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What in the World is Going On? A Consideration of the California Euthanasia Proposal

by Edward R. Grant

Mr. Grant, a Chicago attorney, delivered this talk at the Inter-professional Symposium sponsored by the Illinois State Bar Association on May 12, 1988.

The quiet but powerful groundswell of support for relaxing the taboo against euthanasia has been evident since the beginning of the decade. In 1985, the Surgeon General of the United States sounded the warning in a speech referring to the "euthanasia juggernaut." Dr. Koop predicted that euthanasia would become a means to medicalize the social problem of caring for the forthcoming boom of elderly, dependent patients. The potential savings in health care costs, as well as the relief that could be provided to suffering patients and their families, would make legalized euthanasia too tempting for society to pass up. And, as Dr. Koop noted the following year in a speech at the Notre Dame University Law School, the erosion in legal prohibitions against mercy-killing is well underway.

This is why the outraged tone of the response to the "Debbie" case caught me by surprise. Consider these quotes from the letters column of the April 8 issue of *The Journal of the American Medical Association*. A professor of law and medicine at the University of Chicago: "I suggest the physician involved find himself a criminal defense lawyer — he's going to need one."

Two lawyer-ethicists at Boston University: "A textbook example of medical arrogance, ignorance, and criminal conduct." The directors of four of the nation's leading institutions in the study of medical ethics: "*What in the world is going on?*" These experts in medical ethics were clearly aware — or should have been — of the forces which have made the discussion of this physician's deliberate homicide of his patient a matter for polite discussion. What's going on is a classic advent of social engineering, embraced by many out of the highest motives of compassion, but nevertheless directed at the most vulnerable persons in our society.

We must move beyond the "Debbie" case, therefore, to the question of what is to be done. Are we to legalize mercy killing, as Mr. Humphry lobbies for in California? Or shall we draw the line, however difficult that may be, and insist that the one who heals shall not also be the one who kills?

The many facets of that question cannot be answered in these brief remarks. But it is useful to return to that question, posed by Dr. Siegler and his three distinguished colleagues: "What in the world is going on?" — specifically, what does the attempt to legalize euthanasia in California mean for American law and medicine?

Many Ironies

Among the many ironies of the "Debbie" case was the criticism voiced by *supporters* of legalized euthanasia. The president of Hemlock of Illinois wrote: "We condemn the Debbie case as both illegal and unethical." Physician aid-in-dying, he stated, may only be permitted under these circumstances: 1) legal documentation of the patient's request for euthanasia; 2) the physician performing the aid-in-dying must have known the patient, been fully aware of the medical history, and the desire for euthanasia; 3) the physician must have a second opinion confirming the terminal condition. Mr. Humphry confidently added that if the Debbie incident had taken place in America after passage of his Humane and Dignified Death Act, "(The doctor) would be prosecuted." Given the frustration of the authorities who have investigated the Debbie case, Mr. Humphry's prediction is curious. And consider — if it were perfectly legal for a physician to kill a patient in Debbie's condition if that patient had signed a directive, isn't it more than likely that such killings will occur regardless of such directives? If killing is seen as merciful, even therapeutic, in the first case, wouldn't it be equally merciful and therapeutic in the second?

However much its proponents may say to the contrary, the Humane and Dignified Death Act cannot ensure that such "unauthorized" mercy-killings will not occur. Nor can the act ensure that euthanasia will not be extended beyond the paradigm case of the terminally ill and pain-ridden patient. Indeed, the act, when read in conjunction with recent judicial developments, ensures just the opposite.

First, the act clearly attempts to place direct killing, called aid-in-dying, on a par basis with decisions to have life-sustaining procedures withheld or withdrawn. The act states that aid-in-dying is only for the terminally ill. But how long will this limitation be honored? Consider the case law from California itself. The right to refuse medical treatment, including nutrition and hydration, is *not* limited to the terminally ill. In the second *Bouvia* decision, the California appellate court held that Elizabeth Bouvia's decision to starve herself was fully justified, given her great impairment. [quadriplegia]. No terminal illness was required to invoke this right. One

judge went even further, writing that the state, rather than seeking to preserve Miss Bouva's life, should seek ways to help her end it, painlessly. If the case of a similar patient seeking aid-in-dying were to come before this panel, can anyone seriously predict that the court would refuse the plea, citing the statute's limitation of terminal illness?

Entitlement Problems

In broader terms, if the state is to create an entitlement to aid-in-dying for the terminally ill, what basis is there for denying that entitlement to those who claim to suffer as much as, or more than, the terminally ill? While the terminal cancer or AIDS patient presents the paradigm case for euthanasia, the case for euthanasia is no less compelling for the chronically dependent victims of strokes, Alzheimer's disease, senile dementia, ALS, Batten's disease, or severe trauma. Indeed, the case may be stronger in these situations. The percentage of cancer patients for whom pain cannot be controlled is small, and suffering will end, upon death, in a relatively short time. In contrast, the numbers of those with severe and permanent neurological deficit will grow as America ages, and the burden these patients present to the health care system, and to family, can persist indefinitely. The courts have cited such burdens in permitting life-sustaining treatment to be withdrawn from such patients. If the legislature or a plebiscite amends the homicide law to permit mercy-killing, the courts will cite these burdens as justification for extending that entitlement. Time and time again, American courts have extended the right to remove life-sustaining medical care beyond the circumstances permitted in state living statutes. Yet, in each case, after having overridden the express limitations of the legislature's statute, and having drafted a judicial statute to take its place, the courts conclude with a ritual plea for "legislative standards" that will keep such cases out of court. After 10 years of this, we all know what will happen if even a strictly limited entitlement to aid-in-dying finds its way onto the statute books. Litigation will multiply, and courts will find it exceedingly difficult to limit euthanasia to the terms of the statute.

