Notre Dame Journal of Law, Ethics & Public Policy

Volume 12
Issue 2 *Symposium on the Beginning and End of Life*

Article 2

1-1-2012

Dealing with Death

John T. Noonan Jr.

Follow this and additional works at: http://scholarship.law.nd.edu/ndjlepp

Recommended Citation

John T. Noonan Jr., *Dealing with Death*, 12 Notre Dame J.L. Ethics & Pub. Pol'y 387 (1998).
Available at: http://scholarship.law.nd.edu/ndjlepp/vol12/iss2/2

This Speech is brought to you for free and open access by the Notre Dame Journal of Law, Ethics & Public Policy at NDLScholarship. It has been accepted for inclusion in Notre Dame Journal of Law, Ethics & Public Policy by an authorized administrator of NDLScholarship. For more information, please contact lawdr@nd.edu.

SPEECH

DEALING WITH DEATH

JOHN T. NOONAN, JR.*

Both our professions, the medical and the legal, deal with death—not all the time but enough of the time that awareness of it lurks in our subconscious as it lurks in the subconscious of ministers of the Gospel. This afternoon I shall speak to you about how assistance to die provided by a physician has been addressed by judges. I shall do so concretely in terms of *Compassion in Dying v. State of Washington*, the case with which I am most familiar by virtue of having decided it on appeal. I shall go on to sketch the larger contexts, moral, cultural and religious, that are relevant to consideration of the issues raised. I hope to outline for you the central legal factors and at the same time convince you that the legal factors need to be set in the larger contexts.

To begin with the case, I first encountered *Compassion in Dying* in the fall of 1994 when by a random selection process it was assigned to me to preside at argument in Seattle over the state's appeal from a judgment of the district court. The district court had passed judgment on a statute entitled "Promoting a suicide attempt" and reading as follows:

> (1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.
>
> (2) Promoting a suicide is a Class C felony.[1]

The district court held the statute to violate the Constitution of the United States on two grounds. First, the Supreme Court in *Planned Parenthood v. Casey* had announced an extraordinary new autonomy centered on "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of

* United States Circuit Judge, United States Court of Appeals for the Ninth Circuit. This speech was originally given as part of the J. Phillip Clarke Family Lectures in Medical Ethics at the University of Notre Dame, Notre Dame, Indiana, on March 20, 1998.

1. WASH. REV. CODE § 9A.36.060 (1994).

human life."[2] Conceivably such a right could have been linked to freedom of religion; but the Court made no attempt to so link and limit what was announced in such encompassing and absolute terms. This announced right, this liberty interest, was read by the district judge as "highly instructive and almost prescriptive" in indicating that there was a constitutional liberty for terminally ill persons to decide whether or not to end their lives.[3]

To this decoding of the famous "mystery passage" of *Casey*, the district court added a thought taken from the *Cruzan* case, decided by the Supreme Court in 1990. *Cruzan*, as you may recall, was the case where the parents of Nancy Cruzan, in a coma from an automobile crash, sought a court order directing the withdrawal of their daughter's artificial feeding and hydration equipment. The state court held there was not clear and convincing evidence of Nancy's own desire to have life-sustaining treatment withdrawn. The Supreme Court affirmed the state decision, but in passing acknowledged the common law right not to be touched against one's will and almost as the corollary of that right "a constitutionally protected liberty interest in refusing unwanted medical treatment."[4] If a competent adult could terminate a life support system, then—so the district court reasoned—a competent adult could ask a physician's help in ending life. What difference would there be between disconnecting the life-sustaining tubes and injecting a fatal dose of poison?[5]

Hearing the argument on appeal I was first struck by the abstractness of the case. The name plaintiff, Compassion in Dying, was a nonprofit, whose avowed purpose was to assist persons described by it as "competent" and "terminally ill" to hasten their deaths by providing them information, counseling, and emotional support but not by administering fatal medication. Three individuals were plaintiffs in their own right, their identities cloaked by an order permitting them to litigate under pseudonyms. They were now deceased. Jane Roe had been a 69-year-old physician, suffering from cancer; she had been bedridden for seven months at the time the suit was brought and died before judgment was entered by the district court. John Doe had been a 44-year-old artist, who was partially blind at the time of suit and was also suffering from AIDS; he had been advised that his disease was incurable; he died prior to judgment. James Poe had been a 69-year-old patient suffering from chronic pulmonary dis-

2. Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992).

