 1997).

[106]Instead, the court summarily concluded without analysis that the state "may have a valid [i.e.,

did, assuming a rational basis review, focus squarely on the question whether Oregon's scheme rationally serves (or "fits") the State's asserted interest in promoting patient autonomy, concluding that Oregon's statute is constitutionally defective because it fails in three critical ways rationally to advance Oregon's stated goals -- and all three of these points bear on the question whether courts should accept Oregon's experiment as a "legitimate medical purpose" under the CSA consistent with the notion that human lives are equal and inviolable.[107]

First, as the trial court observed, under Oregon's law there is no guarantee that terminally ill patients seeking death will have trained mental health professionals to evaluate them for competency and signs of depression. Yet, when the state wishes to confine persons with suicidal impulses for a period not to exceed five days, the patient is first entitled under Oregon law to an examination by a mental health

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rational] public policy to allow" terminally ill patients to seek assistance in suicide. See 891 F. Supp. at 1434.

[107]Of course, the lack of a rational fit between Oregon's asserted purposes and its statutory regime would be even more intolerable under a strict scrutiny or intermediate level review.

expert.[108] It is hard to see a rational reason for a state to afford terminally ill patients less protection against the possibility of a mistaken death driven by a psychiatric ailment than it affords all patients against the possibility of a mistaken five-day confinement from the same cause. As the trial court in Lee put it, "[w]ith death at issue . . . the court is unable to conceive of a set of facts under which it would be rational to not require mental and social evaluations by appropriately trained professionals."[109]

Second, doctors helping to kill terminal patients are immunized from liability under Oregon's law so long as they act in "good faith." Yet physicians treating non-terminally ill patients are held to a duty of care commensurate with that used by careful physicians in the same or similar circumstances, and Oregon courts have expressly considered and rejected substituting this standard for a "good faith" duty of care.[110] It is unclear how a state could rationally hold physicians

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[108]Or. Rev. Stat. § 426.231, et seq. While an ordinary physician may hold mentally ill persons who are dangerous to themselves for a period of twelve hours, any further detention must be preceded by an examination from a qualified mental health expert. Id.

[109]891 F. Supp. at 1436.

[110]Id.

engaged in hangnail operations to a higher standard of care than it does physicians who engage in acts deliberately aimed at killing their patients. Nor does the lower "good faith" standard of care advance any state interest in promoting autonomous end-of-life decisions; to the contrary, it would immunize doctors from liability even when they negligently kill patients who are not competent or who have not consented -- directly undermining, rather than advancing, patient autonomy. As the court in Lee explained, there

> is no set of facts under which it would be rational for terminally ill patients . . . to receive a standard of care . . . under which it did not matter whether [physicians] acted with objective reasonableness, according to professional standards. This defect goes to the very heart of the state's reliance on a person's consent to die. The physician is allowed to negligently misdiagnose a person's condition and competency and negligently prescribe a drug overdose . . . . This distinction in the physician's standard of care . . . is not rationally related to any legitimate state interest.[111]

Finally, under Oregon's law, physicians must assess patients for consent and competency only at the time the lethal prescription is given; the statute does nothing to assure patient rationality and voluntariness at the actual time of death -- which can, as we saw in

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[111] Id. at 1437.

Chapter VII, come months (and perhaps even years) after the prescription is issued. Though Oregon's assisted suicide regime purports to promote autonomous self-determination, its law does nothing to assure such preconditions at the time death is actually sought. As a result, there is little to prevent mistake, abuse, or coercion from playing a role after a prescription issues.[112] In the trial court's words in Lee, it is irrational "to conclude that a state may sanction providing people to commit suicide without consideration of their circumstances at the time of the suicide."[113]

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[112]See, e.g., Ch. VII.6, supra (discussing the case of Ms. Cheney and her daughter).

[113]Id.

# CHAPTER X

## TOWARD A CONSISTENT END-OF-LIFE ETHIC: THE "RIGHT TO REFUSE" CARE FOR COMPETENT AND INCOMPETENT PATIENTS

### X.1 Introduction

I have suggested that life is a fundamental good, that it should not be intentionally destroyed, and I have suggested, too, how that principle might apply to the assisted suicide and euthanasia debate, as well as to the distinct yet related legal dispute over the use of controlled substances to assist suicides in Oregon. Before closing, however, one might reasonably ask what this inviolability of life principle might say about still other, far more common end-of-life scenarios. Along the way, we have discussed the decision to withdraw or reject life-sustaining care by competent patients; how, we might ask, does the inviolability of life principle apply in these important and everyday

cases? Similarly, as I alluded to previously,[1] courts have sought to give meaning to the right to refuse treatment even for patients who have never been capable of making treatment decisions for themselves (e.g., infants) and for those who have lost their ability to do so (e.g., Alzheimer patients), often permitting a guardian to decide for the patient on a proxy basis. Indeed, most of the reported right to refuse treatment cases in America have arisen in just these circumstances. But the question how far guardians may go in refusing life-sustaining care for incompetent wards who have made no living will and given no oral directives is increasingly a source of litigation in American (and English) courts. When may guardians discontinue basic (e.g., food and water) treatment? On what authority may they act? How should their decisions be reviewed when under legal challenge? The case law, to date, has produced inconsistent and often under-reasoned results in these important cases; before closing, I briefly outline some of the leading cases and suggest the beginnings of potential answers to each of these questions.

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[1]See Ch. IV.1, supra.

## X.2 The Inviolability of Life and the "Right to Refuse"

To begin, we might ask how the inviolability of life principle has fared in right to refuse treatment cases where there is a competent patient. It is fair to say, I think, that some courts have taken pains to avoid endorsing the intentional taking of life. Other courts, however, have suggested that patients may have a right to discontinue care even when they have a suicidal intent to die, and doctors may not only intentionally assist such killings, but may have a duty to do so. While a complete review of the growing case law in this area is beyond the scope of this work, a few emblematic right to refuse cases involving competent patients in America and England and how they have variously treated the question of intent are outlined below, as well as some suggestions for how the inviolability of life principle might come to inform the analysis in future disputes. We will then turn to examine separately the issues associated with incompetent patients, both infant and adult.

## Applications of the President and Directors of Georgetown College[2]

An early American case frequently cited in subsequent right to refuse treatment decisions involved Jesse Jones, a 25 year-old mother of a seven month-old child, who was brought to Georgetown University hospital's emergency room having lost two thirds of her body's blood as a result of a ruptured ulcer. Without a prompt infusion of blood, doctors estimated that there was a better than 50 percent chance Jones would die. Jones, however, was a Jehovah's Witness, a sect that historically has rejected the appropriateness of blood transfusions on religious grounds. As Jones faded in and out of consciousness, permission for a transfusion was not clearly forthcoming from her, and her husband expressly objected to any transfusion, so the hospital, fearing potential liability for being an accomplice to suicide, sought a declaratory judgment from the court permitting it to administer a blood transfusion. U.S. Circuit Judge Skelly Wright ultimately granted the declaration on the ground that, as yet, there had been no competent direction from the

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[2]331 F.2d 1000 (D.C. Cir. 1964).

patient herself and the transfusion would permit her to regain her faculties and direct her medical care. In the process, however, the Court rejected the hospital's purported concerns about assisting suicide, describing Jones's case very much in the terms of double effect doctrine and rejecting any sort of simple vitalism: "[T]he Gordian knot of this suicide question," the court correctly explained, "may be cut by the simple fact that Mrs. Jones did not intend to die. . . . Death, to Mrs. Jones, was not a religiously commanded goal, but an unwanted side-effect of a religious scruple."[3] Under such circumstances -- where death is accepted, not sought -- the Court suggested treatment plainly may be rejected without raising the issue of suicide.

## Satz v. Perlmutter[4]

Seventy three year-old Abe Perlmutter was afflicted by Lou Gehrig's disease, completely incapacitated in a hospital bed, and dependent on a respirator to breathe. He filed a petition seeking to allow his physicians to remove the respirator, after failing to do so himself. The Florida court of appeals

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[3] Id. at 1009.

[4] 362 So.2d 160 (Fla. App. 1978).

granted the petition, recognizing a right to refuse life-sustaining treatment emanating from the constitutional right to privacy and the common law doctrine of informed consent which requires physicians to obtain advance informed permission from a patient before they may undertake medical procedures. At the same time, the court -- like the court in Satz -- acknowledged the state's interest in preserving life and preventing suicide and, in turn, squarely focused on the question of intent. The court acknowledged that "the facts here unarguably reveal that Mr. Perlmutter would die, but for the respirator."[5] But, invoking the rule suggested by Georgetown College, the court held, suicide was not an issue because of the unequivocal evidence of the patient's intent: While he was "fully aware of the inevitable result . . . [t]he testimony of Mr. Perlmutter, like the victim in the Georgetown College case . . . is that he really wants to live, but do so, God and Mother Nature willing, under his own power. This basic wish to live plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment being classed as

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[5] Id. at 162-63.

attempted suicide."[6] While the facts are not further elucidated in the opinion, it appears that the court granted the petition based precisely on the strength of the double effect distinction, again recognizing that the right to refuse can extend even to basic care so long as intent to die (and help kill) is not present.

In re Kathleen Farrell[7]

This case involved a thirty seven year-old competent terminally ill patient, Kathleen Farrell, another victim of Lou Gehrig's disease. After an experimental program failed that her husband described as "their last hope" for some restorative gain, Farrell asked to have the respirator that sustained her breathing removed. Farrell's doctor later explained that he was personally opposed to removing the respirator, but he nonetheless arranged for a psychologist to examine Farrell; the psychologist found no signs of clinical depression and no need for psychiatric treatment. Farrell explained that, having

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[6]Id. Likewise, in Eichner v. Dillon, 426 N.Y.S.2d 517 (1980) the New York Court of Appeals recognized the right to withdraw a life-sustaining respirator, but also specifically added that, on the facts before it, the withdrawal of the respirator involved no "intent to die." Id. at 544 (emphasis added).

[7]108 N.J. 335, 529 A.2d 404 (N.J. 1987).

failed at her last chance for some restorative gain, she wished to discontinue the respirator because of the futility of continued care and because she was tired of "suffering." Farrell's husband filed a suit seeking a declaratory judgment that neither he nor anyone assisting his wife in disconnecting her respirator would incur liability for their actions.

The Supreme Court of New Jersey ultimately heard the case and granted the petition, holding that competent patients have a right, grounded in both the common law of battery and the constitutional right to privacy, to order a physician to leave them alone.[8] At the same time, the court, like others before it, acknowledged that the right is not an absolute one but must be tempered against the state's interest in preventing suicide and "preserving the sanctity of all life."[9] The court found those concerns were not implicated in this case, however, given a (now-familiar) causation analysis -- namely that Farrell's declination of further treatment "may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take

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[8]108 N.J. at 348, 529 A.2d at 410-11.

[9]Id.

its natural course."[10] Having acknowledged the right of patients to refuse life-sustaining treatment, however, the court stopped short of imposing a duty on an unwilling physician to participate in the process, at least to the extent it would violate professional ethical canons: "[e]ven as patients enjoy control over their medical treatment, health-care professionals remain bound to act in consonance with special ethical criteria. We realize that these criteria may conflict with some concepts of self-determination. In the case of such a conflict, a patient has no right to compel a health-care provider to violate generally accepted professional standards."[11]

Bouvia v. Superior Court (Glenchur)[12]

Former Surgeon General C. Everett Koop once labeled Bouvia, a leading California right to refuse case, as "the most forthright judicial acknowledgment

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[10]108 N.J. at 349, 529 A.2d at 411. Other cases have involved similar patients and been resolved with similar reasoning. See, e.g., Bartling v. Superior Court, 163 Cal. App. 3d 186 (Cal. 2d App. Div. 1984); Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452 (D.D.C. 1985).

[11]108 N.J. at 351, 529 A.2d at 412.

[12]225 Cal. Rptr. 297 (Cal. App. 2d 1986).

yet of a 'right' to undergo euthanasia by omission."[13] And he is perhaps correct, though even that decision technically, as a matter of legal precedent, offers no support for intentional killings. There, a 28-year-old woman, Elizabeth Bouvia, suffering from cerebral palsy sought a writ of mandamus requiring her physicians to remove from her body a nasogastric tube inserted and maintained against her will to keep her alive through involuntary forced feedings. The trial court heard evidence from Bouvia that suggested serious emotional trouble: she had suffered a recent miscarriage, her husband had left her, her parents had asked her to leave home, and she had repeatedly expressed her intent to commit suicide.[14] After hearing the evidence, the trial court refused the writ on the grounds that Bouvia had "formed an intent to die," and thus, her refusal or care would constitute a suicide which the state (and Bouvia's doctors) had no duty to assist.[15]

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[13]C. Everett Koop & Edward R. Grant, The Small Beginnings of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing, 2 Notre Dame J.L. Ethics & Pub. Pol'y 585, 629 (1986).

[14]Id. See also Michael R. Flick, The Due Process of Dying, 79 Cal. L. Rev. 1121, 1128 (1991) (physician arguing that Bouvia's demand to die was the product of mental illness).

[15]225 Cal. Rptr. at 305 (quoting trial court).

An intermediate trial court reversed, holding that

> we find no substantial evidence to support the trial court's conclusion [that Bouvia had formed an intent to die]. Even if petitioner had the specific intent to take her life [at one point], she did not carry out the plan. . . . [I]t is clear that she has now merely resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube.[16]

While it allowed Bouvia's mandamus petition, the court of appeals' decision is remarkable for the narrowness of its reasoning. The court of appeals did not hold that Bouvia's right to refuse encompassed the right to intentional self-killing by omission (i.e., suicide). It did not hold that Bouvia had a right to assistance in suicide or euthanasia from her physicians. Instead, to arrive at its result, the court took the unusual step of reversing the trial court's factual findings and simply disputed that Bouvia presently had an intention to kill herself, even if she did so previously, thus blinking at the prospect of extending the right to refuse into the terrain of intentional killing.[17]

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[16]Id.

[17]In the end, after her two year wrangle in court, Bouvia changed her mind and opted to continue her feeding tube. See Nat Hentoff, Elizabeth Bouvia and the ACLU: I Used to Go to the ACLU for Help, Now They're Killing Us, Village Voice, at 10 (July 30,

In a separate concurrence that undoubtedly influenced Dr. Koop's opinion of Bouvia, Judge Compton accused his colleagues of "danc[ing]" around the issue.[18] In his mind, there was "no doubt that Elizabeth Bouvia wants [i.e., intends] to die."[19] And, as to that, Judge Compton indicated he would recognize a right to refuse treatment even when an intent to die is present, invoking neutralist and harm principle themes: "Can anyone blame her if she wants to fold her cards and say 'I am out'? . . . I believe she has an absolute right to effectuate that decision."[20]

McKay v. Bergstedt[21]

Kenneth Bergstedt was a mentally competent 31 year-old quadriplegic who had lived in that condition since a swimming accident at the age of ten; though he was able to read, orally operate a computer, and use a wheelchair, Bergstedt was dependent on a respirator. After learning that his father had been diagnosed with a terminal illness, Bergstedt "despaired over the

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[18]Bouvia, 225 Cal. Rptr. at 1146.

[19]Id.

[20]Id. at 1146, 1148.

