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An Idea Whose Time Should Never Have Come

Roger B. Dworkin

An old American newspaper cartoon by Jimmie Hatlo was entitled, "There Oughta' Be a Law." It would always show a picture of one of life's annoyances and suggest that there "oughta" be a law prohibiting it. Unfortunately, the mentality that there should be a law to deal with everything one does not like or to assure one whatever one wants, has caught the public's imagination and extended far beyond comic page annoyances. Now many ordinary persons and lawmakers respond to every perceived evil by attempting to remedy it through law. That is a huge mistake. Law is a collection of imperfect tools for social organization and control. Each of the law's tools is of limited utility, and the entire collection has limits too. In addition, other kinds of social controls – professional ethics, schools, churches, families, clubs, workplaces, etc. – are available as alternatives to law. Sometimes turning to law does more harm than good. One example of this phenomenon is the so-called right to die.

To make my own preference clear, let me tell the reader that I carry a living will in my wallet. It even specifically eschews the use of artificial nutrition and hydration should I be in a terminal condition. This reflects what living wills usually reflect: a desire for autonomy and control, a wish to avoid suffering and maintain dignity, a desire to preserve as good a memory of me as possible among my loved ones, and a desire to spare them from having to make difficult and guilt-inducing decisions about what to do with me as I approach death's door. In other words I want to be able to exercise some control over the manner and timing of my own death.

That said, I believe that the so-called right to die movement has been a mistake. Every American state now recognizes one or more forms of advanced directive. Many state courts have recognized a right to refuse medical care in certain circumstances even when the refusal will certainly lead to death. One state, Oregon, has specifically authorized physician assisted suicide in some circumstances.[1] The United States Supreme Court, which has denied the existence of a constitutional right to assisted suicide,[2] has said that the existence of a right to reject life prolonging medical treatment can be inferred from some of its decisions,[3] and has as-

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1 Ore. Rev. Stat. 127.800 – 127.897 (Supp. 1998).

2 *Washington v. Glucksberg,* 521 U.S. 702 (1997); *Vacco v. Quill,* 521 U.S. 793 (1997).

3 *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261, 278 (1990).

sumed for the sake of argument that such a right would include the right under some circumstances to reject artificial nutrition and hydration.[4]

This is very dangerous. It has created a culture in which death is sometimes viewed as a good and in which doctors are criticized for thinking of death as the enemy. It has led to a mind set that sees those who wish to cling to life as perverse and wrong-headed. It has led to deceiving ourselves into believing that killing incompetent persons can be a way to respect their dignity and autonomy. And it has already led to the idea that people have not only a right to die, but a duty to do so.

Let me give three examples: In Colorado a coroner's inquest found that a hospital patient's death was a homicide after medical personnel removed organs from the terminally ill patient to transplant them to other persons. In a middle western city a hospital ethics committee was called into emergency session because the brother of a very ill, arguably incompetent patient who needed both cardiovascular support and dialysis as well as frequent antibiotics to combat recurrent infections, insisted that the patient be treated. Committee members were told, not only by a physician, but also by the hospital's chaplain, that the brother just did not understand. He insisted on focusing on whether discrete interventions (like antibiotics) could solve discrete problems (like an infection), rather than viewing the situation whole. This was annoying because it required the doctor and hospital to continue to treat the patient and to use up space in its intensive care unit and because the patient's infections posed risks to other ICU patients. Finally, in the disturbing case, *Matter of Spring,*[5] which I have discussed elsewhere,[6] a Massachusetts court authorized the cessation of life-preserving dialysis for a patient with kidney failure and chronic organic brain syndrome. The patient was unpleasant and difficult, and his adult son blamed the stress of caring for him for the patient's wife having had a stroke. Focusing on even an incompetent person's right to reject medical treatment, the court authorized withdrawal because, it concluded, the patient would not have wanted to live in his condition despite the fact that during his long life of mental competence, the patient had never expressed any opinion about the matter at all. The court spoke the language of rights to justify killing a man who was a nuisance.

All of this is terrifying and unacceptable. What has caused the problem? I believe that the problem comes largely from our insistence on having a law to cure all ills and on our preference for extreme measures over moderate ones. Not only do we think, "There Oughta' Be a Law," we often think there "oughta'" be a right. Professor Mary Ann Glendon has persuasively called attention to Americans' obsession with rights,[7] and Professor Carl Schneider has reminded us of the impor-

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[4] *Id.* at 279.

