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Carl A. Anderson

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Waiting for Hippocrates: The "Right to Die" and the U.S. Constitution

by

Mr. Carl A. Anderson

The author is Dean, John Paul II Institute for Studies on Marriage and Family, Washington, D.C., and Vice President for Public Policy, Knights of Columbus

On March 6, 1996, the United States Court of Appeals for the Ninth Circuit decided the case of *Compassion in Dying v. State of Washington*.¹ In doing so, it became the first federal circuit court of appeals to decide a "right-to-die" case and to find that such a "right" was protected by the United States Constitution. Soon thereafter, on April 2, 1996, the United States Court of Appeals for the Second Circuit decided the case of *Quill v. Vacco*. The court in that case also found that physician-assisted suicide by terminally ill patients was protected by the Constitution.² Parties in both cases announced their intention to seek review of these federal court decision by the United States Supreme Court. This article will provide a brief exposition and analysis of the issues considered in both cases.

Compassion in Dying v. State

Compassion in Dying v. State involved a challenge to the Washington State law which makes assisting suicide a crime punishable by imprisonment of up to five years and a fine of up to \$10,000. The law states that "a person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."³ The circuit court concluded "that there is a constitutionally-protected liberty interest in determining the time and manner of one's own death" (p. 1). Moreover, the court ruled that insofar as a state law "prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths" such a statute violates the United States Constitution and is therefore invalid (p. 1). Should the circuit court decision stand it will have extraordinary influence within the United States. Since the Ninth Circuit includes the states of California, Washington, Oregon, Arizona, Nevada, Idaho, Montana, Alaska, and Hawaii its ruling will affect approximately

a quarter of the population of the United States. On March 25, the Attorney General for the State of Washington announced her intention to appeal the court's decision to the United States Supreme Court.

The challenge to the Washington law was brought by eight plaintiffs: four physicians who treat terminally ill patients, three terminally ill patients and a non-profit organization called Compassion in Dying. The three terminally ill patients involved in the case are 'Jane', 'John', and 'James'. 'Jane' is a 69-year-old retired physician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. 'Jane' is completely bedridden and the only medical treatment available to her is medication which cannot fully alleviate her pain. 'John' is a 44-year-old artist dying of AIDS. The court noted that 'John' is "especially cognizant" of the suffering imposed by a lingering terminal illness because he was the primary caregiver for his long-time companion who died of AIDS in 1991. 'James' is a 69-year-old retired sales representative who suffers from emphysema which causes him a constant sensation of suffocating and heart failure related to his pulmonary disease. In addition to the plaintiffs, various organizations also filed briefs in support of the challenge to the law including Americans for Death with Dignity, American Civil Liberties Union, Lambda Legal Defense and Education Fund, AIDS Action Council, and American Humanist Association. Organizations that filed briefs in defense of the law included United States Catholic Conference, Catholic Health Association, Americans United for Life, and Washington State Hospital Association.

In beginning its analysis, the court observed: "In examining whether a liberty interest exists in determining the time and manner of one's death, we begin with the compelling similarities between right-to-die cases and abortion cases. In the former as in the latter, the relative strength of the competing interests changes as physical, medical, or related circumstances vary. In right-to-die cases the outcome of the balancing test may differ at different points along the life cycle as a person's physical or medical condition deteriorates, just as in abortion cases the permissibility of restrictive state legislation may vary with the progression of the pregnancy. Equally important, both types of cases raise issues of life and death, and both arouse similar religious and moral concerns. Both also present basic questions about an individual's right of choice" (p. 7). After noting the similarities between the "right-to-die" and abortion, the court stated that "in deciding right-to-die cases, we are guided by the [U.S. Supreme] Court's approach to the abortion cases" (p. 8) and in particular, the reasoning of the Supreme Court in its most recent abortion case, *Planned Parenthood v. Casey*.⁴

