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Fritz B. Burns Lecture, Loyola Law School, Los Angeles

November 22, 1996

EUTHANASIA, MORALITY, AND LAW

ARTICLE

*John Finnis**

I

Arguments for legalising euthanasia rely on claims about autonomy rights, or claims about political pluralism, or on both sorts of claim. My response will make three main points.

First, those demanding this legalisation have shirked their elementary obligation to describe the alleged right, identify who has it, and delineate its boundaries as a right supposed to trump other goods, interests, and the wellbeing or rights of others.

Second, they have neglected, or at best hugely underestimated, the casualties who would be, and in some places already are being, created by the success of their campaign. That is to say, they are neglecting basic responsibilities of fairness and justice.

Third, they proceed on an inadmissible conception of the nature and value of human life and dignity—on a theory which should be rejected for the same sorts of reasons of equality and dignity that lead us to reject *as a matter of principle*¹ the alleged right (often recognised in former societies) to free yourself from perhaps crushing burdens by selling yourself into slavery.

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1. In his Burns Lecture on 22 November 1996, Ronald Dworkin described this sort of rejection in principle as 'extraordinary', 'blunt', 'blanket', and 'crude'—in the case of euthanasia. He did not take the opportunity, afforded then by my remarks, to say whether these epithets apply also to our law's rejection of slavery, torture, coerced confessions, etc.

We are all going to be involved in this debate, this struggle for power, this great collective deliberation, for the rest of our lifetimes. We will need to keep our critical faculties all the way through. There will be majority decisions by courts, legislatures, electorates, sometimes by wide margins labelled 'consensus'. But to resolve these great issues of moral truth and judgment we each have standards by which we, anyone, can critically assess and *judge* legislatures, Fuhrers, courts. The 'right-thinking' people who call the tune in law schools, media and courts may well be like the right-thinking people who decided for individual autonomy against social justice in *Lochner v. New York*² or for quality of life against radical human dignity in *Buck v. Bell*³ ('three generations of imbeciles are enough', said Justice Holmes to justify sterilising a mentally retarded girl). And, on the other hand, perhaps the laws against homicide, so often re-enacted and confirmed over the centuries, impose as Ronald Dworkin thinks a 'serious, unjustified, unnecessary ...⁴ crippling, humiliating ...⁵ devastating, odious form of tyranny',⁶ when applied to prevent physicians killing terminally ill patients. That's a thought we should certainly consider on its merits.

But if we are to keep our critical freedom we cannot accept that 'History has decided', or is deciding this issue; or has settled other issues so that as a matter of principle and integrity this issue must now be decided in a certain way.⁷ Conscience judges, not by the play of

2. 198 U.S. 45 (1905).

3. 274 U.S. 200, 207 (1927).

4. RONALD DWORKIN, FREEDOM'S LAW: THE MORAL READING OF THE AMERICAN CONSTITUTION 146 (1996).

5. Ronald Dworkin, *When Can a Doctor Kill?*, THE TIMES (London), Apr. 27, 1993, at 16.

6. RONALD DWORKIN, LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA AND INDIVIDUAL FREEDOM 217 (1993).

7. In his Burns Lecture, Dworkin advanced precisely such a claim, making central to his address the contention that in *Cruzan v. Missouri Department of Health*, 497 U.S. 261 (1990), the American people had resolved, or at least supposed (with definitive effect), that patients and their doctors may lawfully, as a matter of constitutional right, *aim at death*. This claim was doubly erroneous. If *Cruzan* had indeed made such a decision, or supposition, it would now be open to the Court and to the people to judge it a false step, an abandonment of the historic and morally sound foundations of the law of murder, a mistaken decision ripe for reform by overruling. But, secondly, it is historically and juridically crystal clear that *Cruzan* neither decided, nor supposed, nor even entertained the possibility that people and their doctors have a constitutional right to aim at death. The dissenting Justices accurately state the core of the majority opinion in the following terms: 'the Court, while tentatively accepting that there is some degree of constitutionally protected liberty interest in avoiding unwanted medical

judicial or any other majoritarian or elite power, opinion, will, but by looking for reasons good *as reasons*. So I shall be considering the issues as they arise for every contemporary community (including the United States), and not as matters of American constitutional law as such.