[5] 405 N.E.2d 115 (Mass. 1980).

[6] *Roger B. Dworkin,* Limits: The Role of the Law in Bioethical Decision Making 116–117 (1996).

[7] *Mary Ann Glendon,* Rights Talk (1991).

tant corollary of rights: Recognizing something as a right implies that the opposite position is a wrong.[8] The fact that I and many others would like to exercise some control over the manner and timing of our deaths does not mean that we have a right to do so. It does not mean that preferring life to death is wrong. And, if preferring death is not "right," and preferring life is not "wrong," it certainly does not imply that anyone has a duty to die.

Be Careful What You Wish For

Many available medical options share a troubling irony: They are desirable for those who do not have access to them and undesirable for those who do. Contraceptive sterilization is a benefit sought by many and an evil sought to be avoided by many of those to whom it is to be applied. Pregnancy is a blessing widely sought and pursued with fervor, desperation, and great expense by some, while its results are so unacceptable to others that they assert a right to terminate a pregnancy. So it is with death. Most sane persons strive mightily to avoid death – obtaining vaccinations against disease, avoiding needless risks, obtaining medical treatment for everything from colds to cancer, and wearing seatbelts when they ride in cars. But others, who are very ill and suffering, often court death, even asserting a right to be allowed to die.

The easy explanation for these apparent contradictions is that each of them simply represents the claim to human autonomy: Individuals do not want contraception or no contraception, pregnancy or abortion, death or life; they want to be able to *choose* which they want, depending on circumstances. Thus there is no pro-abortion movement; there is a pro-choice movement. Unfortunately, this obvious and easily stated distinction between wanting an end and wanting to be able to choose between ends, seems incapable of being accepted and acted on by persons in their political capacities.

There are at least two reasons for this: First, opponents of rights to choose seldom object to the act of choosing. They object to the result of one possible choice. They recognize that a right to choose necessarily implies that sometimes a person will make the choice the opponents find unacceptable. Those who support abortion may call themselves pro-choice. Their opponents, however, do not call themselves anti-choice; rather, they are pro-life or anti-abortion. Second, autonomy claims are often overstated because they ignore the reality that each person's choice affects others as well.[9] In the abortion context, this is obvious. Not only does an abortion have an effect on the fetus's father and possible siblings, grand-

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[8] *Carl E. Schneider,* "Rights Discourse and Neonatal Euthanasia", 76 Calif. L. Rev. 151, 172 (1988).

[9] *See generally, Roger B. Dworkin,* "Getting What We Should from Doctors: Rethinking Autonomy and the Doctor-Patient Relationship", 13 Health Matrix 235 (2003); *Roger B. Dworkin,* "Medical Law and Ethics in the Post-Autonomy Age", 68 Ind. L.J. 727 (1993).

parents, etc., but most importantly, on the fetus itself. That is why so much ink is spilled over the questions of when life begins and whether a fetus is a child. In the death facilitation context, the autonomy claim seems stronger because there is no equivalent of a fetus to be considered. Nonetheless most persons' deaths have significant effects[10] on others – the dead person's relatives, friends, employers, co-workers, clients, etc. "Whose life is it anyway?" is a real question, not a rhetorical one.

Once one recognizes that the death facilitation debate is about dying, not choosing, and that one person's death (or nondeath) affects others, one can begin to see why the idea that there is a right to choose the manner and timing of one's death is an idea whose time should never have come.

While death facilitation is hardly new, the seminal American case on the subject is *Matter of Quinlan.*[11] That case, like all the early cases,[12] involved a person who was incapable of making any choices, much less a choice whether to live or die. Karen Ann Quinlan was in a persistent vegetative state. The Supreme Court of New Jersey, nonetheless, resolved the case by deciding that a competent person has the right in some circumstances to choose to reject even life-saving medical treatment and that therefore an incompetent patient, like Ms. Quinlan, must have the same right. Otherwise, we would be rejecting the dignity of incompetent persons. This is errant nonsense. To pretend that a person who cannot make choices can make them as a justification for authorizing someone else to make them for her is to deny the dignity of the incompetent person. It essentially treats an incompetent human being like an animal. We routinely put nonhuman animals "out of their misery", recognizing that the animals cannot decide what they want and trusting benevolent animal-lovers to make the best choice for the animals. That is what we are doing in the human cases too. The difference is that in the animal cases we make no pretense of recognizing the animal's dignity, while in the human case we do. The result is that we can deceive ourselves into believing that we are acting in accordance with a person's wishes even when we clearly are doing what somebody deems better for others. That is frightening.