3. Compassion in Dying v. Washington, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994).

4. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 278 (1990).

5. *See Compassion in Dying*, 850 F. Supp. at 1467.

ease; he was connected to an oxygen tank. He died after judgment but prior to the hearing of the appeal.[6]

Four physicians also joined the suit asserting their own rights and those of their patients. Harold Glucksberg had specialized in the care of cancer since 1985 and was a clinical assistant professor at the University of Washington School of Medicine. According to his sworn declaration, he "occasionally" encountered patients whom he believed he should assist in terminating their lives, but did not because of the statute; he referred to two such patients, both deceased. Abigail Halpern was the medical director of Uptown Family Practice in Seattle and served as a clinical faculty member at the University of Washington School of Medicine. In her practice, according to her sworn declaration, she "occasionally" treated patients dying of cancer or AIDS, whose death she believed she should hasten but did not because of the statute; she referred to one such patient, now deceased. Thomas A. Preston was chief of cardiology at Pacific Medical Center in Seattle and professor of Medicine at the University of Washington School of Medicine. According to his sworn declaration, he "occasionally" treated patients whose death he believed he should hasten but did not on account of the statute; he referred to one such patient, now deceased. Peter Shalit was in private practice in Seattle and the medical director of the Seattle Gay Clinic; he was a clinical instructor at the University of Washington School of Medicine. According to his sworn declaration, he "occasionally" treated patients whose death he believed he should hasten but did not on account of the statute; he referred to one such patient, now deceased.[7]

The case seemed to me to be a hypothetical—a hypothetical as we use the term in law schools meaning a plausible set of facts that might need decision but do not yet present an actual controversy. The name plaintiff, Compassion in Dying, had a good name—who would not want compassion in dying?—but no discernible interest in the issue as its purpose was not to promote suicide by any physical act. All the patient-plaintiffs were dead. Only the physicians remained. But the physicians were not asserting the interest of any actual patient, only the interest of some hypothetical persons they might have occasion to treat.

There was the additional problem of whom the district court's judgment covered. According to elementary principles of

6. *See* Compassion in Dying v. Washington, 49 F.3d 586, 588 (9th Cir. 1995).

7. *See id.* at 589.

law, the judgment in favor of the dead plaintiffs was a nullity.[8] Did the physicians and their hypothetical future patients represent a class? According to the Federal Rules of Civil Procedure, certification that a class exists is required to sustain a class action.[9] No class was certified. There was good reason why no certification had been attempted: it would have required the court to say who the terminally ill were.

It was suggested in argument that a definition of the terminally ill could be supplied from the Washington statute on the refusal of life-sustaining treatment, a statute which does define "terminal condition."[10] There were three difficulties: "Terminal condition" and "terminally ill" were different terms; the examples given by the plaintiffs showed considerable variation as to whom they considered the terminally ill to be; there was wide disagreement in definition of the terminally ill among the states. Life itself is a terminal condition, unless terminal condition is otherwise defined by a specific statute. A terminal illness can vary from a sickness causing death in days or weeks to cancer, which Dr. Glucksberg noted is "very slow" in its deadly impact, to a heart condition which Dr. Preston noted can be relieved by a transplant, to AIDS, which Dr. Shalit declared is fatal once contracted but can run its course over years. One could only guess which definition of terminally ill would satisfy the constitutional criteria of the district court. Consequently, an amorphous class of beneficiaries had been created in this non-class action; and the district court had mandated the state to reform its law against the promotion of suicide to safeguard the constitutional rights of persons whom the district court had not identified.[11]