However, before the circuit court began its analysis of the "right-to-die" in light of the abortion jurisprudence of the Supreme Court, it first defended its formulation of the legal issue to be resolved. The circuit court stated, "While some people refer to the liberty interest implicated in right-to-die cases as a liberty interest in committing suicide, we do not describe it that way. We use the broader and more accurate terms, 'the right to die,' 'determining the time and manner of one's death,' and 'hastening one's death' for an important reason. The liberty interest we examine encompasses a whole range of acts that are generally not

considered to constitute 'suicide.' Included within the liberty interest we examine, is for example, the act of refusing or terminating unwanted medical treatment" (p. 9). Indeed, the level of generality chosen by the court in defining the question to be addressed was not simply important in resolving the issue of whether the "right-to-die" is a liberty interest protected by the Constitution, but was actually outcome determinative of the question. As one commentator on American constitutional law has written, "Insofar as the right of personhood is limited to liberties long revered as fundamental in our society, it makes all the difference in the world what level of generality one employs to test the pedigree of an asserted liberty claim."⁵ In other words, this commentator continued, "It is crucial, in asking whether an alleged right forms part of a traditional liberty, to define the liberty at a high enough level of generality to permit unconventional variants to claim protection along with mainstream versions of protected conduct."⁶

The recurring issue confronting the United States Supreme Court and all lower federal courts is what standard to apply in determining whether a particular activity is protected within the scope of the liberty specified by the Fourteenth Amendment to the United States Constitution.⁷ In attempting to ascertain whether an activity should be classified as a "fundamental liberty" and therefore protected from state prohibition or infringement, the Supreme Court has stated that the interest to be protected must be "implicit in the concept of ordered liberty such that neither liberty nor justice would exist if [such liberties] were sacrificed" and "where they are characterized as those liberties that are deeply rooted in this Nation's history and tradition."⁸ Like the "right to abortion", the "right to die" is nowhere to be found in the United States Constitution. To the contrary, for most of the constitutional history of the United States, states not only refused to recognize such activity as a "right", but the state governments imposed criminal penalties on those involved in such activity. Thus, if the conduct is narrowly defined, that is, defined so as to limit the description of the so-called "liberty" interest to the conduct at issue and to no other more generally accepted conduct, then it is very difficult to regard the conduct as a "liberty" since it traditionally has been criminalized by the state.

In *Planned Parenthood v. Casey*, the Supreme Court rejected such a close historical context for the definition of the liberty interest at issue. The Supreme Court stated, "It is . . . tempting . . . to suppose that the [Constitution] protects only those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified . . . But such a view would be inconsistent with our law. It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter."⁹ The circuit court quoted this language with approval in *Compassion in Dying v. Washington* and went on to observe that had the Supreme Court not taken such a broad view of what constitutes liberty, "it would not have held that women have a right to have an abortion [since] as the dissent pointed out in *Roe v. Wade*, more than three-quarters of the existing states (at least 28 out of 37 states); as well as eight territorial legislatures restricted or prohibited abortions in 1868 when the Fourteenth Amendment was adopted" (p. 13).

Moreover, the Supreme Court's abortion jurisprudence was found to be persuasive in another important aspect. The Supreme Court in *Planned Parenthood v. Casey* re-affirmed the constitutional right to abortion. It did so by replacing the notion of "privacy" as the constitutional principle which encompassed a "right" to abortion with a broad, seemingly open-ended concept of liberty. After reviewing its decisions related to marriage, contraception, abortion, family relationships and child rearing, the Supreme Court stated, "These 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 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 compulsion of the State."¹⁰

The circuit court found this analysis broad enough to extend beyond the issue of abortion and include the "right to die." According to the circuit court, "the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.' A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him" (p. 19).

In holding that a "right to die" is protected by the Constitution, the circuit court also relied upon the decision of the Supreme Court in the case of *Cruzan v. Director, Missouri Department of Health*.¹¹ In *Cruzan*, the parents of a young woman in a persistent vegetative state sought a court order entitling them to terminate the artificial nutrition and hydration procedures the hospital was providing to their daughter. The Supreme Court observed that while "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment,"¹² and that therefore "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition"¹³ the question was not automatically resolved in favor of the parents' request. The Supreme Court noted that "an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate."¹⁴ The State of Missouri had recognized in its law that a surrogate may act on behalf of a patient to refuse or terminate life-prolonging hydration and nutrition, but the state had required that the surrogate's action must conform to the wishes of the patient. In addition, the law required that the surrogate show by "clear and convincing" evidence that such was the wish of the patient. Thus, in *Cruzan* the Supreme Court limited its ruling to the question of whether such a procedural requirement of the state was an infringement upon the patient's constitutionally protected right to refuse lifesaving treatment. The Court held that such a high evidentiary standard did not violate the Constitution.