Imagining the Unimaginable

Suppose for a moment that we were to consider honestly whether a society should allow persons to be killed at the instance of someone else in any context other than war or punishment for crime. What would the debate look like?

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10 By "significant effects" I mean effects beyond those recognized by the trite observation that everything that affects one person, affects all. One need not speculate about whether a butterfly flapping its wings in Africa contributes to causing a hurricane in Texas to understand that one person's death will affect those close to him.

11 355 A.2d 647 (N.J.), *cert. denied sub. nom. Garger v. New Jersey,* 429 U. S. 922 (1976).

12 *See, e.g.* cases collected in *Cruzan, supra* n. 3, at 270–277.

First, one must recognize that the debate could not be about whether to allow persons' to choose to die. The point of this analysis is to show that allowing such choices is the mistake that has led to persons being put to death without having chosen to do so. Thus, we must see whether we would be willing to allow the latter, involuntary killings if we considered that issue on its own. If we would, then there would be relatively little to object to about recognizing a right to choose to die. Only if we would reject involuntary killings in the first instance is it necessary to see whether a causal link exists between chosen and mandatory death.

Those who favored the policy of allowing persons' to be killed would be disabled from arguing that they were acting out of respect for the candidate's[13] wishes. By definition we are discussing persons who either have expressed no wish about the matter or who have stated their desire to continue to live. Could the supporters justify their position as one rooted in beneficence to relieve candidates' suffering?

If the candidate is competent, then clearly the beneficence argument cannot be made. A competent candidate who does not ask to be killed obviously thinks that life, however horrible, is better for him than nonlife. Therefore, killing him would obviously not be a kindness to him. However, if the person is incompetent, the case becomes harder. The strongest case for a supporter of killing would be that of a person who is totally disabled from forming preferences, not a person who is just technically incompetent. By focusing on the totally incapable, one avoids all questions about which decisions are entitled to some consideration. Imagine a person in a persistent vegetative state (pvs) and a person who is awake, but totally out of touch with reality. As to the person in a persistent vegetative state, so far as we know, that person cannot suffer. Therefore, killing him cannot be justified as a way to relieve his suffering. Any claim that killing him now would have relieved suffering earlier when he was competent – the suffering of fearing that he would live in a pvs or that his relatives would have less good memories of him than he desired – so trivializes the notion of suffering as to make it virtually insignificant in any calculus of policy choices.

But how about the person who is out of touch with reality, but who is awake and therefore able to demonstrate that he is suffering. We think we can tell when animals are suffering by their behavior, noises that they make, etc. Presumably, we could similarly recognize the suffering of a totally incompetent human being. Someone might argue that killing such a person was an act of kindness to him. This argument would apply in very few cases. Almost all physical pain can be relieved by aggressive treatment. Therefore, for almost all patients a less extreme alternative than death exists, at least with regard to physical pain. Even for persons whose pain cannot be relieved, the beneficence argument is of questionable

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13 I use the word, "candidate," to refer to a person whose death is being considered. Use of a more colorful term, like "victim," would unduly prejudice the argument.

strength. What does it mean to suffer if one is unaware of the suffering or if one cannot remember it? Some anesthetic agents render a patient incapable of remembering that he has suffered pain. How much sense does it make to say that the patient is suffering while he is undergoing a painful procedure whose pain he will not remember? To what extent are pain and suffering physical and to what extent mental phenomena?

Despite this question, reminiscent of inquiries about trees falling in unpeopled forests, I will concede for the sake of argument that an awake, totally dissociated person can suffer. The doubts plus the relatively small number of persons who must fall into this category, however, make the argument from beneficence weak.

If there is no valid autonomy argument and only a weak and infrequent beneficence argument to support killing persons who have not chosen death or allowing such persons to die, then is there any other basis on which such expediting of death can be justified? If the expediting of death would not serve the candidate's interests, then it could only be justified by its contribution to others, either specific others or society at large.