In the end, for these and six other reasons you will find set out in 49 F.3d 586, our panel, 2 to 1, reversed the district court. We, in turn, were reversed, 8 to 3, by our own court sitting en banc,[12] which in turn, on June 26, 1997, was reversed by the Supreme Court of the United States, 9-0.[13] Like all professionals, the judges found it hard to agree on a difficult question. Fourteen judges had upheld the law, nine had held it bad; but of course the last word belonged to the Supreme Court. By the time the case had reached this tribunal, the winningly-named plaintiff, Compassion in Dying, had disappeared, and the lead

8. *See id.* at 593.

9. *See* FED. R. CIV. P. 23.

10. *See* WASH. REV. CODE § 70.122.020(9) (1994).

11. *See* Compassion in Dying v. Washington, 79 F.3d 790, 839 (9th Cir. 1996).

12. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).

13. *See* Washington v. Glucksberg, 117 S. Ct. 2258 (1997).

name was Dr. Glucksberg's. The Supreme Court did not pause to ask who the plaintiffs were, who the terminally ill were, or who had actually secured the judgment of the district court. A companion case, *Vacco v. Quill*, was also before the court. Here a three-judge panel of the Second Circuit had held unconstitutional the New York statute that classified aiding a suicide as a species of manslaughter.[14] This decision, too, was reversed.[15]

The state of the law after *Glucksberg* and *Vacco* may be summarized succinctly as follows: The liberty guaranteed by the Fourteenth Amendment and protected from violation by the states does not include the right of competent, terminally ill adults to hasten their deaths by obtaining medication prescribed by their doctors with the intent to kill them.[16] In Chief Justice Rehnquist's opinion in *Vacco* a distinction was accepted between prescribing lethal medication and "aggressive palliative care", which would both mitigate pain and hasten death.[17] The distinction was said to rest on the intention of the physician. In Chief Justice Rehnquist's opinion in *Glucksberg*, *Cruzan* was distinguished as responding to the long-standing common law tradition that one can refuse to be touched; therefore one could refuse to be treated.[18] *Planned Parenthood v. Casey* was explained away as not establishing a general right to autonomy in "any and all important, intimate, and personal decisions."[19] In addition, a remarkable concession was made by justices hitherto opposed to *Roe v. Wade*, Chief Justice Rehnquist and Justices Scalia and Thomas: they agreed that the abortion liberty was a fundamental, traditional liberty.[20] The concession was a high price, presumably paid for Justice Kennedy's vote for the Chief Justice's opinion.

Five justices—Breyer, Ginsburg, O'Connor, Souter and Stevens—also spoke through separate opinions. Justice O'Connor, explicitly joined by Justices Breyer and Ginsburg, said she did not address whether a competent person who was "experiencing great pain," that is, uncontrollable physical pain, had a constitutional interest in controlling the circumstances of death.[21] Justices Stevens and Souter indicated a similar openness to a

14. *See* Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) (holding N.Y. Penal Law § 125.15 unconstitutional).

15. *See* Vacco v. Quill, 117 S. Ct. 2293 (1997).

16. *See Glucksberg*, 117 S. Ct. at 2275.

17. *See Vacco*, 117 S. Ct. at 2298-2299.

18. *See Glucksberg*, 117 S. Ct. at 2270.

19. *Id.* at 2271.

20. *See id.* at 2267.

21. *See id.* at 2303 (O'Connor, J., concurring); *cf. id.* at 2311 (Breyer, J., concurring).

"particularized" case.[22] Five justices, in short, appeared to view the constitutionality of statutes banning assisted suicide as open to challenge if the challenge was narrow and focused on a patient suffering without medical relief.