[21]801 P.2d 617 (Nev. 1990).

prospect of life without the attentive care, companionship and love of his devoted father," and sought to have removed the respirator on which his life depended.[22] Bergstedt's mother had died years earlier and Bergstedt feared that, without his father, he would lack adequate care and "some mishap would occur to his ventilator without anyone being present to correct it, and . . . he would suffer an agonizing death as a result."[23]

Bergstedt petitioned the Nevada courts for a declaration that persons assisting him in the removal of his ventilator would not be subject to criminal or civil prosecution.[24] Confronted with the argument that Bergstedt's death would amount to suicide, the Nevada Supreme Court, much like the appellate panel in Bouvia, strained mightily -- and somewhat dubiously -- to suggest that Bergstedt harbored no intent to kill himself: "as we will attempt to show, [Bergstedt] harbored no intent to take his life, voluntarily or

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[22]Id. at 620.

[23]Id. at 624.

[24]After the petition was granted by the lower court, Bergstedt had the ventilator removed and was dead by the time the case made its way to the state Supreme Court, which chose to hear the case anyway.

otherwise."[25] The Court, like the court in Farrell, reached this conclusion primarily by way of the natural/unnatural or causation distinction we discussed (and questioned) in Chapter IV, finding "substantial difference between the attitude of a person desiring non-interference with the natural consequences of his or her condition and the individual who desires to terminate his or her life by some deadly means either self-inflicted or through the agency of another."[26]

This analysis, perhaps unsurprisingly, provoked a dissent. Justice Springer argued, as the Second Circuit suggested in Quill, that the "[u]se of the term 'natural death' in this case is only a natural and understandable way of averting the excruciating truth. Bergstedt's explicit and express desire and intention was that of putting an immediate end to his own life . . . . There is nothing natural about Mr. Bergstedt's death; he [sought to] kill[] himself."[27] The dissent further suggested that the majority's natural/unnatural or causation distinction made no sense because "Mr. Bergstedt was not dying, except in the sense that we

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[25]Id. at 625, 627.

[26]Id. at 626.

[27]Id.

are all dying, and he was not in least danger of imminent death. He had been living steadily for over twenty-three years, breathing with the aid of a ventilator, until he reached a time in his life when he decided to die because, like most other suicides, life had become, temporarily at least, intolerable for him."[28]

Like Judge Compton in California, Justice Springer accused his colleagues of "'danc[ing]' around the issue [of suicide]'";[29] plainly, to Justice Springer, this case presented an act of intentional self-destruction. Quite unlike Judge Compton, however, Justice Springer argued that, there is no "judicially created or legal 'right' to commit suicide or to have court-ordered assistance in carrying out one's self-destruction."[30] And Justice Springer detected the equal protection overtones inherent in any abandonment the inviolability of life principle: Bergstedt's assisted suicide "was sanctioned and facilitated only because of his disabled condition . . . . What other conditions, physical or mental, I ask myself, will be brought to the courts as

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[28]Id. at 633

[29]Id. at 633 n.4 (internal quotations marks omitted).

[30]Id. at 626.

grounds for judicially approved and assisted self-destruction?"[31] If the law of homicide should be changed, Justice Springer suggested, it was not something for the courts, but for the people's elected legislative representatives to accomplish.

*The English Experience*

In re T[32]

Like Georgetown College, this case involved a blood transfusion and a Jehovah's Witness. The patient, "T," a 20 year-old woman 34 weeks pregnant and living with her boyfriend, was admitted to a hospital following a traffic accident, with symptoms of pneumonia. T's mother was a devout Jehovah's Witness, while her father rejected the religion, and the parents were divorced. T described herself as a former Jehovah's Witness when she entered the hospital, though she also stated that she still had certain beliefs and practices. Once admitted, T's condition deteriorated and she went into labor; a caesarian section birth was necessary. Twice T expressed her opposition to any blood transfusion, though both conversations came shortly after she had met alone with her mother. T

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[31]Id.

[32][1993] Fam. 95.

eventually signed a refusal of care form supplied by the hospital, which was neither read nor explained to her. The following morning, T delivered a stillborn child and her condition deteriorated to such an extent that she was sedated and placed on a ventilator; but for her expressed wishes, she would have been given a transfusion. T's father, at this point, supported by T's boyfriend, applied for a declaratory judgment that it would not be unlawful for the hospital to administer a transfusion.

The case worked its way to the Court of Appeal, which ultimately concluded that the transfusion could be given. The court began its analysis by observing that cases such as this present an apparent conflict between the patient's interest in "self-determination" and society's interest in "upholding the concept that all human life is sacred."[33] While acknowledging that the right of self-determination is of "paramount" importance, the court held that in cases where doubt exists about whether the individual is actually exercising that right, "that doubt falls to be resolved in favour of the preservation of life for if the individual is to override the public interest, [she]

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[33] Id.

must do so in clear terms."[34] This, the court held, presented just such a case because the right to refuse treatment "presupposes a capacity to do so."[35] T, the court explained, was deeply impaired by narcotic medications at the time she signed the refusal forms and made her oral statements. Doctors faced with refusals of care cannot simply defer to statements made by an impaired patient, but have a duty "to give very careful and detailed consideration to the patient's capacity to decide at the time when the decision was made. . . . What matters is that the doctors should consider whether at that time [she] had a capacity that was commensurate with the gravity of the decision which [she] purported to make."[36]

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[34]Id.

[35]Id.

[36]Id. In addition to her limited capacity, the court added that the mother's influence appeared to have overborne T's own will and suggested that courts faced with similar cases should, in the future, examine whether the patient is "very tired, in pain or depressed," such that he or she "will be much less able to resist having his will overborne" and also examine "the relationship of the 'persuader' to the patient . . . . [because] [t]he influence of parents on their children . . . can be, but is by no means necessarily, much stronger than would be the case in other relationships." Id.

## In re B[37]

While In re T stressed the care with which a finding of competence must be made in English law, it did not have occasion to address whether a fully competent person may insist on an apparently suicidal refusal of care. In re B picked up where In re T left off, raising just that question.

In re B involved a 43 year-old hospital social worker who suffered paralysis from the neck down in February 2001 due to malformation of blood vessels in her spinal cord; she was placed on a ventilator on which she became immediately dependent. In March 2001, B underwent an operation, after which she regained the ability to move her head, but no more; at that point, B asked for the ventilator to be switched off. Psychiatrists were brought in to assess B's competence, but they rendered conflicting and amended reports, with the upshot being that B was found incompetent. B was subsequently prescribed anti-depressants and, by April, reported that she was relieved the ventilator had not been turned off; in May, long-term plans were made to move B to home care or, alternatively, to a nursing home. Doctors reassessed B's competency in June, but

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[37][2002] 1 FLR 1090.

reached no firm conclusion. In July, B suffered a setback when her left lung collapsed and a bronchoscopy had to be undertaken to clear and reopen the passageway. At B's request, on August 8 another reassessment was conducted, at which time she was found competent to make a decision whether to discontinue care. In September, two further bronchoscopies were performed with B's consent, though, at some point thereafter, B sought the removal of the ventilator. Her doctors responded by offering a one-way weaning program, whereby, over a period of time, the number of breaths supplied by the ventilator is gradually reduced and the patient's body is allowed to become used to breathing on its own again. B rejected this suggestion and sought the immediate removal of the ventilator, without any weaning process, though she was informed the chances of her dying were 99%.

At approximately the same time, B filed a claim for a declaratory judgment and damages, arguing that any continued treatment would constitute a tort of trespass on the person. The parties fought primarily over the question of B's mental competency, with the hospital trust's lawyers arguing that B's mental competence was affected, among other things, by her

grave physical disability, the absence of her experience of rehabilitation, which was thought likely to be a positive experience, and the effect of so many weeks living in an ICU environment. The hospital also pointed to the history of B's ambivalence about ventilation and to her consent to bronchoscopies. Dame Butler-Sloss, however, was unpersuaded and found B sufficiently competent to make her own medical choices: "There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient . . . . I am . . . entirely satisfied that Ms. B is competent to make all relevant decisions about her medical treatment."[38]

With the issue of competency resolved, one might have expected the parties and the court to turn to and address with some care the question whether the refusal of life-sustaining care should be treated as a matter of right under the circumstances of the case. One might have expected, for example, the parties and the court to have considered whether B's refusal of care amounted to a suicidal intent to die and whether the hospital could be required to assist in a suicide, or

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[38]Id.

whether B bore no intent to die, but merely accepted death as a consequence of a rational decision that the proffered weaning program or the prospect of remaining on the ventilator carried with it too many burdens.

The parties, however, apparently did not join issue on B's intent or these related issues, apparently all assuming instead that, if competent, B had the right to make any decision regarding the removal of care -- even if suicidal in nature. Nor did the court, seemingly because it was without any aid from the litigants, explore in any meaningful way the question of suicide and its assistance. Instead, the court seemed to assume that a competent patient has a right to refuse care, even if in doing so it might evince an intent to die: "[o]ne must allow for those as severely disabled as Ms. B., for some of whom life in that condition may be worse than death."[39]

The court not only seemed to endorse a right to refuse care that would embrace suicidal decisions, it suggested that doctors who choose not to assist such decisions might be liable for at least nominal damages: the hospital's failure in this case to "have taken steps to deal with the issue . . . has led me to the

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[39]Id.

conclusion that I should mark my finding that the claimant has been treated unlawfully by the NHS hospital trust by a small award of damages."[40] In essence, the court arguably here suggested a duty to assist in suicide. Perhaps again as a result of being unaided by the parties, the court nowhere sought to explain how such a holding might be squared with the traditional legal rule holding that persons not only may decline to assist a suicide, but may actually interfere with its attempt, privileged from any claim of battery.[41]

### *The Future of the Law Surrounding the "Right to Refuse" for Competent Patients*

Plainly, as we have seen from this sampling, while the courts universally recognize the right of a competent patient to refuse unwanted care, the exact source and, perhaps more importantly, the scope of this right is confused.

Some courts (e.g., Georgetown College, Satz, and In re T) emphasize that patients are free to refuse life-sustaining treatment, at least when no intent to die is present, and some (especially illustrated by In

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[40]Id.

[41]See Ch. III, supra.

re T) seek strenuously to ensure that any rejection of care is indeed made while the patient is competent in order to guard against potential abuse, mistake, and coercion.

Other courts, however, have claimed to acknowledge that the state has a legitimate interest in preventing the intentional taking of human life, but then arguably have "danced" around its fair application to the facts before them (e.g., Bouvia, McKay), seeking, somewhat disingenuously, to avoid admitting that the patients before them intend to kill themselves.[42]

Still other courts and judges have not attached much significance at all to the state's interest in preventing the intentional taking of human life (and thus preserving the equality of all lives), suggesting that competent patients may direct the discontinuation of care without regard to whether they intend death (e.g., Judge Compton in Bouvia, In re B).

What does the inviolability of life principle have to contribute to this muddled legal landscape? Several

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[42]This is not to say that persons in the shoes of Bouvia or Bergstedt -- non-terminal patients dependent on medical intervention -- cannot refuse care that will foreseeably result in their deaths; it is only to say that the facts in those cases seem to suggest Bouvia and Bergstedt did, in fact, intend to kill themselves.

things, I think.

On their facts, Georgetown College, Satz and Farrell each involved patients who apparently wished to live but were held entitled to execute a competent decision to refuse life-sustaining treatment. Such cases illustrate that a right to refuse treatment limited to refusals where no suicidal intention is present is a far cry from a vitalist's demand that life-sustaining care may never be declined. Patients can refuse even the most "basic" forms of care (e.g., blood transfusions) for a variety of reasons (e.g., to abide one's religious beliefs, to forgo futile care and avoid the strains of continued dependence on medical machinery) without implicating suicide. Indeed, as we discussed in greater detail in Chapter IV.6, we have every reason to think that the right to refuse is usually exercised in just such circumstances -- the patient usually wishes to live, but sees no point in further futile care or no longer wants to tolerate the burdens of the respirator, the chemotherapy, the radiation treatment. Patient and doctor may foresee death, even accept it as the inevitable consequence of the decision to forgo treatment, but that is not to say (and indeed it is far from saying) that they seek out

death. An inviolability of life principle, thus, is by no means a vitalist's demand that society use maximum efforts to keep all patients alive; instead, it affords a wide berth of liberty in which patients may refuse even seemingly simple treatment and may do so even where death is foreseen as a complete certainty.

At the same time, virtually every court to recognize the right to refuse has held that the right, whatever its source, is not absolute (e.g., Satz, Farrell).[43] And, in fact, to deem as a matter of right all patient refusals of care, even in order to commit suicide, could reasonably be said to amount to an implicit endorsement of a right to assisted suicide by omission. In re B hints at how the argument would proceed: if a patient has an absolute right to refuse care (including with an intent to commit suicide), why not permit the patient to solicit volunteers to assist him or her? Taking the argument a step further (as In re B suggests), if a medical practitioner refuses to assist the patient, why shouldn't he or she become liable (including perhaps in damages) for violating the

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[43]See also Meisel, The Right to Die § 3.2, at 45 (collecting cases). Indeed, battery doctrine traditionally has included an exception permitting volunteers to intercede to prevent an act of suicide. See Ch. III, supra.

patient's protected right? Further, as Justice Springer noted in McKay and we developed more fully in Chapter IX, recognizing a right to assisted suicide by omission that is contingent on a patient's physical or mental condition will lead to discrimination among persons based on judicial perceptions about the comparative value of different human lives. And while some decisions we have reviewed seek to distinguish between refusals of care where an intent to die is present from assisted suicide on causation grounds (e.g., Farrell, McKay), much as some courts sought to do in the Quill controversy, we have already seen how tenuous a distinction that may prove.[44]

A right embracing suicidal refusals of care not would only run contrary to the inviolability of life principle and raise serious questions of equal protection, it would also disregard repeated state statutory guidance. As we saw in Chapter III, most American jurisdictions have laws banning the practice of assisted suicide (i.e., assisting someone intentionally seeking self-destruction), and many of these statutes have been expressly reexamined and reaffirmed in recent years. So, too, the bulk of

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[44]See Ch. IV.2, supra.

American states have enacted advance medical directive statutes that preclude courts from construing any living will or advance medical directive authorized by state statute to "authorize . . . mercy killing or physician assisted suicide or to permit any . . . deliberate act or omission to end life."[45] To be sure, these state medical directive statutes formally pertain only to the construction and interpretation of medical directives left by formerly competent persons, not to refusals of care voiced by currently competent persons, but the policy embodied in these statutes is in no way logically contingent on the patient's competency.

Finally, though I have suggested that suicidal patients such as Bouvia should not be said to enjoy a right to refuse treatment with suicidal intent, it bears recalling that patients who in fact commit such acts commit no crime at law: as with any act of suicide, the patient is performing something that, as we saw in Chapter III, is, under law, considered neither a matter of right nor of crime. Should the suicidal patient find a physician or other person willing to assist them in effecting the termination of

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[45]Ill. Comp. Stat., ch. 755, § 35/9(f) (emphasis added). For many other analogous examples, see Ch. III, supra.

treatment, moreover, the appropriate legal analysis is subtle: As I explored in Chapter IV and IX, assisted suicide is a narrowly defined offense dependent on a showing of the assister's purpose and, so, if the assisting doctor harbors no intent to make the patient dead, but, say, simply discontinues treatment to fulfill his professional obligations, that is no crime. Equally, however, a suicidal patient should have no right to compel a doctor to assist in the intentional taking of human life -- an act which would run contrary to the inviolability of life principle, constitute a crime in jurisdictions proscribing assisted suicide, and (as Farrell, quite unlike In re B, seemed to notice) amount to a violation of professional medical ethics canons prohibiting (as the AMA has recognized[46]) acts undertaken with the intention of seeing a patient dead.[47]

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[46]See Ch. IV.6, supra.