A number of specific persons will be substantially affected by a decision whether another person should continue to live. Most obvious are the candidate's relatives with the closest relatives being the most affected. I have argued elsewhere that it is appropriate to consider the interests of significantly affected individuals in addition to patients in making decisions about medical obligations.[14] No one is an island, and every person's death will have an impact on those close to him. If those persons (dependent children of a parent who may recover his or her health, for example) will benefit from the candidate's continuing to live, then the issue of whether to consider their interests as a basis for expediting his death will not arise. If, however, the others will benefit from the candidate's death, then the issue should be considered.

A number of different benefits are possible. If the benefit one imagines is financial, the case for considering it seems unappealing, especially if one envisions greedy heirs awaiting an inheritance. If, though, one envisions a spouse and children being bankrupted by the costs of the candidate's illness, with consequences to their own health, nutrition, employment, and education, their concerns do not seem so unworthy. Ought it to be acceptable to expedite the death of a person to satisfy true financial needs of his dependents?

Clearly, the answer is no. Many persons – almost all children, the unemployed, those with special health, education, or other needs, profligate individuals, alcoholics, drug users, compulsive gamblers, etc. – are a financial drain on their families. A decision that killing such persons is justified would lead to wholesale slaughter and reduce human dignity to a financial calculus. It may be possible to distinguish a dying patient from a person who is drinking away his family's re-

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[14] *See, Dworkin,* Getting What We Should from Doctors, *supra* n. 9.

sources, but the distinctions would be so hard to draw and the dangers of a slippery slope so great that the effort ought not to be made.

However, one might imagine other benefits from a relative's death. In the *Spring* case[15] the candidate's adult son allegedly thought that the stress of caring for his father had caused his mother to have a stroke. Suppose that the strain of caring for a very sick relative really did imperil another person's health. Then would it be acceptable to kill the candidate in order to save or preserve the health of the other person?

Now the caretaker's interests surely deserve consideration. That person's life is as valuable as anybody else's. However, that recognition does not lead to the conclusion that it is acceptable to kill the candidate. Both persons' interests can be protected by transferring the responsibility to care for the candidate to somebody other than the endangered caretaker. If the society refuses to pay for professional caretakers, then a decision to kill the candidate will be a decision to save the taxpayers money, a decision that is unacceptable as argued below. If the caretaker is unwilling to pass the responsibility to a third person, then the caretaker has chosen his or her own lot. Moreover, it would be wildly illogical to be so committed to a person that one insisted on caring for him personally, while at the same time being willing to have him killed.

Similarly, psychological interests of those close to the candidate – feeling really terrible about seeing the candidate suffer – are too easy to fake and too hard to prove to deserve much weight in reaching a decision to kill another human being.

If then the interests of identifiable persons cannot justify killing a candidate, can the interests of society at large justify doing so? Clearly not. There are two problems with deferring to society in these matters. First as I have argued elsewhere,[16] the interests of society usually turns out to mean the interests of taxpayers. Second, the interests of society are likely to mean the interests of the powerful in the society, thus creating a real risk of using the "interests of society" as a code phrase for bigotry and excuse for eliminating the "unfit."

Surely, no civilized society can tolerate the view that persons who cost the state more than they contribute to it should be killed in order to save the taxpayers' money. Such a position would lead to the deaths of not only the terminally ill and the incurable, but also all prisoners, all persons on welfare, and countless others. Similarly, the world does not need another example of what happens when those who are thought to be unfit are put to death for the good of society. Whether one thinks about Serbs and Croatians, Arabs and Israelis, Irish Catholics and Protestants, the Sudanese government and Darfur refugees, or majority whites and minority groups in the United States, it would be naive to believe that consideration of the good of society would lead to anything other than genocide.

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15 Note 5, *supra.*

16 *See, Dworkin,* Getting What We Should from Doctors, *supra* n. 9 at 280–281.

Thus, the conclusion is that if faced directly, freed of euphemisms and myths, no justification for killing an innocent person, who is not one's enemy in war, against his will exists. What does that suggest about recognition of a right to die?

What Have We Done?