Looking back at this course of three years of litigation, one thinks that the role that the medical profession should have in bringing about death would appear to be normally one for that profession to decide and for the legislature that licenses and regulates that profession to approve. As you are aware, the American Medical Association disapproves of doctors killing their patients even with a patient's consent; the legislature of Washington, like most legislatures, had concurred in this judgment and had made such medical practice criminal. These judgments appear to be quintessentially professional and legislative. How do judges acquire the superior status to scoff at the professionals' reasoning and mock the legislative judgment and declare the law violative of a fundamental liberty?

I entered on the consideration of this case with some reluctance because it asked me to empathize, to a degree, with someone wanting to put himself or herself to death and with a doctor wanting to help effectuate this desire. I knew neither desire from experience. Like every other living being I did not and do not know what death entails—what follows on the cessation of physical life. So how judge sensibly of a desire to bring about this condition cloaked in mystery?

I have no doubt that some particular personal characteristics such as age and health and the death of close relatives influenced the judges who actually took up such a question. The judges' own experience of life played a part. But there were also larger, more public variables at work. I list them as moral, cultural, and religious, and I look at those favoring the result ultimately reached.

MORALS

Law and morals are intermixed, for every legal position, every judgment of a court, every enactment of a legislature incorporates some position on the human good, that is, on what is moral. Analytically, however, law and morals can be separated, and the moral positions embodied in the law can be examined for their soundness. Having set out what the law now is and may

22. *See id.* at 2290 (Souter, J., concurring); *see id.* at 2309 (Stevens, J., concurring). See the commentary of M. Cathleen Kaveny, *Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law*, 27 HASTINGS CENTER REP. 31-32 (1997).

become after *Cruzan, Glucksberg* and *Vacco,* I will look at three moral positions reflected in the law. I think none of them are easy to arrive at.

The first is that it is morally proper to administer medication with the intention of alleviating pain even though you as the physician know that medication will also impair vital functions and hasten death. Traditionally this practice has been defended under the rubric of double effect: you are doing a single act with two effects, one good and one bad, and the good effect is proportionate to the bad effect, and your intention is focused on the good effect. The analysis is based on Thomas Aquinas's example of self-defense: you strike the aggressor threatening your life; your intention is self-defense; your blow has the effect of preserving your life and taking his; your action is good.[23] To the traditional terminology it is objected that when you foresee exactly what the bad effect of your double-effect act will be, you cannot disclaim responsibility for the bad effect by claiming that you only meant to accomplish the good effect.[24] In plain English, you have both defended yourself and killed another in the case of self-defense. You have relieved pain and killed the patient in the case of lethal medication. In each case you are responsible for a death. But in each case your action was justified. You have a right to defend yourself. You have a right to relieve pain. You are not doing bad things and trying to justify them by good ends—a morality that is elastic. You are, rather, acting in a world where you cannot control all the consequences. If you are justified in seeking the good effect, the bad effect not disproportionate to the good effect will not make your action evil. This analysis supports the position, although not the terminology, of Chief Justice Rehnquist.

The Catechism Of The Catholic Church also supports his terminology and his focus on intention. Theologians—at least a reputable number of them—insist that a human being can distinguish between the effect intended and the effect foreseen, and to be without sin you must intend only the good effect, such as the preservation of your life in self-defense and the alleviation of pain in lethal medication.[25] This emphasis on intention may be rationalized in terms of intention forming individual character or in terms of the intentions of physicians forming the character

23. *See* THOMAS AQUINAS, SUMMA THEOLOGIAE, II.II, 64, 7 (Blackfriars 1964).

24. *See* Quill v. Vacco, 80 F.3d 716, 729 (2d Cir. 1996); Note, *Physician Assisted Suicide and the Right to Die with Assistance,* 105 HARV. L. REV. 2021, 2028-31 (1992).