Although in *Cruzan* the Supreme Court ruled only on the narrow issue of whether the state's evidentiary standard to ascertain the patients' desire to terminate treatment was unconstitutionally strict, the dissenting and concurring opinions of justices raised issues that would resurface in *Compassion in Dying*. Dissenting Justices Brennan, Marshall and Blackmun (all strongly supportive of the constitutional right to abortion announced by the Supreme Court in the case of *Roe v. Wade*) argued that Missouri's evidentiary standard was unconstitutional because it amounted to an "obstacle to the exercise of a fundamental right."¹⁵ They maintained that "the only state interest asserted here is a general interest in the preservation of life. But the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment. The regulation of constitutionally protected decisions . . . must be predicated on legitimate state concerns other than disagreement with the choice the individual has made . . . Thus, the State's general interest in life must accede to Nancy Cruzan's particularized and intense interest in self-determination in her choice of medical treatment. There is simply nothing legitimately within the State's purview to be gained by superseding her decision."¹⁶

In his concurring opinion, Justice Scalia directly disputed the contention of the dissenting justices that "the state has no legitimate general interest in someone's life . . . that could outweigh the person's choice to avoid medical treatment." Justice Scalia insisted that while the dissenter's proposition sounded "moderate enough" it could not be "logically" limited to only the circumstances of the *Cruzan* case. He argued that if one agrees with the dissenter's view that the general interest of the State in protecting life must always yield to the individual's particularized and intense interest in self-determination to refuse medical treatment, then "he must also believe that the State must accede to her particularized and intense interest in self-determination in her choice whether to continue living or to die . . . It seems to me, "Justice Scalia continued, that the dissenters' position "ultimately rests upon the proposition that it is none of the State's business if a person wants to commit suicide . . . But it is not a view imposed by our constitutional traditions, in which the power of the State to prohibit suicide is unquestionable."¹⁷

In *Compassion in Dying*, the circuit court held that "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" articulated by the Supreme Court in *Cruzan* should be applied to the question of physician-assisted suicide (p. 19). With virtually no analysis, the circuit court simply announced that "we conclude that *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" (p. 20). The circuit court, however, failed to explain why this should be so. Nor did the court explain why it is that the common law prohibition of suicide existed alongside that of the common law right to be free of medical treatment without consent. Both principles reach back beyond the American constitutional tradition to the English common law.

After having asserted a constitutionally protected "liberty interest in hastening

one's own death," the circuit court then considered six interests of the state to determine whether one or more of those interests outweighed the individual's liberty interest. As defined by the circuit court these interests were: "(1) the state's general interest in preserving life; (2) the state's more specific interest in preventing suicide; (3) the state's interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence; (4) the state's interest in protecting family members and loved ones; (5) the state's interest in protecting the integrity of the medical profession; and (6) the state's interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional." The circuit court concluded that in no instance did the state interest or any combination of state interests outweigh the individual's "liberty interest in hastening one's own death".

The original three-judge panel which heard the appeal from the federal district court decision had upheld the Washington law. Judge Noonan, author of the original circuit court opinion, found all of the above state interests to be substantial and sufficient to sustain the Washington State law. In particular, Judge Noonan found persuasive the Supreme Court's determination in *Cruzan* that "there can be no gainsaying" a state's interest "in the protection and preservation of human life".¹⁸ Significantly for Judge Noonan, the Supreme Court cited in support of its determination that "the majority of States in this country have laws imposing criminal penalties on one who assists another in criminal suicide."¹⁹ Another important state interest enumerated by Judge Noonan was the interest in protecting the poor, racial minorities, the handicapped and the elderly from exploitation and pressure. In reaching this conclusion Judge Noonan agreed with the conclusions of the New York State Task Force on Life and Law report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*. The Task Force appointed by the Governor of New York in 1984 unanimously recommended that New York laws prohibiting assisted suicide and euthanasia should not be changed. It concluded that "No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services . . . The practices will pose the greatest risks to those who are poor, elderly, members of a minority group."²⁰