To paraphrase the comment of a learned professor of history: "The American judiciary takes to the slippery slope with the glee of a small boy dragging along his very first sled." So when we talk about legalizing voluntary euthanasia, honesty compels us to consider the full range of patients for whom this entitlement will become a reality.

A Second Consideration

Second, we must consider whether the entitlement to euthanasia will long remain strictly a voluntary choice. On its face, the Humane and Dignified Death Act permits the exercise of aid-in-dying in reliance upon an advance directive. For an incompetent patient, however, someone other than that patient will have to decide when, and under what

circumstances, to put that directive into effect. Anyone who is familiar with American jurisprudence on this question since the *Quinlan* case can see what is coming next. The courts have not considered a written directive essential to authorize removal of treatment and nutrition from an incompetent patient. Nor have the courts insisted upon clear and convincing evidence of the patient's wishes, or any evidence at all. Consider the case of Clarence Herbert, a California man who arrested in the recovery room following routine surgery, and remained in a coma. Two days after the arrest, his physicians, with family permission, turned off his ventilator. When the patient survived, to his doctor's surprise, they ordered removal of his feeding tubes. In the subsequent court case, no evidence of the patient's wishes regarding treatment under such circumstances was recorded. Yet, the doctors were exonerated, for their actions were found to be consistent with the standards set forth for the treatment of such patients by *Quinlan*. If aid-in-dying is to become a standard and accepted form of therapy for patients in certain conditions, what *medical* basis is there for requiring the consent of the patient, who is now incompetent? Certainly there will be no legal barrier. The doctrines of substituted judgment and best interests of the patient, affirmed in dozens of cases involving life-support treatment, will be invoked by those who stand in the position of Karen Quinlan's father.

If there were any doubt whether the humane and dignified death act permits such developments, consider section 2526.1 of the act.

This title shall not impair or supersede any legal right or legal responsibility which any person may have to effect the withdrawal or withholding of life-sustaining procedures or administering aid-in-dying in any lawful manner. In this respect the provisions of the title are cumulative.

By its very terms, therefore, the Humane and Dignified Death Act does not universally govern the practice of aid-in-dying, and the door for judicial amendment is wide open. Under the *Bouvia* decision, aid-in-dying is likely to become available for the handicapped or chronically ill, who are not terminal. Under the *Barber* decision, and those of the New Jersey courts, aid-in-dying will become available to those incompetent patients who have not signed a directive, but whose family is permitted to substitute its judgment.

Concluding Points

Finally, as aid-in-dying becomes more firmly ingrained in medical practice and ethics, aid-in-dying for those who have never had the capacity to make treatment decisions will be considered. The current ethical arguments in favor of euthanasia do not rest solely on the principle of consent. Historically, no serious literature in favor of euthanasia has so relied. Rather, the common thread, running through the German euthanasia literature of the 1890's and 1920's, through the English and American arguments of today, is that there is such a thing as a life not,

or no longer, worth living. Under this ethic, euthanasia is seen as beneficent. It is not, as its proponents claim, simply a matter of personal choice. Rather, enactment of such a law will indelibly affect our society's entire attitude toward the terminally ill, the comatose, the profoundly handicapped, and the aged. Removing the 2500-year-old taboo against euthanasia is no "modest" proposal. If we are to debate the proposition, let us at least know what we are about.

Much of what I have said may be characterized as "slippery slope" argumentation. Mr. Humphry and his colleagues dismiss this line of argument as a "parade of horrors," not responsive to their own modest and carefully crafted proposals. My response is two-fold. First, I am not arguing about a parade of horrors which *may* occur if euthanasia is legalized. Rather, I am pointing out what the *immediate* effect of the act will be, given the current state of judicial decisions in this area. Second, I submit that this type of argument cannot be dismissed out of hand. Legal philosophers have long recognized that certain actions are so generally harmful to people that the law prohibits those actions in order to protect the common good. This prohibition does not allow exceptions for individual discretion, even when it can be shown that the harm which the law seeks to prevent will not occur. The common good, therefore, is not to be placed at risk by private discretion or self-exemption from the law.

Prof. Yale Kamisar of the University of Michigan Law School, responds in this way to those who dismiss the "slippery slope," and particularly, any reference to the German euthanasia program.

It cannot happen here. Well, maybe it cannot, but . . . no small number of our supreme court opinions stem from the feat that *it can happen here unless we darn well make sure that it does not* by adamantly holding the line. To flick off the fears about legalized euthanasia as a parade of horrors is to sweep away much of the ground on which all our civil liberties rest.