The Netherlands is the one country in which voluntary euthanasia is legal. While the practice was tolerated under certain guidelines for many years, it was finally officially legalized in 2002. Now the Royal Dutch Medical Association has asked the Ministry of Health to create a body to evaluate and sometimes permit euthanasia for "persons with no free will."[17] The request grows out of a desire to authorize the "mercy killing" of certain babies. The specific example given is babies with "extreme spina bifida."[18] While what is "extreme" may be in the eye of the beholder, spina bifida is not necessarily fatal if treated, and persons with spina bifida can become contributing members of society.[19] On the other hand, they are expensive to treat, and their lives are not what nondisabled persons would choose. The Dutch proposal, growing out of the Dutch practice of first tolerated and now legal euthanasia, is exactly the kind of proposal that a tolerant view of euthanasia, beginning out of respect for autonomy, can become. Respect for autonomy and choice has rapidly become a movement to kill those who lack autonomy[20] and who are a drain on the state and, perhaps, on their families.

In the United States will we be able to resist such pressures? Scholars[21] and political figures[22] have already suggested that there is a duty to die and that old persons should get out of the way of young, productive ones.

So far only one American state has authorized physician assisted suicide,[23] and none permits euthanasia. Nonetheless, clouds appear on the horizon. As noted, every state now recognizes some form of advanced directive, which permits persons to reject in advance life saving treatment should they be in a terminal condition. Ironically, these statutes have proved to be almost worthless for actually giving patients the power to control the manner and timing of their own deaths.[24]

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17 "Dutch ponder 'Mercy Killing' Rules," http://www.cnn.com/2004/HEALTH/12/01/netherlands.mercykill/index.html.

18 *Id.*

19 I have spoken on the same program as a woman with spina bifida who flies around the country lecturing about rights for persons with disabilities.

20 At least in the sense of liberal individualism, if not in the sense of physical essentialism. *See, Dworkin,* Medical Law and Ethics in the Post-Autonomy Age, *supra* n. 9 at 733; *Dworkin,* Getting What We Should, *supra* n. 9 at 238–239.

21 *See, e.g., Daniel Callahan,* Setting Limits: Medical Goals in an Aging Society (1987).

22 *Richard D. Lamm,* Duty to Die (speech, 1984).

23 Ore. Rev. Stat. 127.800–127.897 (Supp. 1998).

Nonetheless, it is these advance directive statutes that open the door for the kind of responses seen in the case of the woman in the middle west with several serious conditions.[25] Whatever their form they actually transfer decision making authority to relatives and doctors, and occasionally to courts,[26] to decide what a person would have wanted. Doctors are much more likely to have trouble with healthy relatives than with dead patients or even very sick ones. It is not surprising then that the wishes of soon-to-be survivors take precedence, and that they are the persons subjected to pressure to agree to patients' deaths.

However, constitutional developments raise even more questions about a putative right and duty to die. After fourteen years of state court developments[27] the United States Supreme Court entered the death expediting debate in 1990. In *Cruzan v. Missouri Department of Health*[28] the Court considered whether parents could refuse artificial feeding and hydration for their adult, previously competent daughter who was in a pvs as a result of an automobile accident. Rather than hold that there is a constitutional right to refuse even life saving medical care, the Court said merely that such a right for competent patients could be inferred from its prior decisions.[29] The right would not be part of the so-called right of privacy, but rather would be a Fourteenth Amendment liberty interest, protected from deprivation without due process of law.[30] The Court then assumed for the sake of argument that the inferred liberty interest would include the right to refuse nutrition and hydration.[31] The assumption was harmless because the Court held that the assumed right was properly overridden in the case before it. Nonetheless five justices[32] did conclude that there is a right to refuse nutrition and hydration.

All cases decided before *Cruzan* had agreed that it is necessary to accord the same rights to incompetent persons as to competent ones in order to respect the dignity of incompetent persons. The *Cruzan* majority correctly rejected that view, noting that it begs the critical question: What are the rights of incompetent persons, and how may they be exercised?[33] This is crucial because if one were to ignore the differences between competent and incompetent persons, there would be a risk that in the rush to protect the right to die, incompetent persons would lose the right to live.

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24 *Angela Fagerlin* and *Carl E. Schneider,* "Enough: The Failure of the Living Will", 34 #2 The Hastings Center Report 30 (2004).

25 *See* p. 2, *infra.*

26 *See,* e.g., Matter of Spring, *supra* n. 5.

27 Beginning with *Quinlan, supra* n. 11. Many of the cases are collected in the majority opinion in *Cruzan, supra* n. 3 at 270–277.

28 *Supra* n. 3.

29 *Id.* at 278.

30 *Id.* at 278–279.

31 *Id.* at 279.