Perhaps most importantly, the Task Force identified four major factors contributing to the clinical background of the medical context regarding physician-assisted suicide. First, the Task force found that "Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal. Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide." Second, the Task Force concluded that "Uncontrolled pain, particularly when accompanied by feelings of hopelessness and untreated depression, is a significant contributing factor for suicide . . . Medications and pain relief techniques now make it possible to treat pain effectively for most patients." Third, the Task force determined that "Despite the fact that effective treatments are available, severely and terminally

ill patients generally do not receive adequate relief from pain." And fourth, the Task Force stated the "Numerous barriers contribute to the pervasive inadequacy of pain relief and palliative care in current clinical practice, including a lack of professional knowledge and training, unjustified fears about physical and psychological dependence, poor pain assessment, pharmacy practices, and the reluctance of patients and their families to seek pain relief."²¹ In regard to the fourth finding the Task Force noted that "The provision of pain medication is legally acceptable even if it may hasten the patient's death, if the medication is intended to alleviate pain (pain) not to cause death."²²

However, the Ninth Circuit Court rejected such concerns and instead concluded that "even though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill . . . and has expressed a wish that he be permitted to die . . . When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling" (p. 22). Moreover, the circuit dismissed the concern regarding possible exploitation of historically disadvantaged groups such as the elderly, handicapped and minorities, saying merely that "The argument that disadvantaged persons will receive more medical services than the remainder of the population in one, and only one, area — assisted suicide — is ludicrous on its face" (p. 27).

Quill v. Vacco

Quill v Vacco involved a challenge to a New York State statute which provides that a person is guilty of manslaughter when "he intentionally . . . aids another person to commit suicide."²³ The Second Circuit Court ruled that state laws which deny mentally competent patients who seek to end their lives during the final stages of a terminal illness through the assistance of a physician deny such patients the equal protection of the laws in violation of the United States Constitution. Because the Second Circuit includes the states of New York, Connecticut and Vermont, its decision also affects a significant number of Americans. The New York law challenged by several physicians and by three terminally ill patients: "Jane", a 76-year-old retired physical education instructor who was dying of thyroid cancer; George Kingsley, a 48-year-old publishing executive suffering from AIDS; and William Barth, a 28-year-old fashion editor under treatment for AIDS. Friend of the Court briefs were also filed by many of the organizations that filed similar briefs in *Compassion in Dying v. State*, including United States Catholic Conference, American United for Life, Lambda Legal Defense and Education Fund, National Association of People with AIDS, Americans for Death with Dignity, and Hemlock Society.

The Second Circuit Court specifically rejected the claim that physician-assisted suicide was a liberty interest protected by the Fourteenth Amendment to the United States Constitution. In doing so, the Second Circuit Court's opinion could be said to significantly undermine the reasoning of the Ninth Circuit's decision. The Second Circuit Court observed that "rights that have no textual

support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so 'implicit in the concept of ordered liberty' that 'neither liberty nor justice would exist if they were sacrificed'" (p. 9). The court went on to conclude that "the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense" (p. 10).

Moreover, the Second Circuit Court continued its different approach than that of the Ninth Circuit by finding that New York's criminal prohibition of physician-assisted suicide constituted a violation of the equal protection of the law. The court stated that this guarantee of the Fourteenth Amendment "simply requires the states to treat in a similar manner all individuals who are similarly situated" (p. 11). The court arrived at its conclusion invalidating the law through a tenuous process of generalization, refusing to consider distinctions in the medical circumstance among various terminally-ill patients and instead considering all terminally-ill patients who sought to "hasten" their death to be "similarly situated". The court dismissed any significant difference under the law between two types of decisions which the law had always recognized as profoundly different; that is, the difference between the decision to refuse or withdraw certain medical treatments and the decision to administer death-causing drugs with the intention to thereby cause the death of the patient. In doing so, the court ignored important distinctions that both medicine and law had traditionally recognized and instead generalized that all such decisions would be considered under a single category of decisions to "hasten death".