25. *See* CATECHISM OF THE CATHOLIC CHURCH 491 (1994).

of their profession: no one wants a profession whose character is formed collectively by the intention to kill. The emphasis on intention may also be explained, perhaps better explained, in terms of being what is subject to God's judgment.

Modern American law does make a distinction between intention, defined as purpose, and knowledge of what one's action is "practically certain" to bring about; but the distinction often makes no difference to criminal liability.[26] Rather than rely on the terminology of the criminal law, I would draw attention to our common sense response to the difference between intention and foreknowledge of a certain result. For example, we wear a comfortable pair of old shoes. We know that wearing them we will wear them out. Our intent, however, is not to wear them out, although that is what will surely happen. Or take a more romantic situation. Cyrano tells Roxanne that he will kill himself if she marries François. Roxanne goes ahead and marries François. Cyrano caries out his threat. Roxanne did not intend to kill Cyrano, even though she knew he was a man of his word. Or take a collective example: We all drive our automobiles, knowing that as a consequence 50,000 persons will be killed this year. We know the deaths will happen. We do not intend them.

The second moral position to be considered here is the one undergirding *Cruzan*, the right to refuse treatment. As stated in *Cruzan*, the right may be argumentatively construed as the right to kill yourself by starvation or dehydration.[27] So stated, it is offensive to common morality. It is also contradicted by Chief Justice Rehnquist's declaration in *Glucksberg* that there is no constitutional right to suicide.[28] Accordingly, to even pose a plausible position, *Cruzan* must be recast to find at its heart the view

26. *See* WAYNE LA FAVE & AUSTIN W. SCOTT, JR., CRIMINAL LAW § 3.5 (2nd ed. 1986). For example, in *Regina v. Hancock*, (H.L. 1986), the defendants—strikers patrolling a bridge and watching for strikebreakers on the road below—pushed a 46 pound block off the bridge, killing a strikebreaker in an oncoming taxi. The defense was that the strikers were merely trying to put a barrier in the road. The House of Lords held if the defendants appreciated that their act was highly likely to cause death, the jury could infer their intent to kill. In other words, foreknowledge of the likely result is a normal basis for attributing intention to the one causing the result. John Finnis seems to me to agree, defining murder as "killing with intent to kill" or "the doing without lawful justification or excuse an act which one is sure will kill." John M. Finnis, *Intention and Side Effects*, *in* LIABILITY AND RESPONSIBILITY: ESSAYS IN LAW AND MORALS 49 (R.G. Frey & Christopher W. Morris eds., 1991).

27. For a vigorous critique of such an interpretation, see M. Cathleen Kaveny, *Assisted Suicide, Euthanasia, And The Law*, 58 THEOLOGICAL STUD. 129-131 (1997).

28. *See* Washington v. Glucksberg, 117 S. Ct. 2258, 2270 (1997).

that no one has an obligation to preserve life by extraordinary means. That proposition does require examination.

The proposition is open to at least three objections: (1) If nature is our norm, does not the natural drive of self-preservation make no distinction between the ordinary and the extraordinary? If you are on the Titanic you will grasp anything to stay afloat. (2) As what is ordinary is constantly changing with technological developments, the distinction between ordinary and extraordinary is unstable. A glass to hold water and a fork to eat food with might have been extraordinary once. (3) There are extraordinary things like a rare drug and there are ordinary things like food and water delivered by unusual methods; the ordinary-extraordinary distinction blurs these categories. It might be that one would naturally refuse to try a rare drug, but one does not naturally refuse food and water.