II

The opinion of Judge Reinhardt for eight judges of the Ninth Circuit in *Compassion in Dying v. Washington*⁸ (March 1996) uses the term ‘euthanasia’ in an almost uniquely eccentric way, as the *unrequested* putting to death of persons suffering from incurable and distressing disease.⁹ Almost all other English-speakers call that *non-voluntary euthanasia*, and so shall I. I shall assume Ronald Dworkin’s agreement, since he defines euthanasia simply as ‘deliberately killing a person out of kindness’¹⁰—not very serviceable as a legal definition, but compatible with common usage and not with the Ninth Circuit’s.

The official Dutch definition of ‘euthanasia’ is precisely opposite to the Ninth Circuit’s, but equally eccentric: termination of life ‘by

treatment, including life-sustaining medical treatment such as artificial nutrition and hydration, affirms the decision of the Missouri Supreme Court’. *Id.* at 302 (Brennan, J., dissenting, joined by Justices Marshall and Blackmun) (emphasis added). They add: ‘Justice O’Connor’s [concurring] opinion is *less parsimonious*. She openly affirms that “the Court has often deemed state *incursions into the body repugnant* to the interests protected by the Due Process Clause”, that there is a liberty interest in avoiding unwanted medical treatment, and that it encompasses the right to be free of “artificially delivered food and water”.’ *Id.* at 304 (Brennan, J., dissenting) (emphasis added). Thus the interest presupposed by the Court was simply the interest in *refusing unwanted interventions on one’s body*. The fact that some patients or doctors may foreseeably abuse or exploit the protected liberty interest by making it the instrument of an *aim* (intent, purpose, etc.) to bring about death in no way makes such motives a part of the constitutionally protected interest. The easily foreseeable fact that defendants will exploit their constitutionally protected *liberty to testify*, by aiming to deceive the jury, does not make such an aim a part of the constitutionally protected liberty right—as if that great liberty could be accurately understood as ‘*the right to lie*’, and as if counsel, after hearing a client’s unambiguous confession of guilt, would nevertheless have the constitutional right to put that client on the stand precisely in order to lie.

8. 79 F.3d 790 (9th Cir.), *rev’d sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).

9. *See id.* at 832 n.120.

10. DWORKIN, *supra* note 6, at 3. Mysteriously, when he comes to the part of the book dealing with euthanasia, he offers a new and highly eccentric definition which greatly eases his task as an advocate: ‘euthanasia in its various forms—suicide, assisting suicide, or withholding medical treatment or life support—may be [etc.] ...’ *Id.* at 213.

someone other than the person concerned *upon the request of the latter*.¹¹ Almost everyone in the English-speaking world calls that 'voluntary euthanasia', and so shall I.

We must have the odd Dutch definition firmly in mind when we read that 2% of all deaths in the Netherlands in 1990 resulted from 'euthanasia'.¹² If we do, we will remember to read more deeply into the figures. Then we will find that a further nearly 1% of all Dutch deaths—over 1,000 further deaths—followed immediately the administering of a drug 'with the explicit purpose of hastening the end of life *without an explicit request of the patient*'. These 1,000 cases are not called euthanasia, in the eccentric Dutch sense; they are the *only* euthanasia in Holland, in the eccentric Ninth Circuit sense. In the more usual idiom which I am adopting they are of course cases of non-voluntary euthanasia.

In his new book, *Freedom's Law*, Ronald Dworkin says: 'Some critics worry about the practice in Holland, where doctors have given lethal injections to unconscious or incompetent terminal patients who had not explicitly asked to die'.¹³ Indeed 'doctors have'. But in fact about 40% of those 1,000 people officially known to have been killed without their request were neither unconscious nor incompetent.¹⁴ We might use the label 'involuntary euthanasia' for this sub-class of non-voluntary euthanasia: killed while competent to request but not requesting death. We still lack an accepted label for physicians' terminating people's life against their request: perhaps 'contra-voluntary euthanasia'.