[47]To be sure, the requirement of proof regarding the assister's intention sets a high bar before the government may enmesh itself in private affairs, and prosecutions are purposefully rare. As we saw in Chapter IV, some, such as John Griffiths, reject focusing on intention and therefore see no distinction between refusals of care and assisted suicide. Precisely because of this absence of any distinction, Griffiths seeks to impose a comprehensive state-run "regulatory regime" that would treat refusals of care, provisions of palliative care, assisted suicide, and even non-voluntary euthanasia as an undifferentiated mass -- presumably imposing the same consultation

## X.3 The "Right to Refuse" and Infant Patients

Turning from competent to incompetent patients, the "right to refuse" has been extended to and applied in many cases involving both infants and disabled adults and, given the absence of a competent patient able to make her own decisions, concerns associated with abuse and mistake at the hand of proxy decisionmakers naturally increase. In this section, I attend to some of the leading cases in the infant care context, the issues they raise, and the role the inviolability of life principle might play in such disputes.

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requirements, waiting periods, and reporting requirements that are currently required for assisted suicide and euthanasia in jurisdictions where they are lawful. Such global state intervention is not logically dictated, however, for those who recognize an intent-based distinction between various of these practices -- and Griffiths himself acknowledges that many doctors he interviewed were "critical" of his comprehensive regulatory proposal precisely because they sense assisted suicide cases to be different and meriting different treatment from the run cases involving the refusal of treatment precisely because the former cases necessarily involve the intentional taking of life and the latter cases do not. See Griffiths, Euthanasia & Law 297 n.65.

## Baby Doe (Indiana)[48]

"Baby Doe" (an appellation used to protect the family's privacy) was born in Bloomington, Indiana, on April 9, 1982 with two congenital anomalies, Down's syndrome and esophageal atresia with tracheoesophageal fistula. Down's syndrome is an chromosomal disorder that involves both a certain amount of physical deformity and some degree of mental retardation.[49] Esophageal atresia with tracheoesophageal fistula means that the esophageal passage from the mouth to the stomach ends in a pouch, with an abnormal connection between the trachea and the esophagus. As a result, food and drink pass to the lungs instead of the stomach, eventually resulting in suffocation unless

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[48]In re Infant Doe, No. GU8204-004A (Monroe County Cir. Ct. Apr. 12, 1982) (unpublished declaratory judgment) at 1.

[49]"Virtually all individuals with Down's syndrome have some degree of developmental retardation. The range of IQ scores has been wide, but most individuals are trainable by adulthood. Social skills usually are closer to the normal range than performance abilities . . . . The degree of mental retardation is quite variable, but most children learn to walk and develop some communication skills; there is a steady progress of development, at a slower pace than usual . . . [and c]hildren reared at home have higher IQs than those reared in institutions." A. Rudolph, Pediatrics 244 (17th ed. 1983).

surgery is performed to correct the malformation.[50] Surgery to correct esophageal atresia with tracheoesophageal fistula is routinely performed with success, but the parents of Baby Doe refused to consent to the surgery.

Shortly after Baby Doe was born, a hearing was held at Bloomington Hospital to determine whether the parents had the right to refuse the surgery on behalf of their child. An attorney was present at the hearing to represent the parents, though no one was present to represent Baby Doe's interests. Six physicians attended, three of whom had obstetric privileges and three of whom had pediatric privileges at Bloomington Hospital. The obstetricians "recommended that the child remain at Bloomington Hospital with full knowledge that surgery to correct tracheoesophageal fistula was not possible at Bloomington Hospital and that within a short period of time the child would succumb due to inability to receive nutriment and/or pneumonia."[51] The pediatricians, meanwhile, stated that the appropriate treatment was to undertake corrective surgery immediately, and one of the pediatricians

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[50]See R. Behrman & V. Vaughan, Nelson Textbook of Pediatrics 893-94 (12th ed. 1983).

[51]In re Infant Doe, declaratory judgment at 1-3.

testified that the child might enjoy a reasonable quality of life.[52] The dispute wound up in a state court where the trial judge concluded that the parents had the right to refuse corrective surgery even though their child would die.[53] The Indiana Supreme Court refused to hear an appeal, and the child died on the sixth day after he was born while a guardian ad litem was on his way to Washington, D.C., to appeal the case to the United States Supreme Court.[54]

## Phillip B[55]

In re Phillip B. involved a 12 year old California boy with Down's Syndrome with a ventricular septal defect in need of surgical correction. The court received evidence from cardiologists that the risk of death from the procedure was normally between 5 and 10 percent, though Down's Syndrome children face a higher than average risk of postoperative complications. Without the operation, Phillip was certain to become severely incapacitated and his life span would be

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[52]Id.

[53]Id.

[54]No Decisions Yet on Possible Prosecution, Bloomington Sunday Herald-Times, at 1, col. 3 (Apr. 10, 1983).

[55]In re Phillip B., 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), cert. denied, 445 U.S. 949 (1980).

significantly diminished. The parents refused to grant permission for the operation, and a trial court affirmed the decision as "within the range of debateable action."

On appeal, the state's intermediate court of appeals began by noting that

> parental autonomy . . . is not absolute. The state is the guardian of society's basic values. Under the doctrine of parens patriae, the state has a right, indeed, a duty, to protect children. . . . State officials may interfere in family matters to safeguard the child's health, educational development and emotional well-being. One of the most basic values protected by the state is the sanctity of human life. (U.S. Const., 14th Amend., § 1.) Where parents fail to provide their children with adequate medical care, the state is justified to intervene.[56]

The court, however, held the state "should usually" defer to the wishes of the parents, and that it has a "serious burden" to carry before parental wishes can be overcome. In deciding whether the state had carried that burden in the case before it, the court explained:

> Several relevant factors must be taken into consideration . . . . The state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; the evaluation for the treatment by the medical profession; the risks involved in medically treating the child; and the expressed preferences of the child. Of course, the

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[56]Id., 92 Cal. App. 3d at 801, 156 Cal. Rptr. at 51.

> underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment.[57]

In applying the foregoing standards to Phillip's case, the court of appeals did not directly endorse the trial court's result, finding instead merely that its decision "attempt[ed] to balance the possible benefits to be gained from the operation against the risks involved."[58] The trial court had before it a child "suffering not only from a ventricular septal defect but also from Down's Syndrome, with its higher than average morbidity, and the presence of pulmonary vascular changes."[59] "In light of these facts," the appellate panel held, "we cannot say as a matter of law that there was no substantial evidence to support the decision of the trial court."[60]

John Pearson

A third prominent case, involving the British infant John Pearson, pushed the boundaries of infant non-treatment yet further. John was a Down's syndrome

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[57]Id.

[58]Id.

[59]Id.

[60]Id., 92 Cal. App. 3d at 803, 156 Cal. Rptr. at 52.

baby with no other apparent abnormalities. When John's mother was given the news of his handicap, she reportedly told her husband, "I don't want it, Duck." Later that day, the baby was examined by Dr. Leonard Arthur who gave the instruction that the child was to be sedated with a pain-killer and given water but no food. By the evening of his first day, John was "going grey"; within 69 hours after birth, he died.

Dr. Arthur was charged with murder. The court, however, permitted only an attempted murder charge to go to the jury after an autopsy established that John also suffered from pneumonia and a heart defect and, thus, may have died of "natural" causes rather than from physician-directed starvation. At trial, medical professionals testified both for and against Dr. Arthur. One, the President of the Royal College of Physicians, Sir Douglas Black, opined that when "a child [is] suffering from Downs and with a parental wish that it should not survive, it is ethical to terminate life." (Notably, only 15% of the Dutch public agree with this proposition.[61]) Before submitting the case for decision, the judge summed up and, in doing so, described Dr. Arthur's directions as

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[61]See Griffiths, Law & Euthanasia 200.

a mere "holding operation," despite much contrary evidence; expressed open doubt whether an omission of care ("simply allowing the child to die") can be murder; suggested that a life in an orphanage may not be worth living;[62] and directed the jury to "think long and hard before deciding that doctors of the eminence we have heard . . . have evolved standards which amount to committing a crime." The jury acquitted on the remaining attempted murder charge, leading some to speculate about the role and influence of the judge's thinly-disguised endorsement of the defendant's conduct.[63]

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[62]Specifically, the judge remarked that, "[i]n nearly every case [involving a Down's syndrome child] if the parents want the child the doctor will give them every encouragement to have it and keep it. But if not[,] the likelihood of the child ever being taken into another family, either by adoption or fostering, is very remote and the most likely course is that it will be placed in some form of institution. So it is not just a simple question of saying: it is a mongol child; it will have to be put down. It is a case, say the defence, in putting this case before you, of where the most careful and agonising consideration has to be given as to what should be done in the best interests of the child." Quoted in Luke Gormally, Note: Regina v. Arthur, in Euthanasia, Clinical Practice and the Law (hereinafter, "Gormally, Note") 104-07 (1994).

[63]For details and views on the unreported Pearson case, see Gormally, Note; Helga Kuhse, A Modern Myth. That Letting Die is Not the Intentional Causation of Death: Some Reflections on the Trial and Acquittal of Dr. Leonard Arthur, 1 Journal of Applied Philosophy 21-38 (1984).

What would the principle that life is a fundamental and inviolable good mean for Baby Doe, Phillip B., John Pearson and cases like theirs? Would it mean any and all treatment must be provided to infants born with Down's syndrome, spina bifida, and other serious maladies? If not, when and under what circumstances can treatment be withheld? A few overarching concepts can be discerned from the cases.

First, John Pearson's case demonstrates as surely as any the moral superfluousness of the act-omission distinction. Here was an infant with a full life expectancy whose only defect apparent to anyone at the time was Down's Syndrome. (His other maladies became evident only upon autopsy.) All he seemingly required was food, but that was deliberately withheld from him with the specific design of killing him. While the jury may have developed sympathy for the apparently well-regarded physician (perhaps at the judge's very active prodding), Dr. Arthur's conduct was undeniably an attempt to kill.

Second, these cases highlight the need for a mechanism to permit parents feeling understandably

overwhelmed by the prospect of caring for handicapped children to give up legal custody. Simply because a parent is unable to cope (as John Pearson's mother put it, "I don't want it, Duck"), and the child may be relegated to an orphanage or foster care, should not mean that the child's right to life may be forfeited. Without such intervention, we run the risk of acquiescing to Peter Singer's "replaceability" ideal, in which an infant's right to live depends on parental satisfaction.

Third, Phillip B. highlights the importance of the appropriate standard of judicial review when cases of alleged parental neglect do arise. In Phillip B., the courts permitted but never endorsed the parents' decision to deny treatment to their twelve-year old son, describing it as, at best, a "debatable" decision and declining to overturn that decision primarily because of traditional notions that parents are due a wide berth in making child-rearing decisions. But it does not follow from the settled common law principle that parents get to choose how to raise their child (what schools they should attend, etc.) that parents also get to choose whether the child lives or dies; the case for a more searching standard of review is

bolstered by the fact that anytime a patient's "refusal of care" is more fictional than real, being made not by an individual but for him by others, the possibility of (often hard-to-defect) selfish motives necessarily arises. Had the parents' decision in Phillip B. been reviewed under a less deferential standard, the result might very well have been different, and this is an area where, if the courts fail to act, legislatures might productively enter the field.

Fourth, the cases we have examined raise the related question whether judges and jurors (and parents) have made silent judgments about the relative worth or worthwhileness of the infant's life. In each instance the treatment needed to save the child was relatively simple: Baby Doe needed a routine operation; the proposed operation on Phillip B. had a 5%-10% chance of mortality (death was certain to follow without the operation), and a high likelihood of ensuring a normal life span; John Pearson appeared to require no medical attention, just food like any other infant. Had the infants been physically and mentally healthy, can we imagine that the courts would have acceded to parental decisions to starve John Pearson to death, or to forgo treatment of Phillip B. and Baby

Doe? If starving a child to death is an abuse of parental discretion for a "normal" child, from an inviolability of life perspective it must also be an abuse of discretion if the child is handicapped for all persons are equal, with each person enjoying the right to life no less than any other person. So, too, with forgoing treatment that is affordable, available, safe, and promises to return the child to health: the relevant issue should not be whether the child is handicapped or healthy, but the quality and nature of the proposed treatment.[64]

How do the foregoing general principles apply to the Baby Doe cases we have discussed? Taking John Pearson's case first, the "treatment" at issue there would have imposed little burden on anyone and appeared likely (so far as anyone knew at the time) to promise complete health to the child. Baby Doe and Phillip B. required progressively more extensive treatment with progressively higher risks. But there was no evidence that the contemplated treatments would have imposed any undue expense on the parents or threatened worsened health for the children; to the contrary, the proposed

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[64]See generally John Keown, Restoring Moral and Intellectual Shape to the Law After Bland, 113 L.Q.R. 481 (1997).

operations, according to the evidence submitted, were relatively simple and promised complete restorative gain. Further down the continuum, one can readily imagine cases where the proposed treatment is riskier, more dangerous, and less likely to assist the child; in such circumstances, a parental refusal of treatment would be easiest of all to sustain.

Perhaps seeking to set forth bright line rules rather than leave the issue to an often subjective case-by-case adjudication, Congress, shortly after the Baby Doe incident, amended the Child Abuse Prevention and Treatment Act with legislation that provides a model of how the inviolability of life logic might be applied in end-of-life legislative solutions.[65] In order for states to be eligible for federal funding

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[65]The Department of Health and Human Services also promulgated new regulations under Section 504 of the Rehabilitation Act of 1973 forbidding discrimination by parents against handicapped newborns. When the federal government requested a hospital's records to see if there was a violation of its rule, however, a legal challenge ensued and the U.S. Supreme Court eventually overturned the Department's rules, holding that Congress's intent in banning discrimination based on handicap under Section 504 was to focus upon discrimination by federally funded doctors and agencies; such a law was too thin a reed on which rest the promulgation of regulations directed at parents, especially when the states, not the federal government, have traditionally overseen and regulated the parent-child relationship. See Bowen v. American Hospital Ass'n, 476 U.S. 610 (1986).

under the Act, the amendment requires state authorities, among other things, to establish procedures to identify and report to child protective service officials potential cases of "medical neglect," which is now expressly defined to include the "withholding of medically indicated treatment."[66]

Not all decisions to withhold treatment, however, are subject to scrutiny. The "withholding of medically indicated treatment" means the

> failure to respond to an infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions.[67]

To trigger the statutory reporting requirement, the non-treatment must result in a life-threatening condition. Even when the withholding of treatment is life-threatening, the statute comes into play only if the

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[66]Specifically, the state must formulate a plan to ensure "prompt notification by individuals designated by and within appropriate health-care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions); and . . . authority, under State law, for the State child protective services system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction." 42 U.S.C. § 5106a(b)(2)(A).

[67]42 U.S.C. § 5106(g).

treatment withheld would be "most likely" to "ameliorat[e] or correct[]" the life-threatening condition. Thus, medically risky and untested treatment may be withheld and so may tested treatment that is not likely to substantially benefit the infant. This series of statutory steps confines close review of parental decisions to life-or-death situations and tracks precisely the inviolability of life's focus on the quality of the proposed treatment rather than on the quality of the infant's life.