The answer to the first objection appears to be that an average or mediocre human nature, not an heroic one, should be taken as the norm, and mediocre human nature will seek only average remedies or means of survival. The answer to the second objection is that the categories of ordinary and extraordinary will change over time but for a given period they are stable. The answer to the third objection is that the lines could be drawn differently but a line that treats the complicated delivery of food and water as extraordinary is not unreasonable. In the end, as some modern moralists have concluded, it is the patient himself or herself who must decide what is extraordinary.[29] In sum, the ordinary-extraordinary distinction is not written in stone, but is fairly flexible and as flexible passes moral muster. Cruzan's dictum on the right to refuse medical treatment is salvageable if this position is adopted. In the background is the common sense position that one is not called to remedy all the evils of the world of which one becomes aware. One, in short, is not called to the morality of Don Quixote. If one is not called to remedy all evils, one may—even in the case of one's own body—draw a line where extraordinary efforts are not required. The morality is not mediocre but that of common humanity.

The third moral position to be examined is the one foreshadowed for the law by the openness of a majority of the justices in *Glucksberg* to a narrow challenge to the law on assisted suicide. By implication, assisted suicide to stop intolerable pain is good. That cases of untreatable pain occur—"compelling, heart-wrenching cases," as Yale Kamisar calls them—appears to be a

29. *See* Kaveny, *supra* note 27, at 141; *cf.* PAUL RAMSEY, THE PATIENT AS PERSON 131 (1970).

datum.[30] They are the kind of case effectively presented by newspapermen sympathetic to legalized euthanasia. How frequent these cases are is a matter of dispute. Timothy Quill and Robert Brody, physician advocates of physician-assisted suicide, put them at 2 percent in their experience of dying patients.[31] The New York Task Force On Life And The Law simply said that the cases were "extremely rare."[32] I assume that there are no reliable statistics. It may be true, as Dr. Ira Byock in his book *Dying Well* observes from experience, that the pain of dying is never wholly physical, and "comfort is always possible."[33] Nonetheless, I think we must confront the possibility that, in some cases, physical pain can be assuaged only by life-threatening medication.

The principal argument, it seems to me, for permitting assisted killing here is this: You agree that it is proper to relieve pain medically even though one effect of the medication is to hasten death. Here is simply a case where instant pain relief is required; the dosage will relieve the patient totally while killing him. Surely the speediness of the solution should not make a moral difference.

From a religious perspective, the speed does make a difference in its complete arrogation to the doctor of the decision of God. I shall return to this objection but not consider it further at this point. The main objection is that it's wrong to frame any law on the basis of rare examples. "Hard cases make bad law"—a legal truism that holds as well for moral rules. If the hard case is focused on, the easy, ordinary case is overlooked. The majority of dying persons—the poor, the emotionally disturbed and the handicapped—would be injured by a rule facilitating assisted suicide.[34] A law or rule should be made for the majority of cases.

The reply to this reply is why not set a norm for the majority but also create a well-marked exception for the unusual case? And the counter-reply here is that, at least where there is legislation and also some public pressure, the predictable tendency will be to push the exception so that it swallows the rule. If only *moral* rules and exceptions are at issue, the reliance is on conscience to keep the distinction between norm and exception clear, and it

30. YALE KAMISAR, PHYSICIAN-ASSISTED SUICIDE: THE PROBLEMS PRESENTED BY THE COMPELLING, HEARTWRENCHING CASE 4 (1998).

31. *See* Timothy E. Quill and Robert Brody, *You Promised Me I Wouldn't Die Like This*, 155 ARCHIVES INT'L MED. 1250, 1251 (1995).

32. *See* NEW YORK TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 40 (1994) [hereinafter WHEN DEATH IS SOUGHT].

33. IRA BYOCK, DYING WELL 214-15 (1997).

34. *See* WHEN DEATH IS SOUGHT, *supra* note 32, at 100, 129.

can be argued that conscience should be trusted. If that is done, then the objection that the exception will swallow the rule fails as a moral objection, leaving only an objection that seems to me to be focused on religious faith and to be considered further under that heading.