32 *Id.* at 287 (O'Connor, J., concurring), 301 (Brennan, J., dissenting), 330 (Stevens, J., dissenting).

33 *Id.* at 279–280.

In addressing the incompetent person's assumed right to have nutrition and hydration withheld the Court affirmed the Missouri Supreme Court's holding that the state may refuse to stop providing nutrition and hydration unless there is clear and convincing evidence that that is what the *patient herself* wanted because the elevated level of required proof served the state's interests in protecting life and freedom of choice and preventing fraud and abuse.[34] Unfortunately, however, the Court reached its position without providing any analysis of how important the right to refuse nutrition and hydration is, or of how important the state's interest must be and how closely related to its interest its intrusion must be in order to justify infringing upon the right.

Importantly, Justice Brennan, joined by Justices Marshall and Blackmun rejected the majority's view that the rights of competent and incompetent persons need not be the same.[35] Justice Scalia argued that it is impossible to distinguish a right to refuse lifesaving medical treatment from a right to commit suicide.[36] If the Brennan opinion and the Scalia opinion were to be put together, they would lead to the conclusion that competent and incompetent persons must have the same rights with regard to suicide. Scalia took the impossibility of distinguishing refusal of care[37] from suicide as grounds for rejecting a right to refuse lifesaving medical care for anybody. Of course the inability to distinguish could just as easily lead to the conclusion that everybody has a right to commit suicide if they have a right to reject lifesaving care. Then the question that would arise would be whether the right to reject care (and to commit suicide) must also include a right to euthanasia. If it must, and if competent and incompetent persons must have the same rights, then exactly the problem I am worried about would occur: We would have euthanasia of the incompetent.

The question of whether it is possible to distinguish assisted suicide from rejecting medical care arose directly in *Washington v. Glucksberg*[38] and *Vacco v. Quill.*[39] In those cases the Supreme Court rejected the suggestion that the Constitution includes a right to assisted suicide and upheld the Washington and New York statutes that prohibited it. Significantly, however, Justice Stevens said that there may be circumstances in which application of a statute that prohibited assisted suicide might be unconstitutional.[40] Justice Souter, who agreed that the statutes are uncon-

34 *Id.* at 280–281.

35 *Id.* at 301, 308 (Brennan, J., dissenting).

36 *Id.* at 296–298 (Scalia, J., concurring).

37 Refusing or rejecting care is the way to phrase what is going on if one focuses on the patient. Operationally, however, the way that refusal or rejection is effected is that the doctor must withhold or withdraw treatment. A decision by the doctor followed by an act of commission or omission is always required.

38 *Supra* n. 2.

39 *Supra* n. 2.

40 *Washington v. Glucksberg, supra* n. 2, at 738, 739 (Stevens, J., concurring in the judgments).

stitutional today, specifically reserved the right to change his mind.[41] Even the majority specifically recognized the possibility of unconstitutional prohibitions of assisted suicide, although they said that it was unlikely that they would find one.[42]

The majority concluded that the liberty which the Fourteenth Amendment protects against deprivation without due process of law does not include a right to commit suicide and, therefore, does not include a right to assistance in committing suicide.[43] It reached this conclusion not through analysis of principle, but rather by considering American tradition. The Court said that if it recognized a right to physician assisted suicide it would be striking down centuries of legal doctrine and practice and the considered policy of almost every state.[44] Of course that is exactly what the court did when it decided *Roe v. Wade,*[45] which recognized a constitutional right of privacy that was "broad enough" to include a woman's decision whether to terminate her pregnancy. Apparently, the Court relies on tradition only when it wants to. Given the views discussed above, one cannot be sure that it will always want to in the area of death expedition.

Having decided that Fourteenth Amendment liberty does not include a right to assisted suicide, it was easy for the Court to decide that numerous state interests – preserving life; preventing suicide and studying, identifying, and treating its causes; protecting depressed and mentally ill persons; protecting the ethics and integrity of the medical profession; protecting vulnerable groups; and avoiding starting down the path to euthanasia – justified prohibiting the practice.[46]

In *Glucksberg's* companion case, *Vacco v. Quill*[47] the question was whether a statute that prohibits assisted suicide deprives competent persons who are not on life support of the equal protection of the laws vis a vis competent persons who are on life support. The argument was that those on life support could hasten their deaths by having life support withdrawn, while patients not on life support could not hasten their deaths by getting lethal medication from their physicians. In other words the patients who were not on life support claimed that there is no meaningful difference between withholding and withdrawing care (which was permitted) and physician assisted suicide (which was not). Therefore, they argued it is unconstitutional to treat the two groups of patients differently.