While the statute provides general guidelines for when treatment may be withheld, it also enumerates certain specific conduct for which it offers a "safe harbor" from charges of medical neglect. These include decisions to withhold treatment when:

> (A) the infant is chronically and irreversibly comatose;
>
> (B) the provision of such treatment would -
>
> (i) merely prolong dying;
>
> (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or
>
> (iii) otherwise be futile in terms of the survival of the infant; or

(C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.[68]

Even in these circumstances, however, the physician is always required to provide nutrition and hydration.[69]

Peter Singer charges that "[t]here are quality of life judgments lurking under all of" Congress's safe harbor statutory provisions; these lurking quality of life judgments are so obvious, Singer asserts, that they "should need no further spelling out."[70] In fact, however, Congress's safe harbor provisions focus on whether treatment will have beneficial or inhumane effect, not on whether the patient's quality of life meet certain arbitrary criteria. The statute requires a comparison of the infant's after-treatment condition against his or her current life-threatening condition, not against some standard of human functioning that someone has judged to be necessary to merit protection by the state. The law allows nontreatment when the potential for restorative gain is low or the treatment would be inhumanely burdensome on the infant. Under

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[68]Id.

[69]Id.

[70]Peter Singer, Rethinking Life and Death 115 (1994) (hereinafter, "Singer, Rethinking").

subsection (A), the proposed treatment by definition must be incapable of providing restorative gain: the child must be in an "irreversible" condition. Subsection (B) endorses withholding treatment only when treatment would "merely" (that is, "only") prolong dying (thus not offering the promise of any restorative gain). Subsection (C) expands the safe harbor to "virtually futile" treatment. Though the statute fails to define the modifier "virtually," Congress gave some sense of its intent to restrict this safe harbor provision to narrow circumstances: the treatment, if not strictly useless, must be not only "virtually futile," but also "inhumane."

Singer argues that terms like "'medically beneficial' serve[], like the term 'futile,' to disguise the fact that a quality of life judgment is being made."[71] To be sure, provisions authorizing the discontinuance of treatment where it is "futile" or not "medically beneficial" do not require the use of maximum efforts to preserve life in all cases. But that does not mean they differentiate between cases based on quality of life assessments. To the contrary, under the statutory regime, determining whether

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[71] Id. at 112.

nontreatment is a justified option in no way depends on whether the child is handicapped or healthy, only whether the proposed treatment is likely to help; all lives are treated equally.

Despite Congress's statute, there remains room for state legislation. All that hinges on compliance with the federal law is the continuation of federal funding for certain child abuse programs. Moreover, federal law requires that health care providers only report violations; it does not assure intervention. In the American federal system, Congress is, of course, hamstrung in regulating many internal state affairs. Some states have already passed laws worthy of consideration, including Indiana in the aftermath of the Baby Doe incident there, and Arizona. In Indiana, an investigation by child protection services is triggered when a "handicapped child . . . is deprived of nutrition that is necessary to sustain life," or "is deprived of medical or surgical intervention that is necessary to remedy or ameliorate a life threatening medical condition, if the nutrition or medical or surgical intervention is generally provided to similarly situated handicapped or non handicapped

children."[72] In Arizona, consistent with the inviolability of life principle and eschewing the act-omission distinction, medical workers and hospitals are prohibited from withholding "nourishment" or "necessary lifesaving medical treatment or surgical care" from handicapped infants "with the intent to cause or allow the death of the infant for any reason."[73] If a violation is detected by a health care worker, it must be reported to state authorities and the individual reporting the violation is legally protected from workplace recriminations.[74]

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[72]See Ind. Code Ann. § 31-34-1-9.

[73]Ariz. Rev. Stat. Ann § 36-2281(A) & (B) (emphasis added).

[74]Id. § 36-2284(D). Drawing the line between ordinary cases where parental decisions are given wide latitude and life and death decisions where they are reasonably subject to greater scrutiny, the Arizona statute adds that "[t]his section shall not be construed to prevent an infant's parent, parents or guardian from refusing to give consent to medical treatment or surgical care which is not medically necessary, including care or treatment which either: 1. Is not necessary to save the life of the infant. 2. Has a potential risk to the infant's life or health that outweighs the potential benefit to the infant of the treatment or care. 3. Is futile treatment or treatment that will do no more than temporarily prolong the act of dying when death is imminent." Id. § 36-2284(C). The statute adds a further layer of deference to doctors by providing that "[i]n determining whether any of the possible medical treatments will be medically necessary for an infant, reasonable medical judgments in selecting among alternative courses of treatment shall be respected." Id. § 36-2881(D).

*The Case of Mary and Jodie*

In September 2000, in a case captioned In re A,[75] the English Court of Appeal addressed some of the most fundamental end-of-life questions facing family and criminal law in the infant patient context. While the facts in that case involved newly born conjoined twins and were somewhat extraordinary, the legal questions presented go to the very core of how life-and-death decisions are made for young children, and what principles should apply to guide decisionmakers.

Mary and Jodie were born joined at the pelvis and the lower ends of their spines were fused. Internally, each twin had her own brain, heart, lungs, liver, and kidneys; the only organ they shared was a bladder. But, critically, Jodie's heart supported both infants. Medical observation showed that Jodie was intelligent, healthy, and doctors believed that, if separated, she could live a relatively normal life. But doctors also found that Jodie's heart was suffering terrible strain from having to support her sister Mary as well as herself.

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[75]See In Re A, [2001] Fam. 147.

Mary, meanwhile, was in a much different condition. Her heart was malformed; if Jodie's heart was not also pumping blood and oxygen through Mary's body, Mary would have died almost immediately after birth. Mary's lungs and brain were also seriously malformed. Doctors confirmed that Mary had no prospect of living independently of Jodie, and that Mary's only hope of survival rested on Jodie's heart. Yet, doctors conjectured that the strain on Jodie's heart from having to support both infants would eventually, indeed, soon, lead to heart failure and the death of both twins if they remained conjoined. Doctors estimated that both infants would die within a matter of weeks or months if no action was taken to separate them.

Mary and Jodie's parents were devoutly religious and interpreted their faith as preventing them from seeking the separation of the twins, nor could they contemplate that one of their children might die to enable the other to survive. The hospital filed suit seeking an order allowing it to disregard the parents' wishes and separate the twins. The hospital wanted to save Jodie, but did not want to be held criminally liable for Mary's certain death, and it was also unsure

whether it could trump the parents' stated wishes for their own children. The case quickly arrived at the Court of Appeal.[76]

On the question who is permitted to decide Mary and Jodie's fate, the three-judge panel reached unanimous agreement and their views were summarized by Lord Justice Ward in a way that is entirely consonant with the inviolability of life principle and that should supply a model for future courts. When the patient is incompetent or a minor, the Court reaffirmed the traditional Anglo-American principle that the parents normally have the right to step into their children's shoes and make treatment decisions. But, the Court emphasized, there is a close link between the right to make treatment decisions and the duty to do so responsibly; a parent's failure to agree to necessary medical treatment can be a culpable omission.[77] As long ago as Blackstone, the Court noted, it was accepted that parental power over children "exists to enable the parent more effectively to perform his duty, and partly

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[76]For a detailed description of the twins' medical condition and the facts of the case, see id.

[77]Contrast this with another English decision -- Bland -- where the Lords failed to acknowledge that omissions of care can amount to a violation of a duty of care (and murder). See Ch. IV.2, supra; Ch. X.3, infra.

as recompense for his trouble and care in the faithful discharge of it."[78]

That is not to say parental wishes are readily ignored: in family law, parental decisions are usually reviewed only for whether they fall within a wide "band of reasonable[ness]."[79] But when it comes to the exceptional question of life or death, the Court held, the parents' decisions cannot be afforded such latitude; when contested, all life and death decisions -- even parental decisions -- deserve a more searching review:

> An appraisal of parental reasonableness may be appropriate in other areas of family law (in adoption, for example where it is enjoined by statute) but when it comes to an assessment of the demands of the child patient's welfare, the starting point -- and the finishing point too -- must always be the judge's own independent judgment.[80]

Very much unlike most of the infant cases we have explored, In re A correctly observed that, while courts ordinarily defer to parental choices about how children should live and be raised, parents have not historically been afforded such deference over life and

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[78]In Re A, [2001] Fam. 147.

[79]Id.

[80]Id.

death decisions, nor should they be granted such wide berth when the consequence of error is homicide.

Turning from procedural issues to the question who decides to the substantive question whether the operation might constitute the murder of Mary under criminal law, the Court's reasoning was far less satisfactory. The Court certainly heard from counsel the argument that the principle of double effect should be applied -- that the death of Mary, while foreseeable, could not be said to be part of the doctors' intentions in carrying out the operation, and, thus, that there would be no basis for calling the doctors murderers for carrying out an operation to save Jodie's life. The appellate judges, however, considered themselves bound by Woollin's expansive understanding of "intent," under which, as we saw in Chapter IV, persons may be deemed to have "intended a death," even when they (only) foresee serious bodily harm as virtually certain to result from their conduct.[81] The double effect principle, as Lord Justice Ward recognized with a degree of understatement, "may be difficult to reconcile with Woollin";[82] indeed, as we

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[81] See, e.g., id. (opinion of Lord Justice Ward).

[82] Id.

explored in Chapter IV, Woollin is fundamentally inconsistent with double effect doctrine, conflating the analytically separate concepts of intent and foreseeability.

Constrained by the House of Lords's decision in Woollin, the judges in the Court of Appeal found no question, on the evidence before them, that the death of Mary was virtually certain to follow from the operation: "[u]npalatable though it may be . . . to stigmatize the doctors with 'murderous intent,' that is what in law they will have if they perform the operation and Mary dies as a result."[83] As Lord Justice Brooke put it,

> there are certainly some powerful dicta in support of a proposition that if a surgeon administers surgical treatment in the best interest of his or her patient and with the consent (except in an emergency) of the patient or his or her surrogate, there can be not question of a finding that the surgeon has a guilty mind in the eyes of the criminal law,

but, nonetheless, after Woollin,

> an English court would inevitably find that the surgeons intended to kill Mary, however little they desired that end, because her death would be the virtually certain consequence of their acts, and they would realise that for all practical purposes her death would invariably follow the

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[83] Id.

clamping of the common aorta.[84]

Feeling unable to distinguish between intent and foresight for purposes of English criminal law after Woollin, the judges in the Court of Appeal each struggled more or less unsatisfactorily to find other ways to defend the doctors' conduct as something less than "murder." Lord Justice Ward sought to invoke the concepts of self-defense and defense-of-others to justify Mary's death. The (so-called) "intentional" killing of Mary was justified, he argued, because Mary constituted an "unjust aggressor" who was, in effect, attacking her sister:

> The reality here -- harsh as it is to state it, and unnatural as it is that it should be happening -- is that Mary is killing Jodie. . . . How can it be just that Jodie should be required to tolerate that state of affairs? One does not need to label Mary with the American terminology which would paint her to be an 'unjust aggressor,' which I feel is wholly inappropriate language for the sad and helpless position in which Mary finds herself. . . . [But] I can see no difference in essence between th[e] resort to legitimate self-defence and the doctors coming to Jodie's defence and removing the threat of fatal harm to her presented by Mary's draining her life-blood. The availability of such a plea of quasi self-defence . . . makes the intervention of the doctors quite lawful.[85]

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[84] Id.

[85] Id.

Lord Justice Ward's colleagues declined to follow this reasoning, recoiling from the suggestion that Mary was in any sense "an unjust aggressor"; to Lord Justice Walker, "[i]t would be absurd to suggest that Mary, a pitiful and innocent baby, is an unjust aggressor."[86] As we saw in Chapter IX.3, however, the term "unjust aggressor" is something of a misnomer: Lord Justice Ward is correct that, to invoke the doctrines of self-defense or defense-of-others, it does not formally matter whether the "aggressor" is unjust or innocent, only that the threat faced, (i) is employed without the consent of the person against whom it is directed, and (ii) is not affirmatively privileged at law.

Lord Justice Brooke, largely followed by Lord Justice Walker, relied on the (now-familiar) argument that the intentional killing of Mary was "necessary." In doing so, Lord Justice Brooke offered a lengthy history of the application of necessity doctrine in other common law arenas, but ultimately was unable to identify meaningful precedent for applying the doctrine in the realm of intentional homicide, and was forced to rely instead on the persuasive force of "modern

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[86] Id.

academic writ[ings],"[87] which, he argued, would protect the doctors because their "conduct was not harmful because on a choice of two evils the choice of avoiding the greater harm was justified."[88]

As we saw in Chapter IX.3, introducing necessity as a defense, at least to cases involving a true intentional taking of human life, raises with it potential risks. If some human lives may be taken intentionally, which lives may be so taken? And who is to be the judge? The fundamental guarantee of equal protection for all human lives can be placed at risk if courts may pick and choose which human lives may be extinguished and which may not. Lord Justice Brooke acknowledged such concerns about the implications of necessity doctrine for the inviolability of life and equal treatment among all persons but responded by arguing that, in this particular case, Mary had "self-designated" herself as the appropriate one of the twins to be killed because there was no way to "extend her life beyond a very short span."[89] Accordingly, Lord Justice Brooke seemed to suggest, unlike other cases of

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[87]Id.

[88]Id.

[89]Id.

where necessity had been rejected as a defense to intentional homicide (e.g., Dudley and Stephens), here comparative value judgments about the importance of different human lives need not enter the picture. But is this really so?

To be sure, the case of conjoined twins is certainly unusual, but if a conjoined twin can "self-designate" herself for intentional killing without consent because she lacks any prospect for an extended life span, how much of an analytical step really remains before courts might say that terminal patients "self-designate" themselves for non-consensual euthanasia because they lack any prospect of improvement? Arguably, very little, especially, when, say, killing the terminal patient might allow a doctor to harvest organs so that another patient might live.[90] Recall, in this regard, the rationale the Dutch government used to defend the 1000 cases of non-consensual euthanasia found by the 1990 Survey: "The degrading condition the patient is in confronts the doctor with a case of force majeure. According to the Commission, the intervention by the doctor can easily be regarded as an action that is justified by

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[90]See A.P. Simester and G.R. Sullivan, Criminal Law Theory and Doctrine (Update Apr. 4, 2002).

necessity."[91] The Dutch government might just as easily have said that the patients "self-designated" themselves for being killed without their consent by virtue of their terminal condition.

The problem posed by Woollin not only led Lord Justice Brooke to endorse a potentially problematic version of necessity doctrine to justify the operation on Mary and Jodie, it opened the door to other, serious problems in run-of-the-mill end-of-life cases. If we say, with Woollin, that the doctors here are "inevitably" guilty of murder because they foresaw the death of Mary as a "virtual certainty," what about doctors who administer strong doses of palliative care to patients suffering grave pain? Or medical care workers who help patients unhook life support machines because the patients wish to go home or prefer to avoid the invasiveness of modern medical care? If the Lords meant what they said in Woollin, and a murder charge may follow whenever death is foreseen as virtually certain, doctors and nurses in such situations are arguably just as susceptible to a charge for murder as the doctors operating on Mary and Jodie. And to defend such everyday, upright actions, In re A gives us little

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[91]1990 Survey, Translated in Keown, Further Reflections 229.

with which to work. Lord Justice Ward's self-defense and defense-of-others theory would not apply: while Mary could be cast, albeit with difficulty, as an "aggressor" against Jodie, that fact seems unique to conjoined twin cases, and the option doesn't exist to defend the ordinary palliative care or refusal of care case involving a single patient. That leaves us only with Lord Justice Brooke's necessity doctrine and the risks its application may entail for the concept of human equality and inviolability of life.