The court placed great emphasis in its analysis upon the fact that the New York legislature in 1990 enacted a new law to allow a person to sign a "health care proxy" to appoint an agent with "authority to make any and all health care decisions" on the person's behalf including "those relating to the administration of artificial nutrition and hydration."²⁴ As a result of the passage of this statute, the court ruled that "New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems' but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs" (p. 16-17). Thus, the court held that there is no legally relevant distinction between assisted suicide and the withdrawal or withholding of life-sustaining medical treatment.

The court stated, "Indeed, there is nothing 'natural' about causing death by means other than the original illness or its complications. The withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiration failure. By ordering the discontinuance of these artificial

life-sustaining processes or refusing to accept them in the first place, a patient hastens his death that by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers" (p. 17). Whether or not it can be said that the death that ensues is the "natural" result of the patient's medical condition, the medical condition is directly related to the inability of the patient to perform the function "naturally" that is being provided by artificial means. That is a circumstance of the patient which has always been regarded as significant for both medical and legal purposes. Moreover, those who justify the termination of such procedures from the standpoint of *medical ethics* do so essentially on the basis that such procedures have become excessively burdensome to the patient or have become futile. They are not justified on the basis that they are necessary to hasten the death of the patient. Thus, the court was only able to reach its conclusion by overturning distinctions which both medicine and law have historically recognized as vital.

Moreover the court in *Quill v. Vacco* misconstrued the nature of the liberty interest involved in the right to refuse medical treatment by failing to appreciate the relationship of such a right to the principle of bodily integrity . . . Suicide enjoys no such foundational support, however. When one acts to end one's life, it is the intrusion of the lethal agent that violates bodily integrity."²⁵ The New York State Task Force on Life and the Law reached a similar conclusion when it found that, "The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity . . . It is this right against intrusion — not a general right to control the timing and manner of death — that forms the basis of the constitutional right to refuse life-sustaining treatment."²⁶

Finally, the circuit court dismissed the state's interest in protecting human life in such circumstances. It stated that "the state's contention has been that its primary interest is in preserving the life of all its citizens at all times and under all conditions. But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes . . . What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life'" (p. 17-18). While it is true that the court's language addresses the circumstances of a mentally competent patient suffering a terminal illness, it must also be recognized that the court's premise, that "the state's interest lessens as the potential for life diminishes", is surely one which cannot *logically* be limited to the situation of terminal illness or to the mentally competent patient. Certainly, the mentally handicapped, the physically disabled and the elderly all experience in significant ways a "diminishing" in their "potential" for life. Many of these citizens also experience a "diminishing" ability to "define [their] own concept of existence, of meaning, of the universe, and of the mystery of human life." To recognize in the law a concurrent "lessening" in the state's interest in protecting such life, as the court does, is a dangerous precedent.

Conclusion

Although the circuit courts in both *Compassion in Dying v. State* and *Quill v. Vacco* asserted that the physician-assisted suicide of mentally competent, terminally ill patients was protected by the United States Constitution, the fact that both courts reached this conclusion through different and potentially contradictory rationales highlights the tenuous link between suicide and the protections of American constitutional law. The equal protection of the law rationale used in *Quill v. Vacco* appears to rest almost entirely upon the circuit court's strained approach to the realities of medical care at the end of life by ignoring the very real distinctions between decisions to withdraw burdensome or futile procedures and affirmative actions undertaken with the intention of killing the patient. One cannot expect that such judicial reasoning can endure over time — constitutional law, like the practice of medicine, is dependent upon specificity and the recognition of difference, not the reverse.