The Court rejected the argument for three reasons: The distinction between withholding and withdrawing care and assisted suicide is widely recognized and endorsed; causation is different in the two situations; and intent is different in

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41 *Id.* at 752, 789 (Souter, J., concurring in the judgment).

42 *Vacco v. Quill, supra* n. 2 at 809, n. 13.

43 *Washington v.Glucksberg, supra* n. 2, at 723, 728.

44 *Id.* at 723.

45 410 U.S. 113 (1973).

46 *Washington v. Glucksberg, supra* n. 2, at 728 – 735.

47 *Supra* n. 2.

the two situations.[48] None of these distinctions is persuasive, either alone or in combination.

The fact that the distinction is widely recognized and endorsed, if true, is of no significance. Many perceived distinctions, including those between the sexes, between different races, and between heterosexual and homosexual conduct are widely recognized and endorsed or have been at one time. That does not make them constitutionally acceptable. One role of the Supreme Court is to correct the errors of the majority.

The causation argument is unsound. The claim is that if life sustaining treatment is withheld or withdrawn, the patient's underlying condition causes his death; in assisted suicide the medication provided by the doctor causes the death. This is grasping at straws. In each case the underlying condition and the doctor's action are both causes of death. In the withdrawing and withholding setting, the patient would not have died but for the underlying condition. However, he could have been kept alive by continuing treatment. Therefore, he would not have died but for the withholding or withdrawing, and they too were a cause of his death. Similarly, in the case of physician assisted suicide, the doctor's providing the medication or prescription permitted the patient to kill himself and therefore was a cause of his death. The physician would not have provided the medication but for the patient's condition, so the condition also was a cause of death.

The argument from intention is simply disingenuous. In withholding or withdrawing, we are told, the doctor's intent is to ease the patient's suffering or to respect his dignity or autonomy. Death is just an undesired consequence. In assisted suicide, on the other hand, death is the goal. Whom are we kidding? If a doctor withholds or withdraws life support from a dying patient, the doctor intends the patient to die. He may intend that the death be free of suffering and respectful of the patient's dignity and autonomy, and he may be sorry about the patient's death, but he is planning to cause the death of this person. This direct plan to end the life of a specific, identified human being is no different than what a doctor intends when he participates in assisted suicide. He means to cause the patient's death as painlessly as possible while maintaining maximum patient dignity and autonomy.

The distinction between euthanasia and either withholding and withdrawing care or assisted suicide is also unconvincing. Once again a physician (or other person) is engaging in conduct that expedites another person's death, ostensibly out of a desire to relieve suffering or maintain dignity. In one case the physician turns off a respirator or removes a feeding tube; in the second, he prescribes lethal medication for the patient to take; in the third, he administers the medication himself. Whatever the specific act, he is doing something that he means to cause the patient's death and that does cause it. There is no more significant difference among

[48] *Id.* at 800–808.

the three acts than there is between driving too fast and failing to step on the brakes. If either leads to injury or death of another, noone would argue that failure to apply the brakes was more acceptable than driving too fast. If doctors feel that there is a difference (as in my experience they do) and that they are opposed to euthanasia and assisted suicide, but not to withholding or withdrawing care, they should re-examine their beliefs to see whether the alleged difference is only a rationalization. If so, and if they are uncomfortable with performing euthanasia, then perhaps they should also refuse to allow patients to die by withholding or withdrawing life support.

The one valid distinction that exists in the area of death facilitation is between competent and incompetent patients. If all forms of death facilitation could be limited to competent persons, then withholding and withdrawing medical care, assisted suicide, and euthanasia might all be acceptable. However, as long as courts refuse to draw that distinction and purport to distinguish among three forms of death facilitation, nobody is safe.