One possibility that the Court did not consider is whether "necessity" might be construed much more narrowly than Lord Justice Brooke (and the drafters of the Model Penal Code[92]) have suggested, limited perhaps to cases where medical professionals, with appropriate permission from the patient or guardian, perform their services in consonance with sound clinical judgment and with no intent to kill or help kill either as a means or an end -- even if death should occur as a foreseeable side-effect. This narrower version of necessity -- limited to medical treatment where the principle of double effect applies -- would cover not only the case of Mary and Jodie, but would avoid also

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[92]See Ch. IX.3, supra.

any possibility (however practically unlikely it may be) of English doctors being held responsible for homicide under Woollin simply for administering potentially lethal doses of palliative care or unhooking patients from futile life support machines when they "foresee" death as virtually certain to follow. At the same time, such a rule would be less susceptible to the problem of judicially declared inequality among different human lives because the justifying "need" would depend not at all on the patient's condition (or, in Lord Justice Brooke's terminology, "self-designation") and the rule would sanction the intentional killing of no person. Such a narrowly drawn rule could also be reconciled with cases such as Dudley and Stephens because, quite unlike the situation I posit, there an intent to do that which the law prohibits (viz., killing the cabin boy for food) indubitably existed. Here, we conceive of using necessity only to justify non-intentional homicides.[93]

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[93]Holmes, too, seemed to involve a case of intentional killing, though some have suggested otherwise and raised the possibility that the defendants actions there could have been (though they were not) defended under the self-defense rubric without any need to resort to necessity at all. See Ch. IX.3, supra. In either event, Holmes would not be inconsistent with the narrow necessity rule we are considering.

Notably, when writing on a clean slate rather than bound by prior case law from the Lords, the Court of Appeal in In re A was quick to adopt and deploy the principle of double effect I endorse for end-of-life decisionmaking. Confronted with the argument that the surgery would not only constitute murder under English law, but would also violate Mary's right to life under the European Convention, the Court of Appeal judges -- formally, at least, unconstrained by Woollin -- emphasized that the Convention provides that "[n]o one shall be deprived of life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."[94] This provision, Lord Justice Walker argued, should be given its "natural and ordinary meaning," and therefore, should "appl[y] only to cases where the purpose of the prohibited act is to cause death."[95] Simply put, the Court rejected the notion that the term "intention" here embraces mere foresight, distinguishing between, rather than conflating, the two concepts. As Lord Justice Brooke put it,

> I do not consider that the Woollin extension of

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[94]See European Convention art. 2(1) (emphasis added).

[95]In re A, [2001] Fam. 147 (emphasis added).

> the meaning of the word 'intention' is appropriate when determining whether a doctor who performed a separation on conjoined twins in circumstances like these was intentionally killing the twin whose life was to be sacrificed. The doctor's purpose in performing the operation was to save life, even if the extinction of another life was a virtual certainty.[96]

The judges of the Court of Appeal, thus, seemed to recognize that end-of-life care cases such as Mary and Jodie's merit and virtually beg for the application of the doctrine of double effect, going so far as to throw overboard Woollin's contrary teaching as soon as they found themselves in a context where they were not strictly bound by the Lords' holding on English criminal law.

### X.4 The "Right to Refuse" and Incompetent Adult Patients

The inviolability of life principle appears to be slowly -- over objections from some like Peter Singer and despite setbacks in certain cases -- gaining ground in the growing body of American law surrounding the non-treatment of young children, especially through legislative initiative. By contrast, the law surrounding incompetent adult patients remains murky.

More and more people are completing living wills or preparing other forms of advance directives and

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[96] Id. (emphasis added).

these, as we have seen, are subject to statutory directive against judicial interpretations that "condone . . . mercy killing or physician assisted suicide or to permit any . . . deliberate act or omission to end life."[97] Still, a great many people do not leave behind any written instructions and some persons never become legally competent; for such persons, the question remains: what to do? The Supreme Court in Cruzan recognized that the states have developed a variety of tests seeking to give meaning to the right to refuse treatment for incompetent adult patients. Cruzan held, too, that states may, without running afoul of the substantive component of the due process clause, require "clear and convincing evidence" that any discontinuation of care comports with the wishes expressed by the patient while competent. The Court did not, however, consider the related question whether states should demand clear and convincing evidence of the patient's wishes before permitting the discontinuation of life sustaining care. At present, there are, in fact, two central and competing strands of cases on just this question. One, exemplified by two Massachusetts decisions and another from England,

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[97]Ill. Comp. Stat., ch. 755, § 35/9(f). For many other analogous examples, see Ch. III, supra.

uses an instrumental approach toward the value of human life; another is well represented by a 2001 California decision that illustrates how the inviolability of life approach might inform this area of the law as well.

Brophy v. New England Sinai Hospital, Inc.

Paul Brophy was afflicted with an aneurysm in his brain in March 1983. Despite the efforts of physicians, surgery was not successful and Brophy never regained consciousness, remaining in what the Massachusetts Supreme Judicial Court called a "persistent vegetative state."[98] In December 1983, with the consent of his wife (who was also his legal guardian), Brophy received a gastrostomy tube ("G-tube") to make it easier to provide him food and water. Fifteen months later, in February 1985, Mrs. Brophy announced her wish that the G-tube should be removed; when Brophy's attending physician objected that removing the tube would be tantamount to causing Brophy's death willfully, Mrs. Brophy sought a declaratory judgment granting her legal authority to override Brophy's physician and secure its removal.

The trial court disallowed the wife's request. The court found that Brophy was not terminally ill, and

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[98]497 N.E. 2d 626, 642 (Mass. 1986) (internal quotation marks omitted).

that, while the use of a G-tube can have certain adverse side-effects, Brophy had experienced none of them in a period that, by then, had already lasted approximately 18 months. The court also found that Brophy showed no signs or symptoms of discomfort, while removing the G-tube would cause death by dehydration, a form of death, the court found, that typically is "extremely painful and uncomfortable," and, while Brophy was unconscious, evidence from his attending physician suggested to the court that it could not "rule[] out" the possibility that Brophy would experience such pain. The court noted evidence from Brophy's wife that her husband had previously stated that he did not want to be placed on life support. But the court also found that Brophy's statements suggested that he would have refused life support not because of a lack of confidence in the procedure or because it would have been painful or burdensome (reasons entirely consistent with the inviolability of life principle), but because he would have wished to commit suicide.[99]

The Massachusetts Supreme Judicial Court, by a vote of 4 to 3, reversed. The court held that the right to refuse treatment is a "fundamental principle[]

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[99] Id. at 643-44.

of individual autonomy,"[100] but also acknowledged that the right to refuse is "not absolute"; the right to refuse treatment must, the court explained, be "balanced" against the state's dual interests in the "preservation of life" and the "prevention of suicide."[101] Having set forth this "balancing test," however, the court did not elucidate <u>how</u> such competing and incommensurable interests -- individual autonomy versus the state's interest in preserving life (especially against killings due to mistake, abuse, and pressure) -- can be weighed, compared, or "balanced" to arrive at a single correct legal resolution.[102]

Instead, the majority simply proceeded to devalue the state's interest in preserving life by characterizing the patient's condition in this case as "helpless" and offering a low quality of life.

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[100]<u>Id.</u> at 633.

[101]<u>Id.</u> The court also mentioned the state's interest in protecting innocent third parties, such as dependents, but none was present in this case. The court stated that the state had a further interest in maintaining the ethical integrity of the medical profession, but this question largely folds into the question whether removing the G-tube constitutes an assault on the preservation of life or an act of suicide. If the act is not one of suicide, then there is no reason to suppose it would be necessarily antithetical to medical ethics.

[102]<u>See</u> Chs. VII.7 & VIII.2.4, <u>supra</u> (discussing the consequentialist's incommensurability problem).

Meanwhile, on the other end of its scale, the court took the (unusual) step of reversing the trial judge's factual finding that the G-tube was not an "intrusive" treatment on the ground that it was Brophy's subjectively expressed view prior to his illness that he would consider such a tube to be "degrading."[103] Having thus tipped the balancing scales of competing interests, the court took the now-smaller step to conclude that the right to have the G-tube removed -- as an exercise of autonomy -- was of more significant weight than the state's interest in preserving life.

The court's analysis raises as many questions as it answers. Somewhat surprisingly, the court never paused to consider the possibility that <u>all</u> human life is worthwhile, simply disregarding the argument that all lives are worthy of equal protection in the eyes of the state (an argument vocally pressed by all three dissenters). Rather, the court took an entirely instrumental/utilitarian view of human life, assuming without deciding the notion that life's value rests on its capacity to provide pleasure, and it then appeared to make its <u>own assessment</u> that Brophy's life was worth little given his "helpless" condition. But if a

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[103]<u>Brophy</u>, 497 N.E.2d at 434-35.

court's evaluation of the instrumental value of individual lives is a relevant (or apparently decisive) factor, isn't that a sure sign that the judiciary will become enmeshed in the business of subjectively determining on a case-by-case basis whether the quality of life available to each given patient that comes before it is sufficiently "bad," in the eyes of the particular judges at hand, to justify ending it intentionally? Also, the court suggested (much as Epstein has[104]) that the patient's subjective assessment (albeit via his guardian) that his life is "degrading" determines whether death is an acceptable option. But if that is so, doesn't it then follow that the young and healthy as well as the old and sick have a right to suicide whenever they wish? The Massachusetts court addressed neither of these questions pointedly raised by its reasoning.

Instead, the court proceeded to distinguish away the state's interest in preventing suicide on causation grounds, arguing that removing the G-tube would only allow "natural causes" to kill the patient. But its analysis falls squarely into the previously-discussed

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[104]See Ch. VIII, supra.

causation trap.[105] Brophy's wife frankly testified that she intended to cause her husband's death by removing the G-tube, the trial court made an express finding on this score, and the Supreme Judicial Court did not challenge this testimony or finding. Brophy's underlying illness surely contributed to his inability to swallow water and, thus, his death. But how one could characterize the act of removing the feeding tube as playing no causal role in Brophy's death -- when the tube had been in place for 18 months without incident and the guardian admitted her intention to kill -- goes unexplained and undefended in the court's analysis.

The Massachusetts Supreme Judicial Court also misunderstood two critical aspects of the "right to refuse." Like the respondents in Glucksberg who argued that Cruzan compels a right to assisted suicide, the court overread the right to refuse treatment as embracing a fundamental right to "autonomy" and "self-determination" "root[ed]" in the teachings of "John Stuart Mill."[106] Such a reading of Cruzan would not only suggest a right to suicide and assisted suicide on demand, it would, as we have seen, militate in favor of

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[105]See Ch. IV.2, supra.

[106]Brophy, 497 N.E.2d at 633.

legalizing a broad range of currently prohibited conduct from prostitution to drug use that might be considered "harmless" to unconsenting third parties. The Massachusetts court nowhere considered the more modest reading of right to refuse case law (subsequently endorsed by Glucksberg, as we saw in Chapter V) -- namely that it is a right developed from battery doctrine and designed simply to prevent patients from suffering certain unconsented-to touchings.

Perhaps even more fundamentally still, the Massachusetts court rested its decision on an entirely fictional right. Brophy "refused" nothing and was capable of refusing nothing. He left no living will, no written instructions, no specific oral health care instructions; the notion that Brophy was exercising anything remotely akin to a right to refuse treatment or a right to control his self-destiny borders on the incoherent. There may be sound reasons for courts to allow the treatment of non-terminal incompetent patients to be discontinued, but such decisions cannot be cogently defended as an exercise of autonomy or a "right to refuse" care.

## Superintendent of Belchertown State School v. Saikewicz[107]

Joseph Saikewicz was a 67 year-old man with an I.Q. of 10, a "mental age" estimated to be approximately 2 years and 8 months and, as a result of his condition, Saikewicz had lived in a state mental institution for over 50 years. In April 1976, Saikewicz was diagnosed with a form of leukemia considered "invariably fatal."[108] A guardian ad litem was appointed and charged with reporting to the court regarding whether and what treatment should be administered. The guardian subsequently issued a report indicating that, although chemotherapy was the medically indicated course of treatment, it would cause Saikewicz significant adverse side-effects and discomfort, including anemia, bone marrow depression, increased chance of infection and bladder irritation, among other things. The guardian ad litem concluded that these facts, as well as the inability of his ward to understand the treatment to which he would be subjected and the fear and pain he would suffer as a result, outweighed the prospect of some "uncertain but limited extension of life," estimated to be between two

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[107]373 Mass. 728 (1977).

[108]Id. at 732.

and thirteen additional months.[109]

The trial court adopted the report and the Massachusetts Supreme Judicial Court affirmed. The latter court acknowledged that "most people" would likely choose to accept chemotherapy in Saikewicz's condition and it acknowledged that the treatment would likely extend Saikewicz's life. But, unlike "most people," the court emphasized, chemotherapy would plunge Saikewicz into a state of painful suffering which he would not appreciate or understand. Under these circumstances, the court held, the guardian ad litem had made a reasonable assessment of the benefits and burdens of the proposed course of treatment to Saikewicz.

In reaching this conclusion, the court acknowledged the state's interest in the "preservation of life," but held that "[t]he interest of the State in prolonging a life must be reconciled with the interest of an individual to reject the traumatic cost of that prolongation."[110] In seeking to reconcile these interests, the court suggested that "[t]here is a substantial distinction in the State's insistence that

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[109]Id. at 730, 734.

[110]Id.

human life be saved where the affliction is curable, as opposed to the State interest where, as here the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended."[111] Rather than introducing its own assessment of Saikewicz's quality of life, and suggesting that some persons lives are more valuable than others, the court could have resolved concerns about the state's interest in the preservation of human life simply by pointing out the proposed treatment could be (and was) rejected by Saikewicz's legally appointed guardian without any violation of the guardian's legal duty of care -- i.e., it was not intended to kill Saikewicz or otherwise undertaken carelessly.[112] Proceeding in this fashion, rather than focusing on the quality of life at issue, would have solved this case readily and without suggesting that some persons' lives are more valuable than others. The point was, however, never considered by the court -- likely because it was never presented by the litigants, a not-uncommon problem, as we shall

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[111] Id.

[112] Of course, a guardian's duty to a ward extends beyond avoiding intentional killings, and encompasses a duty to undertake a careful and proportionate decision even where death is an unwanted side-effect. The guardian in this case seemed to have exercised just such care.

see.

## Airedale N.H.S. Trust v. Bland[113]

The Bland case, discussed briefly in Chapter IV, bears further mention here, sharing many facts and issues in common particularly with Brophy and, as we shall see, Wendland. The case involved a 17 year-old young man, Tony Bland, on the cusp of his majority, who was left in a comatose state after being crushed in a spectator's pen at a soccer match. Bland's doctors and parents eventually sought to remove nasogastric tubes supplying him with food and water, and to discontinue the provision of antibiotics that were being used to treat infections.

Three of the five Lords hearing the case expressly admitted or asserted that the cessation of treatment under the circumstances before them involved the intention to kill Tony, yet all five permitted the doctors proceed. Given that an intent to kill was admittedly present, John Keown has asked, "why, then, would this not be murder?"[114] Several of the Lords seemed to assume that merely classifying the doctors' conduct as omissions of care "solved" the murder

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[113][1993] A.C. 789.

[114]John Keown, Euthanasia, Ethics and Public Policy 218 (2002).

question. Lord Goff, we might recall, suggested that the act-omission distinction is something of a moral/legal "Rubicon which runs between on the one hand the care of the living and on the other hand euthanasia -- actively causing his death to avoid or end his suffering."[115] But this is simply wrong. Euthanasia and assisted suicide (like suicide itself) can, as we have seen, be accomplished as much through omissions as through acts. Indeed, medical practitioners in the Netherlands, where euthanasia is tolerated, readily accept that euthanasia be undertaken either through active means or by deliberate omissions of care.[116]

Some of the Lords hearing Bland's case recognized that calling something an omission does not end the inquiry into whether the doctors' conduct constitutes murder, but instead merely raises the question whether the physicians had a duty to supply the (omitted) care, at least in the absence of a living will or other such competent evidence suggesting that Bland would have

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[115]Bland, [1993] A.C. at 789. See also Ch. IV.3, supra (discussing the act-omission distinction drawn by the Lords in Bland).