CULTURE

I turn from moral analysis to the cultural. Mixed as the moral and the cultural are, they are analytically distant. I start with the author whose corpus, next to the Bible, probably most shaped our literary universe: Shakespeare. In *Othello,* there is a suicide, unassisted, presented as the emotional sword stroke of a man who does not know where to go. No one, I think, reads *Othello* as a play about suicide. In *Hamlet* the famous "To be or not to be" speech contemplates suicide—unassisted suicide, "quietus," accomplished by one's own "bare bodkin" or dagger. But Hamlet quickly thinks that the mystery of what lies beyond death, "the undiscovered country," is sufficient deterrent.[35] The prince has already acknowledged that "the Everlasting has set his canon 'gainst self-slaughter."[36] In *King Lear* the king is reduced to a state where suicide would seem to be a desirable option; the pain is entirely psychological but it is overwhelming, intolerable. Lear has been broken. Yet suicide is not attempted by the king. Rather, it is his friend Gloucester who, having lost his eyes and his son Edgar, is tempted to it. Blind, he meets Edgar (not in fact dead). Edgar disguises himself and pretends to assist his father in his suicide attempt. Believing he has been led to the brink of a cliff in Dover, Gloucester leaps, only to fall on the ground. Not realizing that he's been deceived, he is nonetheless repentant and declares:

> You ever-gentle gods, take my breath from me,
> Let not my worser spirit take me again
> To die before you please.[37]

The attempted suicide, foiled rather than assisted by Edgar, and Gloucester's reaction to the failure, stand as a small illustration of what is the great theme of *Lear.* It is given to Edgar to restate it:

> Men must endure
> Their going hence even as their coming hither.

35. WILLIAM SHAKESPEARE, HAMLET act 3, sc. 1, 29 (John Russell Brown & Bernard Harris eds., Arnold Press 1963).

36. *Id.* at act 1, sc. 2, 131-32.

37. WILLIAM SHAKESPEARE, KING LEAR act 4, sc. 6, 221-23 (Philip Edwards ed., Cambridge Univ. Press 1985).

Ripeness is all.[38]

In the face of the greatest adversity it is not for a human being to determine when he dies. Like birth, death is the decision of a Higher Power; and it is that Higher Power who says what ripeness is.

Let me turn to a different sort of cultural icon, Henry James's *The Wings of the Dove.* As you know if you've seen the recent movie, it involves a kind of love triangle; but if you remember the book, it is also the story of the interaction of a London physician with the dying heroine, Milly Theale. The physician is Sir Luke Strett, regarded as "the greatest of medical lights." Conscious that she may be seriously ill, Milly consults him. He treats her not as an object, not as a collection of symptoms, but as a person. "But what does he say?" Kate Croy asks her. "That I'm not to worry about anything in the world and that if I'll be a good girl and do exactly what he tells me, he'll take care of me for ever and ever."[39]

Milly has indeed a mortal illness. Unable to cure, Sir Luke does care for her until the end with absolute devotion, tact, and fidelity. He cannot prevent her death. He does not accelerate it. His ministrations are set off against the manipulations of Kate. It is this contrast that the movie has lost by lopping off Sir Luke, as the movie, like Kate, looks only to the bottom line. *The Wings of the Dove,* James's novel, is as much about how the dying should be treated as it is about dying gracefully. Assisted suicide is implicitly rejected. It is no accident that its physician bears the name of the author of the third Gospel.

RELIGION

Culture and religion are no more sharply distinct than law and morals or morals and culture. Every culture has a religion at its center. Our culture reflects our Jewish and Christian roots. At the same time our religion is affected by our culture. But there is no doubt that for Jews and Christians the first text of religion is scriptural. It is illuminating for a Christian to observe how death is treated in the Gospels.

Killing enters the Gospels only four times. The first time, almost at the outset of Matthew, is the killing of the baby boys of Bethlehem.[40] We are not told the number, though Matthew calls it a "massacre." It is a terrible foreshadowing of the propensity of power to make victims of the most helpless.

---

38. *Id.* at act 5, sc. 3, 9-11.
39. HENRY JAMES, THE WINGS OF THE DOVE 195 (Merrill 1970) (1902).
40. *See Matthew* 2:16-18.