The rationale of the circuit courts in both cases regarding the interest of the state in protecting human life is considerably more troublesome from the standpoint of constitutional law. Both courts seem to have accepted the contention of the dissenting Supreme Court justices in *Cruzan* that the state's general interest in life must accede to the patient's particularized interest. Such a view suggests that the state's interest in protecting life is controlling only when unnecessary; that is, only when there is no conflict between the interest of the state and the desire of the individual. At other times, when there is a conflict, the individual interest in choosing death must be recognized as paramount. Both courts also suggested that the interest of the state in protecting life exists only according to some type of sliding-scale: the state's interest in life is regulated by the patient's potential for life. When the patient's potential for life diminishes so also must the state's interest in the protection of that life diminish. For most of American constitutional history, however, American society has viewed the right to life as "inalienable." One difficulty presented by the courts' opinions in these cases is that if the right to life is now held to be "alienable" by the individual who "possesses" the right, it is also logically "alienable" by others and may one day be so in fact. Couple this dramatic shift in the law with the corresponding weakening of the state's interest in preserving life and American society may be set adrift on dangerous seas.

The United States Supreme Court may still avoid this difficulty by refusing to extend the reach of constitutional protections to physician-assisted suicide. As one commentator has observed, "A Court that refused to 'constitutionalize' a 'right to die' broad enough to uphold the claims of the Cruzan family is hardly likely to 'constitutionalize' a right to assisted suicide."²⁷ In that regard it is significant that the Supreme Court's opinion in *Cruzan* specifically cited the existence of state laws prohibiting assisted suicide as evidence of the state's longstanding interest in the protection of human life. Moreover, all eight justices were silent regarding any purported "right" to suicide within the factual circumstances presented by the medical situation of Nancy Cruzan in the face of Justice Scalia's assertion that "there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental'

or 'implicit in the concept of ordered liberty'."

Compassion in Dying v. State and *Quill v. Vacco* both entirely overlook two important realities constitutive of the practice of medicine in the United States today: one is psychological and the other is economic.

The first reality has been known for some time by physicians and can be summarized as follows: "A request for hastened death may be a way of saying that one does not feel worthy of great attention from the family . . . The request for euthanasia or assisted suicide may also be a means for patients to ask whether they continue to be valued, and whether the burden of illness remains manageable and the tasks of care meaningful. Helping patients to die quickly in such a situation does not represent a recognition of their autonomy; it simply confirms their sense of worthlessness and abandonment."²⁸ To establish a new assisted right-to-die in this context may only serve to further enhance this sense of diminished self-worth.

The second reality involves the economics of medicine at the end of life. In the United States the government-sponsored health program for the elderly, Medicare, consistently experiences large expenditures for patients at the end of life. Studies have shown that between 27 to 30 percent of payments for medical services under the Medicare program are to the five to six percent of Medicare patients who die in that year. For example, in 1988, the mean Medicare payment during the last year of a patient's life was \$13,316 as compared with \$1,924 for all other Medicare patients — a ratio of nearly seven to one.²⁹ Numerous studies have been undertaken to estimate the amount of financial savings possible to both government and non-government health care programs from the greater use of health care proxies (advance directives), hospice care and "less aggressive interventions". While such estimates vary, one study using 1990 expenditures estimated that between \$55 billion and \$109 billion might be saved "from a policy of asking all patients about their wishes regarding life-sustaining treatment and incorporating those wishes into advanced directive."³⁰ Others maintain that the cost savings to be achieved "by reducing the use of aggressive life-sustaining intervention for dying patients" will be much less, for example, only 3.3 percent of total national health care expenditures" — a percentage estimated to save \$29.7 billion in 1993.³¹

The present economic context for the delivery of health care services in the United States is one in which government increasingly demands substantial cost-savings in government-financed health care services. At the same time, an increasingly important number of American hospitals are abandoning their traditional character as not-for-profit, charitable institutions in order to become for-profit corporations. In such an economic climate, it cannot be reasonably assumed that the incentive of potential cost savings of \$29 billion to \$109 billion coupled with a newly established "right" to physician-assisted suicide will not invite varying levels of exploitation of the poor, the elderly, and the handicapped in the name of patient autonomy and death with dignity.