[116]See John Keown, Euthanasia in The Netherlands: Sliding Down the Slippery Slope? in Euthanasia Examined: Ethical, Clinical, and Legal Perspectives 271, 290 (John Keown, ed. 1995) (hereinafter, "Keown, Euthanasia in the Netherlands") (emphasis added).

declined treatment. These Lords, however, proceeded to analyze the duty question in ways that added not clarity but only further confusion. They began with the premise that there is an important distinction between "medical treatment," on the one hand, and "ordinary" care, on the other. On this reasoning, the latter is care which decent persons and communities seek to provide, while the former is an intervention typically performed by doctors and, because of its distinctively "medical" nature, may be withheld when a respectable body of professional medical opinion would so permit.[117] The Lords then proceeded to classify the nasogastric tube and antibiotics on which Bland depended as "medical treatment," and to find that medical opinion would permit its removal: "There is overwhelming evidence that, in the medical profession, artificial feeding is regarded as a form of medical treatment; and even if it is not strictly medical treatment, it must form part of the medical care of the patient."[118] And, because the "patient is unconscious and there is no prospect of any improvement in his conduct," the court reasoned, Bland's doctors had to

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[117]Bland, [1993] AC 789.

[118]Id. (Lord Goff).

withdraw the treatment to accord with the "body of reasonable medical opinion" and, thus, meet their professional obligations.[119]

The Lords' attempt to resolve this dispute by means of semantically classifying certain forms of care as "medical" versus "ordinary" seems as slippery a business as trying to determine whether conduct is an "act" or an "omission," and equally unhelpful. Indeed, a similar classification effort was attempted by some courts in America -- there seeking to distinguish "ordinary" from "extraordinary" treatment -- but was widely criticized and has been largely abandoned precisely because physicians themselves do not always agree on what is medical or ordinary care, and standards of care change over time; what is considered extraordinary or "medical" treatment today may tomorrow be seen as quite ordinary.[120] Indeed, by way of example, some commentators have argued, with some persuasiveness, that the very nasogastric tubes at issue in Bland might be better classified as "ordinary"

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[119]Id.

[120]See, e.g., Conroy, 486 A.2d at 1235; Meisel, Right to Die § 4.6, at 82-87 (collecting cases and providing overview of problems associated with efforts to distinguish "ordinary" from "extraordinary" treatment).

care rather than "medical" treatment because they can be routinely inserted and maintained without any distinctively medical skills.[121]

Distinctions like those between medical/non-medical or extraordinary/ordinary treatment run the risk of becoming conclusory pigenholes, with people simply employing the appropriate label to suit the result they seek. As the Supreme Court of New Jersey has observed, "[t]he claim, then, that the treatment is extraordinary [or "medical"] is more of an expression of the conclusion than a justification for it. . . . [T]o draw a line on this basis . . . leads to a semantical milieu that does not advance the analysis."[122] Such categorizations, moreover, may often do little more than disguise a court's assessment of the patient's quality of life and its endorsement of euthanasia (i.e., intentionally killing), if only by "omission," for persons whose lives the court perceives as inferior.

Indeed, one is left with the sense that the classification of the nasogastric tube in Bland as

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[121]See Keown, EEPP 239 et seq.; John Finnis, Bland: Crossing the Rubicon?, 109 L. Q. Rev. 329, 335 (1993).

[122]Conroy, 486 A.2d at 1235 (internal quotation marks omitted).

"medical" treatment that should be discontinued was driven as much (if not more) by an assessment of Bland's quality of life than by any formal classification of the tube's nature and function. What seemed objectionable to the Lords in Bland was not so much the application of supposedly distinctively medical care in violation of some newly announced professional standard of care as the maintenance of a person who, after three years in a comatose state, they considered to be perhaps less than fully human. Lord Justice Hoffmann, for one, frankly described Bland as "grotesquely alive,"[123] and Sir Stephen Brown called him a "shell of [a] body."[124] Simply put, Bland may well have already crossed Lord Goff's moral Rubicon, allowing a certain form of euthanasia (i.e., those accomplished by omission) for certain classes of persons (i.e., those whom judges, in candid moments at least, would decree only "grotesquely alive").

Why didn't the Lords adopt, or even stop to consider in any extended way, the intent-based alternative we have outlined above? John Keown has suggested that "one plausible explanation is that the

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[123] Id. at 825

[124] Id. at 804.

principle does not appear to have been accurately set out before them by any of the counsel who appeared in the case."[125] The counsel for the Official Solicitor, for example, appeared to confuse the notion that one may not intentionally take life with the idea that one must take steps to preserve and prolong human life at all costs, regardless of the attendant burdens and costs (vitalism), arguing in the Court of Appeal that if Bland showed any signs of dangerous problems with his heart, lungs, liver, kidneys, spleen or pancreas, doctors would be under a duty to perform surgery to rectify the issue under any circumstances. This suggestion led the presiding judge in that court to observe that "[s]uch a suggestion is in my view so repugnant to one's sense of how one individual should behave towards another that I would reject it as possibly representing the law."[126] The fundamental problem with Bland, therefore, may be, as Keown has put it, that the courts were "presented with only two alternatives: vitalism or Quality of life . . . . and . . . the judges (unsurprisingly) opted for Quality of

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[125]Keown, EEPP 230.

[126][1993] AC 789.

life."[127]

## Wendland v. Wendland[128]

In 2001, the California Supreme Court faced a case similar in many respects to those confronted by its sister court in Massachusetts and the Lords in Bland, but it reached a different result by very different reasoning.

On September 29, 1993, Robert Wendland rolled his truck at high speed in a solo accident while driving under the influence of alcohol. Following the accident, Wendland remained in a coma, totally unresponsive, for several months. His wife Rose visited him daily and authorized treatment as necessary to maintain his health. Eventually, Wendland regained consciousness, but remained severely disabled, both mentally and physically, and entirely dependent on artificial nutrition and hydration through a G-tube. At his highest level of functioning, Wendland could throw and catch a ball, operate an electric wheelchair with assistance, turn pages, draw circles, and perform commands. But when therapy was discontinued, Wendland lost his ability to perform some of these tasks,

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[127]Keown, EEPP 231.

[128]28 P.2d 151 (Cal. App. 2001).

remained unable to swallow, and suffered from spasticity, severe paralysis, incontinence, and other maladies.

Wendland's wife Rose authorized surgery three times to replace dislodged feeding tubes, but when physicians sought her permission a fourth time, she refused. Wendland's mother and sister opposed this decision and sought a restraining order to bar the removal of the feeding tube. In turn, Rose petitioned the court to be appointed her husband's conservator; the court granted the motion but reserved judgment on Rose's request for authority to remove the feeding tube.

At the trial, the judge held that Mrs. Wendland, as wife/conservator, would be allowed to withhold artificial nutrition and hydration only if doing so would be in Wendland's "best interests," taking into account the wishes he expressed before becoming incompetent.[129] The court also decided (in consonance with In Re A but in contrast to the court in Phillip B.) that the conservator would bear the burden of proving facts to justify her decision by clear and convincing evidence. The court rejected Mrs.

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[129]Id. at 156.

Wendland's entreaties to impose a more modest preponderance of the evidence standard of proof, holding that the decision to withhold life-sustaining treatment "should be premised on no lesser showing."[130]

During trial, Mrs. Wendland (like Mrs. Brophy) pointed to a handful of pre-accident statements made by her husband to the effect that he would not have wanted to "live like a vegetable" or be left alive in a "comatose state." But Wendland had left no written instructions and had not designated anyone to act as proxy to make medical decisions for him. The trial court found that Mrs. Wendland was acting "in good faith," but had failed to show by clear and convincing evidence that her husband would have wanted to refuse care when, though severely incapacitated, he was not in a "persistent vegetative state" and was not suffering a terminal illness. The court likewise found insufficient evidence that removing treatment would be in the husband's best interests.

On appeal, Mrs. Wendland challenged the burden of proof applied by the trial court, arguing that, so long as a conservator is acting in good faith when "substituting its own judgment" concerning a

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[130] Id. (internal quotation marks omitted).

conservatee's best interests, a court should not interfere. The intermediate appellate court, much like the Massachusetts Supreme Judicial Court in Brophy, sided with Mrs. Wendlend, but the California Supreme Court unanimously reversed and reinstated the trial court's judgment. The Supreme Court began by conceding the right of a competent adult to refuse medical treatment and to leave advance directives in the event of incapacity, noting that the California legislature (like virtually every other American state legislature) has provided for competent persons to execute living wills and medical care proxies authorizing the agent to act "in accordance with the principal's health care instructions . . . and other wishes to the extent known to the agent."[131]

While the right to refuse is guaranteed to competent persons and promotes individual autonomy, the court recognized that the notion that it survives incompetency (assuming no living will or medical care proxy) is a "legal fiction at best."[132] Instead, the court held that

> [i]t would be more accurate to say that incompetent patients retain the right to have

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[131] Id. at 160 (internal quotation marks omitted).

[132] Id. at 162 (internal quotation marks omitted).

appropriate medical decisions made on their behalf. An appropriate medical decision is one that is made in the patient's best interests, as opposed to the interests of the hospital, the physicians, the legal system, or someone else. We do not question the . . . conclusion that incompetent persons have a right, based in the California Constitution, to appropriate medical decisions that reflect their <u>own</u> interests and values. But the right to an appropriate decision by a court-appointed conservator does not necessarily equate with a conservatee's right to refuse treatment, or obviously take precedence over the conservatee's right to life and the state's interest in preserving life.[133]

What is the difference between a right to refuse treatment and a right to have decisions made in one's best interest? This difference may, at first, appear merely semantic but, in fact, it is a substantial one for those who would rely on autonomy theory and the notion of self-governance to justify the discontinuation of care for incompetent patients. Unlike so many other courts, the California Supreme Court recognized that incompetent patients who have left behind no instructions or proxy do not -- and cannot -- make "autonomous choices." Decisions by conservators derive their authority not from an incompetent patient's fictional exercise of autonomy, the court held, but from the long-recognized common law doctrine concerning the "<u>parens patriae</u> power of the

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[133]<u>Id.</u> at 162-63 (internal quotation marks and citations omitted).

state to protect incompetent persons."[134]

Having formulated the legal question at issue in this radically different fashion, the court turned to the question what burden of proof the conservator, exercising her parens patriae power, must satisfy before discontinuing life-sustaining care. The court rejected Mrs. Wendland's argument for a lower preponderance of the evidence standard, and accepted the clear and convincing evidence standard employed by the trial court, stressing a point made in Chapter VII and illustrated by In re A: that a right to refuse, like a right to assisted suicide or euthanasia, can interfere as well as advance individual rights, especially when left in the hands of a proxy. The court explained that the possibility of a conservator deciding to withdraw life-sustaining treatment brought with it not just potential benefits, but also grave risks, thus warranting close judicial review. The risk of an erroneous discontinuation of care, due to mistake or abuse or coercion by the conservator, the court explained,

> represent[s] the gravest possible affront to the conservatee's state constitutional right to privacy, in the sense of freedom from unwanted

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[134] Id. at 161.

bodily intrusions, and to life.[135]

Two aspects of this holding are remarkable. First, unlike Brophy or Saikewicz or Bland, the California court did not hinge the existence of a patient's rights to privacy and life on his or her physical condition or quality of life; rather it proceeded on the view that all lives equally enjoy the full panoply of constitutional protections. Second, because the risk of error is "manifest" when a decision is made for rather than by the patient, and the danger posed to his or her interests in life and privacy and equal treatment by an erroneous decision is so profound (death), the California court reasoned that the "degree of confidence required in the necessary findings of fact" should be correspondingly high.[136]

The California court then proceeded to examine the evidence and the question whether Mrs. Wendland had come forward with clear and convincing proof either that Wendland would have wished to discontinue treatment or that doing so would be in his best interests. The court concluded that Mrs. Wendland had offered only "her own subjective judgment that the

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[135]Id. at 169.

[136]Id.

conservatee did not enjoy a satisfactory quality of life and legally insufficient evidence to the effect that he would have wished to die."[137] On this record, the Court concluded that the trial court's decision was "correct."[138]

## *Wendland* and the Future for Comatose Adult Patients

Throughout its opinion, the California Supreme Court stressed that Wendland was, at least to some degree and at some times, conscious, stating variously that he is "a conscious conservatee who is not terminally ill, comatose, or in a persistent vegetative state";[139] "the trial court found no 'clear cut guidance' on how to evaluate a conservator's proposal to end the life of a conscious conservatee who was neither terminally ill nor in a persistent vegetative state";[140] "the decision to withdraw life-sustaining treatment, because of its effect on a conscious conservatee's fundamental rights, justified imposing [a] high standard of proof."[141] The court never directly stated

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[137]Id. at 174.

[138]Id.

[139]Id. at 153.

[140]Id. at 156

[141]Id. at 175.

that a patient in a "permanently vegetative state" should be treated differently, but its pointed emphasis on the fact that Wendland was minimally conscious raises the question whether, to keep unanimity, that possibility had to be kept open.

The California court's mode of analysis, however, should not change when it is presented with a comatose rather than a semi-comatose patient. The same fundamental liberty interests are at stake: the right to life, the right to privacy, and the right to be treated as equal to all other human beings. The same standard of review (clear and convincing evidence) is necessary to ensure that a conservator does not, by virtue of abuse or mistake, extinguish these fundamental constitutional rights. Indeed, the only way to defend a laxer standard of review for comatose patients than for minimally conscious patients is to suggest that the quality of one's life makes a categorical difference to the content of one's rights - - and this cannot be squared with the inviolability of life principle, equal protection requirements, or with the California court's reasons for rejecting Mrs. Wendland's request.

Consistent application of the Wendland decision

should not, however, be confused with, or lead to a vitalist's conclusion that all comatose and semi-comatose patients must be treated, regardless of the invasiveness or futility or expense of the care necessary to sustain them. To adopt Wendland's reasoning would not necessarily mean that treatment would have been required for each of the patients in Brophy, Bland, or Saikewicz. It would, for example, be entirely consistent with Wendland and the inviolability of life principle for a wife to reject further care for the husband on the ground that the husband expressed his wish, prior to incapacity, to be cared for at home or in a hospice in the event of disability in order to be free from unwanted medical intrusions. Neither does Wendland's reasoning preclude a guardian from refusing care of any kind (whether pigeonholed in Bland-type language as "ordinary" or "extraordinary," "medical" or "non-medical") on the ground that it would prove futile or impose inhumane burdens on the ward (e.g., cause continued infections by the insertion of a new feeding tube, or force food into the ward that he or she cannot digest, or cause painful suffering). Nothing in such decisions necessarily betokens an intent to kill. The inviolability of life principle recognizes and fully

accepts that there are many competing and incompatible goods that persons can legitimately pursue and, thus, many upright reasons why guardians can refuse care for their loved ones that have nothing to do with a desire to end life (as the facts, if not all of the reasoning, in Saikewicz amply illustrate).