The second time is the execution of John the Baptist. He is a prisoner because he has told a powerful man that the woman the man is with is not the man's wife. It is not a welcome message. He is put to death because the woman wants this troublemaker eliminated.[41] Again the episode presages the reaction of the mighty to the Christian message.

Near the end of the Gospel of Matthew, as the Passion begins, a suicide occurs: Judas, characterized as "the betrayer," hangs himself.[42] It has been argued that in the Judaism of that day a suicide could be a sign of repentance.[43] In the context of Matthew, Judas's act does not appear to be penitent or praiseworthy. In Acts, Luke is even more scornful: Judas "falling headlong, burst open in the belly"; an act of suicide is not mentioned but may be assumed to have been known to Luke's readers.[44]

The fourth killing is that of Jesus. Jesus is presented as risking this death, indeed as knowing that this particular kind of death will be inflicted on him. The suffering that accompanies the death is clear, and the Gospels' treatment of the whole sequence culminating in the death emphasizes the suffering. Together, these events constitute the Passion of Our Lord.[45] In Christian theology the death and the accompanying suffering are redemptive.

As the following of Christ and the taking up of the Cross are presented to Christians as what should be done, suffering and death cannot have a wholly negative value for Christians. Not only is death inescapable, not only is some suffering inescapable, the follower of Jesus in undergoing them imitates him. In Christian theology, the follower's suffering and death are also redemptive. In the light of this theology, in the light of the Passion of Our Lord, a Christian cannot make the elimination of suffering a good trumping all other goods. Christian belief therefore provides a basis for the Christian to reject suicide and assisted suicide.

Like all human beings Christians must shun suffering as an evil and death as the ultimate evil, effecting the separation of the soul from its natural setting and depriving the body of its form. The example of Jesus and the participation in redemptive process will not alter these truths, but will confer on the believer a sense that these evils have a purpose, that they are not meaning-

41. *See id.* 14:3-12.

42. *See id.* 27:5.

43. *See* David Daube, *Judas*, 82 CAL. L. REV. 95 (1994).

44. *Acts* 1:18-19.

45. *See Matthew* 26:1-27:56.

less torture. Redemption—why it is needed, how it takes place—is a mystery; but for the believer it is also a reality in which he or she can play a part.

Close to self-contradiction, the Christian paradox of redemption parallels a second paradox: the believer, believing that to die is the necessary step for union with God, must not take the step voluntarily, must not accelerate the end of life on earth. Paradise must be postponed. Why? If one is firm in one's belief, death is the gateway to unearthly happiness. Why should the happiness be put off and misery endured on earth?

The answer—we all know it—is that our lives are not our own. God is the creator, who has brought us into being here and who will determine when we leave. Older theology spoke of God's dominion over us as though we were His property: Pope John Paul II, followed by the new Catechism of the Catholic Church, has emphasized that we are created with a special relation to God, who is our sole end; it is that relation which makes each life sacred.[46] We cannot lay violent hands on the life of another human being or on our own. Our "going hence" is as much in His will as in our "coming hither." We can, for just reason, risk the termination of our lives. We can even take measures to alleviate unbearable suffering that have the effect of hastening death. We can even assent to the respirator's being turned off, the intravenous drops being discontinued, the ending of the sustaining of our life by extraordinary efforts. Assent of this kind does not create a precedent permitting everyone to determine the manner and hour of his or her death.

Acknowledging the sovereignty of God, accepting the mystery of Redemption, following in the footsteps of Jesus, the Christian physician will do all that can be done to postpone the natural evil of death and its accompanying suffering; will not usurp the Creator's choice of the moment for soul to leave the body; and will work to sustain the faith, hope and love of the believer who in suffering identifies with Jesus.

---

46. *See* CATECHISM OF THE CATHOLIC CHURCH, *supra* note 25, at 486.