What is also striking about the reasoning of the courts in *Compassion in Dying v. State* and *Quilly v. Vacco* is their reliance upon the abortion jurisprudence of the Supreme Court in its most recent articulation in *Planned Parenthood v. Casey*. In his now classic treatise on American law, Justice Benjamin Cardozo observed that a judicial principle will tend "to expand itself to the limit of its logic."³² The purported

expansion of the abortion "liberty" to mandate a "liberty" interest in physician-assisted suicide is a tragic example of Cardozo's maxim. Yet it was predicted with surprising accuracy more than twenty-five years ago by the editors of *California Medicine*, the journal of the California Medical Association, when they wrote, "The traditional Western ethic has always placed great emphasis on the intrinsic worth and equal value of every human life regardless of its stage or condition . . . The reverence for each and every human life has also been a keystone of Western medicine and is the ethic which has caused physicians to try to preserve, protect, repair, prolong, and enhance every human life which comes under their surveillance. This traditional ethic is still clearly dominant, but . . . it is being eroded at its core and may eventually even be abandoned . . . The process of eroding the old ethic and substituting the new has already begun. It may be seen most clearly in changing attitudes toward human abortion . . . The part which medicine will play as all this develops is not yet entirely clear. That it will be deeply involved is certain. Medicine's role with respect to changing attitudes toward abortion may well be a prototype of what is to occur . . . One may anticipate further development of these roles as the problems of birth control and birth selection are extended inevitably to death selection and death control whether by the individual or by society . . ." ³³ To say that this "new" ethic has a logic within it which makes certain developments inevitable is not to say that the ethic itself is inevitable.

In *Compassion in Dying v. State* and *Quill v. Vacco*, two federal circuit courts have sought to enshrine this "new" ethic in the United States Constitution so as to control decisions concerning the end of life. It is easy for some at times to view the "old" ethic as one primarily derived from Christian or, more specifically, Catholic sources and the "new" ethic as derived from "neutral" and "secular" sources. Indeed, a significant portion of the circuit court's language in *Compassion in Dying* would suggest just such a view. Yet the emergence of Hippocrates and his Oath in the Western tradition of medicine derives entirely from non-Christian sources. The Ninth Circuit Court's attempt to banish the Hippocratic Oath from such life and death decisions by claiming that it "originated in a group representing only a small segment of Greek opinion and that it certainly was not accepted by all ancient physicians" (p. 31) misconstrues both the direction and dynamic of history. Regardless of how many ancient physicians immediately agreed with Hippocrates, the Hippocratic Oath became the measure of Western medicine for the same reason that democracy and the classical ideal in sculpture arose in fifth century Athens — it was the only response which conformed to the dignity of the human person as a free and moral subject. Margaret Mead summarized this dynamic as follows: "Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with the power to kill had the power to cure, including specially the undoing of his own killing activities. He who had the power to cure would necessarily also be able to kill. With the Greeks [the Hippocratic Oath] the distinction was made clear. One profession, the followers of Asclepias, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect — the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child . . . [T]his is a priceless always

possession which we cannot afford to tarnish, but society always is attempting to make the physician a killer."³⁴ Many in the ancient world embraced the teaching of Hippocrates because of his affirmation of the moral equality and dignity of his patients as human persons. It is for those very reasons that many today are willing to wait for him still.

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2. ___ F.3d ___ (1996); 1996 WL 148605 (2nd Cir. (N.Y.)); all references to the Second Circuit decision will cite the West Law slip opinion.
3. *Revised Code of Washington* 9A.20.020(1)(c)(1975).
4. *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992).
5. Lawrence Tribe, *American Constitutional Law* (Mineola, NY: Foundation Press, 1978), p. 944.
6. *Ibid.*, p. 946.
7. Section One of the Fourteenth Amendment to the United States Constitution reads in part, "No State shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."
8. *Bowers v. Hardwick*, 302 U.S. 186, 191-92 (1986).
9. *Planned Parenthood v. Casey*, 112 S. Ct. at 2805.
10. *Ibid.* at 2807.
11. 110 S. Ct. 2841 (1990).
12. *Ibid.* at 2851.
13. *Ibid.* at 2852.
14. *Ibid.* at 2852.
15. *Ibid.* at 2873.
16. *Ibid.* at 2870.
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