At the same time, to follow where the reasoning of Bland would take seemingly take us, and permit guardians to refuse care with the intent to end life, would indeed to be to cross the Rubicon into the realm of assisted suicide and euthanasia. Consistent application of the Wendland decision and its rationale would augur in favor of reconsidering the sort of reasoning employed in cases like Brophy and Bland and Saikewicz, and suggest that third party decisions to terminate the care of incompetent adult patients should receive the same scrutiny, and be decided with the same appreciation for the inviolability of all human life, that Congress has suggested for incompetent minors. Brophy itself was decided only by a 4-3 vote, with all three dissenters stressing Wendland-like arguments for the inviolability of life, the inappropriateness of judicial assessments about the relative quality of different human lives, and the need for careful review

of any guardian's decision affecting a ward's constitutional rights to life and privacy.

Future courts should consider, too, that states have recently reviewed and reaffirmed their laws banning assisted suicide and have enacted provisions precluding courts from reading advance medical directives or living wills in such as way as to authorize any "deliberate act or omission to end life."[142] If one cannot deliberately kill competent patients (assisted suicide), or construe living wills as permitting the deliberate killing of incompetent patients who have left behind written directives, it would be incongruous indeed for only one class of persons -- the incompetent who has not left behind any written instruction -- to be subject to intentional destruction by others. Ultimately, however, there may be a need for legislative solutions if the courts fail to act. In such an event, good models already exists: Congress and state legislatures can look to their work in the arenas of infant non-treatment and living wills to fashion similar regulations governing the

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[142]Ill. Comp. Stat., ch. 755, § 35/9(f).

discontinuation of care for incompetent adults who have left behind no written directives -- regulations that are focused not on quality of life, but on the quality of the proposed care, bearing in mind the intrinsic value of all human life.

## EPILOGUE

I conclude by returning to the basic questions that have framed this analysis and the answers suggested here. I hesitate to do so because it has already taken hundreds of pages to explore these issues, but it may be useful, nonetheless, to bring at least some of the highlights of the argument together in a summary recapitulation.

I. Whether to legalize assisted suicide and euthanasia is among the most hotly debated contemporary legal and public policy questions. Dr. Kevorkian's very public killings brought attention to the issue in the early 1990s and were rapidly followed by a cascade of voter initiative referenda and legislative proposals throughout the United States. With the exception of Oregon's experiment, none of these initiatives and proposals has yet borne fruit, though each has reinforced the deep social and political division over the question of legalization.

II. In the mid-1990s, assisted suicide and euthanasia proponents turned from legislatures to the judiciary and encountered some initial success in the lower courts. In 1997, the Supreme Court rebuffed their efforts, however, holding 9-0 that laws against

assisted suicide are not facially invalid. But the Supreme Court's decision is far less definitive than it appears at first blush. Indeed, a majority of the Court reserved judgment on the constitutionality of laws banning the practices as applied to terminally ill adults who choose death. The Court's decision, taken with its language encouraging state legislatures to experiment in this area, raise a number of questions for future courts and lawmakers.

III. The Court's decision, for example, raises the question whether historical precedent exists to support either a constitutional right to, or legalization of, assistance in suicide and euthanasia. As we saw, ancient Rome does offer some precedent for legalization, but few today would be eager to emulate the practices the Romans sometimes tolerated (and even applauded). Looking to English and American common law history, there is no meaningful historical antecedent for a right to assistance in suicide or euthanasia, despite contrary arguments by Judge Reinhardt, ethicist Dan Brock, and Lord Hoffmann, all of whom have erroneously suggested that the "decriminalization" of suicide in the eighteenth, nineteenth, and twentieth centuries betokened approval of that practice.

IV. The Court's decision and Justice Stevens's concurring opinion in Quill also raise the question whether principles of equal treatment and fairness require that, because we recognize a right to refuse life-sustaining medical care, we must also recognize a right to assisted suicide and euthanasia. I argued that attempts to distinguish between the right to refuse and assisted suicide on causation and act-omission grounds lack persuasive force. But I also suggested that a meaningful moral distinction based on intent does exist: the right to refuse need not imply any intention to die or to help kill on the part anyone involved; meanwhile, assisted suicide requires someone to assist in the intentional taking of human life. Euthanasia, too, by definition, involves an intent to kill, if sometimes only as a means toward the end of relieving suffering. I tested my conclusions against a number of prominent objections, including those lodged by Dr. Quill, David Orentlicher, John Griffiths, and Justice Stevens, among others.

V. We explored whether Casey and Cruzan's language about the importance of choice and personal self-creation provide a sufficient basis to support the creation of a new right to assisted suicide or

euthanasia as a matter of legal doctrine. After considering competing arguments seeking to read these key decisions more broadly, I suggested that Casey is best read as a stare decisis decision and that Cruzan's reasoning rests on common law concepts of battery and the prevention of unconsented-to touchings, rationales that do not embrace or suggest a right to assisted suicide.

VI. We next considered three competing theories of autonomy found in moral and political theory and whether they might sustain a right to assisted suicide, even if existing judicial doctrine concerning personal autonomy does not. We found that one of them (what we called "perfectionism") does not command a right to assisted suicide or euthanasia (or any other substantive right). I suggested that the two remaining theories, based on the harm and neutrality principles, offer two possible outcomes consistent with their teachings. First, it is possible that persons might reasonably assess the risks associated with legalization of assisted suicide and euthanasia (e.g., unwanted killings due to abuse, mistake, and pressure) to be sufficiently grave that they opt make the practices unlawful -- much as Mill and Feinberg have

argued for the absolute prohibition of dueling and slavery contracts. Second, if assisted suicide and euthanasia are legalized, I argued that consistent application of the neutrality and harm principles would tend toward a rule making the practices available to all competent adults without respect to their physical condition or reason for seeking death.

VII. We also considered whether utilitarianism provides a basis for legalization. Though legalization would clearly entail certain benefits, it would also, I submitted, likely bring with it non-trivial costs and burdens. I considered the contrary arguments of John Griffiths and Helga Kuhse, who seek to suggest that legalization would not result in any additional cases of voluntary or non-voluntary assisted suicide and euthanasia. I acknowledged that the costs and burdens associated with legalization do not obviously preclude legalization on utilitarian grounds, but submitted that they do preclude the easy assumption (voiced by many) that a utilitarian calculus obviously weighs in favor of legalization. In addition, given the existence of legitimate and competing interests on both sides of the legalization debate, we explored whether the utilitarian project of attempting to compare

incommensurate goods -- the liberty to kill oneself versus the lives of persons who would be killed as a result of abuse, mistake, and pressure -- might be analytically unsound.

VIII. I tested several of the foregoing conclusions against recent works by Judge Richard Posner and Richard Epstein. I concluded that Posner's utilitarian arguments are beset by faulty data and unwarranted causation assumptions, as well as by an incommensurability problem. By contrast, the libertarian arguments proffered by Posner and Epstein illustrate and reinforce my conclusion that the harm principle does not necessarily dictate legalization of assisted suicide but that, to be fully faithful to the harm principle, any scheme of legalization attempted would likely have to be open not merely to the terminally ill, but to all rational adults.

IX. After considering arguments from history, fairness, autonomy doctrine and theory, and utilitarianism, I suggested that courts and legislators may wish to consider a less frequently voiced perspective on the assisted suicide and euthanasia question, one grounded in the recognition of human life as a fundamental good. Under this view, private

intentional acts of homicide are always wrong. Recognizing human life as intrinsically, not instrumentally, valuable, I submitted, would rule out assisted suicide and euthanasia, though it would not lead to, and should not be confused with, a vitalist's view that measures must always be taken to keep human beings alive; to the contrary, it would leave significant room for individual autonomy, restricting state interference only to cases where an intent to help kill is present. After sketching out what we called the inviolability of life principle, I considered a number of potential objections, including those suggested by the writings of Peter Singer. I considered, too, the application of the inviolability of life principle to the current administrative law dispute between the federal government and the State of Oregon over the use of controlled substances in facilitating suicide.

X. In closing, I sought to explore how the inviolability of life principle might apply to cases involving competent persons who refuse life-sustaining medical care, as well as to the increasingly common and difficult cases involving nontreatment decisions made on behalf of incompetent persons, both infant and

adult. I analyzed several of the leading cases, suggested how the inviolability of life principle might be applied to such disputes in the future, defended recent legislative initiatives as consistent with that principle, and offered suggestions for additional action by legislatures and courts.

Word count: 99,968

## APPENDIX A

Survey of American Laws Banning Assisted Suicide

My survey of the fifty American states reveals that thirty-seven have statutes clearly banning the practice of assisted suicide. One additional state (Michigan) has a statute that may or may not have lapsed (see annotator's note, infra), but, in any event, that state treats assisted suicide as a common law crime. Yet another state (Montana) treats assisting a failed suicide as an independent statutory crime, but appears to classify assisting a successful suicide as a species of homicide and, thus, subject to the general homicide statute (see annotator's note, infra).

Of the remaining eleven states, six treat assisted suicide as a common law crime. Four states have no statute banning the practice and apparently have not yet had a reported case addressing the common law status of assisted suicide. Two of these four states, however, have health care directive statutes that disapprove of assisted suicide, and a third has a bill pending to make assisted suicide a statutory crime. Only Oregon legally endorses assisted suicide in any form.

In 1997, the U.S. Congress passed a statute, signed by President Clinton, denying the use federal funds in connection with any act of assisted suicide.

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| U.S. Government | 42 U.S.C. § 14401 et seq. "(a) Findings: Congress finds the following: (1) The Federal Government provides financial support for the provision of and payment for health care services, as well as for advocacy activities to protect the rights of individuals. (2) Assisted suicide, euthanasia, and mercy killing have been criminal offenses throughout the United States and, under current law, it would be unlawful to provide services in support of |

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| | such illegal activities. (3) Because of recent legal developments, it may become lawful in areas of the United States to furnish services in support of such activities. (4) Congress is not providing Federal financial assistance in support of assisted suicide, euthanasia, and mercy killing and intends that Federal funds not be used to promote such activities. (b) Purpose. It is the principal purpose of this chapter to continue current Federal policy by providing explicitly that Federal funds may not be used to pay for items and services (including assistance) the purpose of which is to cause (or assist in causing) the suicide, euthanasia, or mercy killing of any individual."<br><br>Common law proscription. In addition, advance medical directive statute provides as follows: Ala. Code § 22-8A-10, "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician assisted suicide or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." |
| Alaska | Alaska Stat. § 11.41.120. "Manslaughter. (a) A person commits the crime of manslaughter if the person (1) intentionally, knowingly, or recklessly causes the death of another person under circumstances not amounting to murder in the first or seconds degree; or (2) intentionally aids another person to commit suicide. (b) Manslaughter is a class A felony." |

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| Arizona | Ariz. Rev. Stat. § 13-1103. "Manslaughter; classification. A. A person commits manslaughter by: . . . 3. Intentionally aiding another to commit suicide." |
| Arkansas | Ark. Code Ann. § 5-10-104. "Manslaughter. (a) A person commits manslaughter if: . . . (2) He purposely causes or aids another person to commit suicide." |
| California | Cal. Penal Code § 401. "Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony." |
| Colorado | Colo. Rev. Stat. § 18-3-104. "Manslaughter. (1) A person commits the crime of manslaughter if: . . . (b) Such person intentionally causes or aids another person to commit suicide." |
| Connecticut | Conn. Gen. Stat. § 53a-56. "Manslaughter in the second degree: Class C felony. (a) A person is guilty of manslaughter in the second degree when: (1) He recklessly causes the death of another person; or (2) he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide. (b) Manslaughter in the second degree is a class C felony." |
| Delaware | Del. Code Ann. tit. 11 § 645. "Promoting suicide, Class F felony. A person is guilty of promoting suicide when the person intentionally causes or aids another person to attempt suicide, or when the person intentionally aids another person to commit suicide." |

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| Florida | Fla. Stat. ch. 728.08. "Assisting self-murder. Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree, punishable as provided in 775.082, 775.083, or 775.084." |
| Georgia | Ga. Code Ann. §16-5-5. "Offering to assist in commission of suicide; criminal penalties. (a) As used in this Code section, the term: (1) 'Intentionally and actively assisting suicide' means direct and physical involvement, intervention, or participation in the act of suicide which is carried out free of any threat force, duress, or deception and with understanding of the consequences of such conduct. (2) 'Suicide' means the intentional and willful termination of one's own life. (b) Any person who publically advertises, offers or holds himself or herself out as offering that the or she will intentionally and actively assist another person in the commission of suicide is guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not less than one nor more than five years. (c) Any person who knowingly and willfully commits any act which destroys the volition of another, such as fraudulent practices upon such person's fears, affections, or sympathies; duress; or any undue influence whereby the will of one person is substituted for the wishes of another, and thereby intentionally causes or induces such other person to commit or attempt to commit suicide shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not |

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| | less than one nor more than ten years." |
| Hawaii | Haw. Rev. Stat. § 707-702. "Manslaughter. (1) A person commits the offense of manslaughter if: (a) He recklessly causes the death of another person; or (b) He intentionally causes another person to commit suicide." |
| Idaho | No direct statute or common law prohibition. But advance medical directive statute provides as follows: Title 56, Chapter 10, Section 56-1022, "Euthanasia, Mercy Killing or Assisted Suicide. Sections 56-1020 through 56-1035, Idaho Code, do not make legal and in no way condone mercy killing, assisted suicide or euthanasia. Idaho Code § 56-1022." |
| Illinois | 720 Ill. Comp. Stat. 5/12-31. "Inducement to Commit Suicide: (a) A person commits the offense of inducement to commit suicide when he or she does either of the following: (1) coerces another to commit suicide and the other person commits or attempts to commit suicide as a direct result of the coercion, and he or she exercises substantial control over the other person through (i) control of the other person's physical location or circumstances; (ii) the use of psychological pressure; or (iii) use of actual or ostensible religious, political, social, philosophical or other principles. (2) With knowledge that another person intends to commit or attempt to commit suicide, intentionally (i) offers and provides the physical means by which another person commits or attempts to commit suicide, or (ii) |

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| | participates in a physical act by which another person commits or attempts to commit suicide. For the purposes of this section 'attempts to commit suicide' means any act done with the intent to commit suicide and which constitutes a substantial step toward commission of suicide." |
| Indiana | Ind. Code § 35-42-1-2. Sec. 2. "A person who intentionally causes another human being, by force duress, or deception, to commit suicide commits causing suicide, a Class B Felony." |
| Iowa | Iowa Code 707A.2. "Assisting Suicide. A person commits a class 'C' felony if the person intentionally or knowingly assists, solicits, or incites another person to attempt to commit suicide, or participates in a physical act by which another person commits or attempts to commit suicide." |
| Kansas | Kan. Stat. Ann. § 21-3406. "Assisting Suicide. (a) Assisting suicide is: (1) Knowingly by force or duress causing another person to commit or attempt to commit suicide; or (2) with the intent and purpose of assisting another person to commit or to attempt to commit suicide, knowingly either: (A) Providing the physical means by which another person commits or attempts to commit suicide; or (B) participating in a physical by which another person commits or attempts to commit suicide." |
| Kentucky | Ky. Rev. Stat. Ann. § 216.302. "Causing a suicide -- Assisting in a Suicide. (1) A person commits a Class C Felony when the person knowingly by force or duress causes |

another person to commit or attempt to commit suicide. (2) A person commits a Class D Felony when the person, with the purpose of assisting another person to commit or attempt to commit suicide, knowingly and intentionally either: (a) Provides the physical means by which another person commits or attempts to commit suicide; or (b) Participates in a physical act by which another person commits or attempts to commit suicide."