In the United States today we must free ourselves from the misguided rhetoric that suggests that competent and incompetent persons must have the same rights. As I have suggested elsewhere,[49] that position is not only senseless, it is also demeaning of and disrespectful to persons with disabilities. It is senseless because it ignores the fact that many competent persons' rights depend on an ability to make meaningful choices, which incompetent persons cannot do. It is demeaning and disrespectful because it ignores what may be the most significant fact of the disabled person's life and forces persons with disabilities into a mold that is designed to fit the rest of us. Plain old negligence law handles the problem much better. It subjectivizes the standard of care in two ways to make it fit the reality of disabled persons. As has often been observed, the law does not expect the blind person to see, but it does expect him to act with awareness that he is blind. That approach, rather than denying the blind person's blindness, is the way to accord him respect.

Conclusion

American death and dying law is perversely paradoxical. Its statutory reforms, which are designed to let competent persons have some measure of control over the manner and timing of their own deaths, does almost nothing for them. Meanwhile, the mere existence of the law, which suggests that one *may* die, imposes pressure on individuals *to* die. The absence of any meaningful distinctions among letting patients die, assisted suicide, and euthanasia opens the door to the killing of incompetent persons and others who burden the state for the supposed benefit of the rest of us, while couching the debate in the language of rights suggests that we are doing something *for* incompetent persons instead of doing something *to* them.

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49 *Dworkin,* Getting What We Should, *supra* n. 9 at 269–270.

This is very perverse. Those of us who want to control the manner and timing of our deaths cannot do so. Those who need protection from being prematurely killed lack it.

This unfortunate state of affairs is a result of our all-or-nothing view of the world and our preference to disguise what we are doing rather than analyze it honestly. We too often act as if everything desirable must be a right. If it is a right, then the opposite must be a wrong. We seem incapable of tolerating ambiguity and recognizing that questions of life and death are far too complicated to be resolved by sweeping constitutional adjudication or abstract legislation. Moreover, while death may occasionally be a blessing, it is usually an evil to be fought against. Doctors are right, not wrong to treat death as the enemy. For those who cannot express their view about whether death would be a blessing or a curse for them, does not a commitment to decency and humane values require us to assume either that nothingness is the ultimate evil or that we are incapable of deciding whether existence or nonexistence is better? Is it not either arrogant or disingenuous to claim that we know what is best?

Before the revolution that started with Karen Ann Quinlan doctors practiced humane death facilitation for patients who sought it, and patients had a fair amount of control over the manner and timing of their deaths. Nonetheless, the criminal law threat reduced the danger of abuse. As is so often the case, law reform made the situation worse, doing nothing for competent persons and endangering incompetent persons. The right to die is an idea whose time should never have come.[50]

Zusammenfassung

Die amerikanische Überzeugung, daß alle Probleme mit Hilfe von Gesetzen gelöst werden können und aus allem, was der Mehrheit wünschenswert zu sein scheint, ein Recht gemacht werden sollte, hat zu der weitverbreiteten Anerkennung eines sogenannten Rechts zu sterben geführt. Dieses Recht taucht in Gesetzen aller amerikanischen Staaten auf, in vielen Urteilen staatlicher und bundesstaatlicher Gerichtshöfe sowie schließlich auch indirekt in Entscheidungen des United States Supreme Court. Paradoxerweise hat dieses Recht zu sterben denjenigen, die fähig sind, es auszuüben, nur wenig eingetragen, während es auf der anderen Seite entscheidungsunfähige Personen in die Gefahr und manchmal sogar in die unmittelbare Lage des Mißbrauches gebracht hat.

Versuche, die Erlaubnis für Patienten zu sterben auf der einen Seite von der Hilfe beim Suizid und von der Euthanasie zu trennen, können nicht überzeugen. Die Behauptung, identische „Rechte“ sowohl entscheidungsfähigen als auch

[50] Of course, some prescient scholars, most notably Yale Kamisar, recognized this even before the idea really took hold. *See, Yale Kamisar,* "Some Non-Religious Views against Proposed 'Mercy-Killing' Legislation", 42 Minn. L.Rev. 969 (1958).

entscheidungsunfähigen Personen gleichermaßen zuzuschreiben, ist sinnlos und respektlos. Sogar die Anerkennung eines nur begrenzten Rechts zu sterben, begleitet von der Behauptung angeblich gleichmäßiger Behandlung, führt zu unangemessenen Tötungshandlungen. Da es sich bei dem Recht zu sterben um eine Entwicklung handelt, die zugleich gefährlich und ineffektiv ist, wäre es besser gewesen, wenn dieses Recht erst gar nicht entwickelt worden wäre. Es sollte erneut überdacht und dann abgeschafft werden.