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| Louisiana | La. Rev. Stat. § 14:32.12. "Criminal assistance to suicide. A. Criminal assistance to suicide is: (1) The intentional advising or encouraging of another person to commit suicide or the providing of the physical means or the knowledge of such means to another person for the purpose of enabling the other person to commit to attempt to commit suicide. (2) The intentional advising, encouraging, or assisting of another person to commit suicide, or the participation in any physical act which causes, aids, abets, or assists another person in committing or attempting to commit suicide." |
| Maine | Me. Rev. Stat. Ann. tit. 17-A, § 204. "Aiding or Soliciting Suicide. 1. A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide. 2. Aiding or soliciting suicide is a Class D crime." |
| Maryland | Md. Ann. Code art. 27 § 416. "(b) An individual may not, with the purpose of assisting another person to commit or to attempt to commit |

suicide: (1) Knowingly cause, by coercion, duress, or deception, another person to commit suicide or to attempt to commit suicide; (2) Knowingly provide the physical means by which another person commits or attempts to commit suicide with knowledge of the person's intent to use the physical means to commit suicide; or (3) Knowingly participate in a physical act by which another person commits or attempts to commit suicide. (c) (1) A licensed health care professional who administers, prescribes, or dispenses medications or procedures to relieve pain, even if the medication or procedure may hasten or increase the risk of death, is not in violation of subsection (b) of this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death. (2) A family member who is a care giver for a patient enrolled in a licensed hospice program and who under the supervision of a health care professional administers or dispenses medications or procedures to relieve pain, even if the medication or procedure may hasten or increase the risk of death, is not in violation of subsection (b) of this section unless the medications or procedures are knowingly administered or dispensed to cause death. (3) A licensed health care professional who withholds or withdraws a medically administered life sustaining procedure in compliance with the Health Care Decisions Act under Title 5, Subtitle 6 of the Health - General Article or in accordance with reasonable medical practice is not in violation of subsection (b)

of this section. (d) An individual who violates this section is guilty of a felony and on conviction is subject to a fine not exceeding $10,000 or imprisonment not exceeding 1 year or both."

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| Massachusetts | Common law proscription. In addition, advance medical directive statute provides in Massachusetts General Laws, Part II, Title II, Chapter 201D, Section 12, as follows: "Suicide or mercy killing not authorized. Section 12. "Nothing in this chapter shall be construed to constitute, condone, authorize or approve suicide or mercy killing, or to permit any affirmative or deliberate act to ends one's own life other than to permit the natural process of dying. Mass. Gen. Laws ch. 201D, § 12." |
| Michigan | Mich. Stat. Ann. § 752.1027. "(1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both: (a) Provides the physical means by which the other person attempts or commits suicide. (b) Participates in a physical act by which the other person attempts or commits suicide. (2) Subsection (1) shall not apply to withholding or withdrawing medical treatment. (3) Subsection (1) does not apply to prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort and not |

to cause death, even if the medication or procedure may hasten or increase the risk of death. (4) This section shall take effect February 25, 1993. (5) This section is repealed effective 6 months after the date the commission makes its recommendations to the legislature pursuant to section 4."

Annotator's Note: "Regarding the recommendations referred to in subsection (5), at the time of publication [2002] recommendations had been submitted to both houses but it was not certain whether the recommendations were those of the full commission or whether both houses 'accepted' the recommendations were presented."

Michigan has also traditionally treated assisted suicide as a common law crime. State of Michigan v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994).

Minnesota

Minn. Stat. § 609.215. Suicide. "Subdivision 1. Aiding Suicide. Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than $30,000, or both. Subdivision 2. Aiding attempted suicide. Whoever intentionally advises, encourages, or assists another who attempts but fails to take the other's own life may be sentenced to imprisonment for not more than seven years or to payment of a fine of not more than $14,000, or both."

Mississippi

Miss. Code Ann. § 97-3-49. "Suicide; aiding. A person who

willfully, or in any manner, advises, encourages, abets, or assists another person to take, or in taking, the latter's life, or in attempting to take the latter's life, is guilty of felony and, on conviction, shall be punished by imprisonment in the penitentiary not exceeding ten years, or by fine not exceeding one thousand dollars, and imprisonment in the county jail not exceeding one year."

Missouri — Mo. Rev. Stat. § 565.023. 1. "A person commits the crime of voluntary manslaughter if he: . . . (2) Knowingly assists another in the commission of self-murder."

Montana — Mont. Code Ann. § 45-5-105. "Aiding or soliciting suicide. (1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide. (2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both."

Annotator's Note: "Under the new sections on Causal Relationship Between Conduct and Result, MCA, 45-2-201, and Accountability, MCA, 45-2-302, a person may be convicted of Criminal Homicide, MCA, 45-5-101 (repealed - now deliberate or mitigated homicide, 45-5-102 and 45-5-103, respectively), for causing another to commit suicide - notwithstanding the consent of the victim."

Nebraska — Neb. Rev. Stat. § 28-307. "Assisting suicide, defined;

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| | penalty. (1) A person commits assisting suicide when, with intent to assist another person in committing suicide, he aids and abets him in committing or attempting to commit suicide. (2) Assisting suicide is a Class IV felony." |
| Nevada | Common law proscription. |
| New Hampshire | N.H. Rev. Stat. Ann. § 630.4. "Causing or Aiding Suicide -- I. A person is guilty of causing or aiding suicide if he purposely aids or solicits another to commit suicide. II. Causing or aiding a suicide is a class B felony if the actor's conduct causes such suicide or an attempted suicide. Otherwise it is a misdemeanor." |
| New Jersey | N.J. Stat. Ann. § 2C:11-6. "Aiding Suicide: A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree." |
| New Mexico | N.M. Stat. Ann. § 30-2-4. "Assisting Suicide. Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth degree felony." |
| New York | N.Y. Penal Law § 120.30. "Promoting a Suicide Attempt: A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony." |

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| North Carolina | No applicable law found. |
| North Dakota | N.D. Cent. Code § 12.1-16.04. "Assisting the commission of suicide-Causing death by suicide-Penalties. 1. Any person who intentionally or knowingly aids, abets, facilitates, solicits, or incites another person to commit suicide, or who provides to, delivers to, procures for, or prescribes for another person any drug or instrument with knowledge that the other person intends to attempt to commit suicide with the drug or instrument is guilty of a class C felony. 2. Any person who, through deception, coercion or duress, willfully causes the death of another person by suicide is guilty of a class AA felony." |
| Ohio | Medical directive statute only: Ohio Rev. Ann. § 2133.12(D) "Nothing in sections 2133.01 to 2133.15 of the Revised Code condones, authorizes, or approves of mercy killing, assisted suicide, or euthanasia." |
| Oklahoma | Okla. Stat. tit. 21, § 813. "Aiding Suicide. Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide. 814. Furnishing weapon or drug. Every person who willfully furnishes another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life, is guilty of aiding suicide, if such person thereafter employs such instrument or drug in taking his own life. 815. Aid in attempt to commit suicide. Every person who willfully aids another |

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| | person in attempting to take his own life, in any manner which by the preceding sections would have amounted to aiding suicide if the person assisted had actually taken his own life, is guilty of aiding an attempt at suicide." |
| Oregon | Physician assisted suicide permitted by statute but currently challenged by federal law. |
| Pennsylvania | 18 Pa. Cons. Stat. § 2505. "Causing or aiding suicide. (a) Causing suicide as criminal homicide -- A person may be convicted of criminal homicide for causing another to commit suicide only if he intentionally causes such suicide by force, duress or deception. (b) Aiding or soliciting suicide as an independent offense. -- A person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide and otherwise of a misdemeanor of the second degree." |
| Rhode Island | R.I. Gen. Laws § 11-60. "Assisted Suicide. 11-60-3 Prevention of assisted suicide. An individual or licensed health care practitioner who with the purpose of assisting another person to commit suicide knowingly: (1) provides the physical means by which another person commits or attempts to commit suicide; or (2) participates in a physical act by which another person commits or attempts to commit suicide; is guilty of a felony and upon conviction may be punished by imprisonment for not more than ten (10) years, by a fine not more than ten thousand dollars |

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| | ($10,000), or by both." |
| South Carolina | S.C. Code Ann. § 16-3-1090. "Assisted suicide; penalties; injunctive relief. (A) As used in this section: (1) 'Licensed heath care professional' means a duly licensed physician, surgeon, podiatrist, osteopath, osteopathic physician, osteopathic surgeon, physician assistant, nurse, dentist, or pharmacist. (2) 'Suicide' means the act or instance of taking one's life voluntarily and intentionally. (B) It is unlawful for a person to assist another person in committing suicide. A person assists another person in committing suicide if the person: (1) by force or duress intentionally causes the other person to commit or attempt to commit suicide; or (2) has knowledge that the other person intends to commit or attempt to commit suicide and intentionally: (a) provides the physical means by which the other person commits or attempts to commit suicide; or (b) participates in a physical act by which the other person commits or attempts to commit suicide." |
| South Dakota | S.D. Codified Laws § 22-16-37. "Aiding and abetting suicide as felony. Any person who intentionally in any manner advises, encourages, abets or assists another in taking his own life is guilty of a Class 6 felony." |
| Tennessee | Tenn. Code Ann. § 39-13-216. "Assisted Suicide. (a) A person commits the offense of assisted suicide who: (1) Intentionally provides another person with the means by which such person directly |

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| | and intentionally brings about such person's own death; or (2) Intentionally participates in a physical act by which another person directly and intentionally brings about such person's own death; and (3) Provides the means or participates in the physical act with: (A) Actual knowledge that the other person intends to bring about such person's own death; and (B) The clear intent that the other person brings about such person's death." |
| Texas | Tex. Penal Code Ann. § 22.08. "Aiding Suicide: (a) A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide. (b) An offense under this section is a Class C misdemeanor unless the actor's conduct causes suicide or attempted suicide that results in serious bodily injury, in which event the offense is a state jail felony." |
| Utah | Medical directive statute only: Utah Code Ann. § 75-2-1118. "Nothing in this part may be construed to condone, authorize, or approve mercy killing, euthanasia, or suicide." |
| Vermont | Common law proscription. |
| Virginia | Va. Code Ann. § 8.01-622.1. "Injunction against assisted suicide; damages; professional sanctions. A. Any person who knowingly and intentionally, with the purpose of assisting another person to commit or attempt to commit suicide, (i) provides the physical means by which another |

person commits or attempts to commit suicide or (ii) participates in a physical act by which another person commits or attempts to commit suicide shall be liable for damages as provided in this section and may be enjoined from such acts. B. A cause of action for injunctive relief against any person who is reasonably expected to assist or attempt to assist a suicide may be maintained by any person who is the spouse, parent, child, sibling or guardian of, or a current or former licensed health care provider of, the person who would commit suicide; by a Commonwealth's attorney with appropriate jurisdiction; or by the Attorney General. The injunction shall prevent the person from assisting any suicide in the Commonwealth. C. A spouse, parent, child or sibling of a person who commits or attempts to commit suicide may recover compensatory and exemplary damages in a civil action from any person who provided the physical means for the suicide or attempted suicide or who participated in a physical act by which the other person committed or attempted to commit suicide. D. A licensed health care provider who assists or attempts to assist a suicide shall be considered to have engaged in unprofessional conduct for which his certificate or license to provide health care services in the Commonwealth shall be suspended or revoked by the licensing authority."

Washington

Wash. Rev. Code § 9A.36.060. "Promoting a Suicide Attempt: (1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to

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| | attempt suicide. (2) Promoting a suicide attempt is a class C felony." |
| West Virginia | Common law proscription. |
| Wisconsin | Wis. Stat. Ann. § 940.12. "Assisting Suicide: Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D Felony." |
| Wyoming | No applicable law found. |

## APPENDIX B

Below are calculations I used to generate certain graphs in the text. All calculations are based on mortality statistics from the World Health Organization.

Graph 2 Suicide Rate of Elderly (75 years +) Women as a Multiple of the Total Female Suicide Rate, 1984-1997

| Year | Elderly (75+) Female Suicide Rate Per 100,000 | Total Female Pop. Suicide Rate Per 100,000 | Suicide Rate of Elderly Women as a Multiple of Total Female Suicide Rate |
|---|---|---|---|
| 1984 | 14.6 | 9.6 | 1.520833 |
| 1985 | 10.8 | 8.1 | 1.333333 |
| 1986 | 13 | 8.2 | 1.585366 |
| 1987 | 13.2 | 8.4 | 1.571429 |
| 1988 | 10.7 | 7.5 | 1.426667 |
| 1989 | 10.8 | 7.5 | 1.44 |
| 1991 | 11.4 | 7.6 | 1.5 |
| 1992 | 12.3 | 7.1 | 1.732394 |
| 1993 | 12.5 | 6.9 | 1.811594 |
| 1994 | 9.4 | 6.4 | 1.46875 |
| 1995 | 9.9 | 6.5 | 1.523077 |
| 1996 | 11.5 | 6.7 | 1.716418 |
| 1997 | 10.9 | 6.8 | 1.602941 |

(data unavailable for 1990)

Graphs 3 & 4

## Suicide Rate of Elderly Persons (75 yrs.+) As a Multiple of the Total Suicide Rate

All data is for the most recent year for which the World Health Organization has prepared statistics for the country in question.

| Country (Year) | Elderly (75+) Suicide Rate per 100,000 | Total Suicide Rate per 100,000 pop. | Suicide Rate of Elderly as Multiple of Total Suicide Rate |
|---|---|---|---|
| Finland (1996) | | | |
| Men | 47.9 | 38.7 | 1.24 |
| Women | 7.1 | 10.7 | 0.66 |
| Norway (1995) | | | |
| Men | 24.4 | 19.1 | 1.28 |
| Women | 5.4 | 6.2 | 0.87 |
| USA (1997) | | | |
| Men | 44.7 | 18.7 | 2.4 |
| Women | 5.1 | 4.4 | 1.16 |
| U.K. (1997) (England and Wales) | | | |
| Men | 16.9 | 10.3 | 1.64 |
| Women | 3.9 | 2.9 | 1.34 |
| Sweden (1996) | | | |
| Men | 39.2 | 20 | 1.96 |
| Women | 14.6 | 8.5 | 1.72 |
| France (1996) | | | |
| Men | 87.2 | 28.8 | 3.03 |
| Women | 20.1 | 10.4 | 1.93 |
| Netherlands (1997) | | | |
| Men | 34 | 13.5 | 2.52 |
| Women | 11.5 | 6.7 | 1.72 |
| Italy (1995) | | | |
| Men | 43.3 | 12.3 | 3.52 |
| Women | 8.2 | 3.9 | 2.1 |
| Denmark (1996) | | | |

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|---|---|---|---|
| Men | 70.8 | 24.3 | 2.91 |
| Women | 20.1 | 9.8 | 2.05 |
| Germany (1997) | | | |
| Men | 70.6 | 22.1 | 3.19 |
| Women | 20.5 | 8.1 | 2.53 |
| Spain (1995) | | | |
| Men | 25.3 | 12.5 | 2.02 |
| Women | 7.0 | 3.7 | 1.9 |

Graph 5 Total Population Suicide Rate
Per 100,000 Deaths

| Country | 1980 | 1985 | 1990 | 1995 |
|---|---|---|---|---|
| Netherlands | 10.1 | 11.3 | 9.7 | 9.8 |
| USA | 11.8 | 12.3 | 12.4 | 11.9 |
| Sweden | 19.4 | 18.2 | 17.2 | 15.3 |
| U.K. | | 8.1 | 8.1 | 7.4 |
| Norway | 12.4 | 14.1 | 15.5 | 12.6 |
| Denmark | 31.6 | 27.9 | 23.9 | 17.7 |
| Germany | | | 17.8 | 15.8 |

(gaps represent years for which data is unavailable)

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