The definitions I have suggested so far leave one important matter unclear. I introduce it, again, by reference to Dutch experience, though it is of universal significance. Euthanasia and assisting suicide were exempted from criminal sanctions by a decision of the Dutch

11. John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 261, 270 (John Keown ed., 1995) (emphasis added).

12. *See id.* at 268.

13. DWORKIN, *supra* note 4, at 144.

14. *See* Loes Pijnenborg et al., *Life-Terminating Acts Without Explicit Request*, 341 LANCET 1165, 1197 (1993); THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 134 n.31 (1994) [hereinafter TASK FORCE]. Pijnenborg's study relates to a different series; the corresponding figures supplied by the official Committee state that 25% of those killed without their request were stated by their doctors to be totally (14%) or partly (11%) competent to request. *See* Keown, *supra* note 11, at 292 n.104.

Supreme Court in 1984.¹⁵ Three months earlier, the Royal Dutch Medical Association had set out criteria for permissible euthanasia, later adopted in national medical 'Guidelines for Euthanasia'.¹⁶ In the Medical Association's report no distinction was drawn between 'active' and 'passive'. 'All activities *or non-activities* with the purpose to terminate a patient's life are defined as euthanasia'.¹⁷

This inclusion of 'non-activities', omissions, 'passive' conduct, is entirely reasonable. Euthanasia, on any view, is an exception or proposed exception to the law of homicide, more specifically the law of murder. And you can unquestionably commit murder by omission. Parents murder children sometimes with a pillow but sometimes by starvation, omitting to feed them. To inherit the fortune, I omit to give the diabetic child his insulin. To be free to marry his secretary, Dr D. omits to switch his wife's life-support system back on after its daily service break. The core concept in the law of murder, everywhere, is *intention to cause death*. Causation—starvation, dehydration, insulin shock—plus intention: murder by omission. Of course, the accused must have had control over the deceased—care or an acknowledged, fulfillable duty of care—otherwise there's no intention but at most a wish.

In short, to make euthanasia lawful, the desired exception to the law of murder needs to cover cases of omission with intent to terminate life. The Dutch Guidelines take care to cover such cases.

But the official Dutch commentary on the 1990 *statistics* selects for presentation only the cases of euthanasia by *action*. One has to look to the underlying official figures to see all the many cases where treatment was withdrawn or withheld with the primary or secondary *purpose* of shortening life, as well as many cases in which pain medication was administered precisely *with the intent* to shorten life.¹⁸

15. See John Keown, *The Law and Practice of Euthanasia in The Netherlands*, 108 LAW Q. REV. 51, 51-57 (1992); Keown, *supra* note 14, at 261.

16. Promulgated jointly by the Royal Dutch Medical Association and the National Association of Nurses. See Keown, *supra* note 11, at 264.

17. See Keown, *supra* note 11, at 271, 290 (emphasis altered).

18. See Keown, *supra* note 11, at 268-73. The additional officially admitted 1,000 terminations without request included only those done by administering a drug with that intention. The missing cases—which are euthanasia under the Guidelines but carried out by *omission*—are grouped under two headings: 'Withdrawal or withholding of treatment partly with the purpose of shortening life' (9,042 cases), and 'Withdrawal or withholding of treatment with the explicit purpose [i.e., solely or primarily for the purpose] of terminating life' (5,508 cases)—a further 14,550 cases in all—about 9% of all deaths in Holland. See *id.* at 270. (Of these additional deaths, the majority (60%) were non-voluntary

When we sum up these official Dutch statistics for the fifth year of their euthanasia regime, we find that in 26,350 cases, death was accelerated by medical intervention intended wholly or partly to terminate life. That is *over 20% of all Dutch deaths*. In the United States that would be over 400,000 deaths.¹⁹ Of these, well over half—59% (15,528)—were without any explicit request. In the United States that would be over 235,000 unrequested medically accelerated deaths per annum.²⁰

Before leaving words and definitions, I should say something more about intention. The entire opinion of Judge Reinhardt for the Ninth Circuit in *Compassion in Dying* relies upon a law school definition of intention as including not only what you intend but also whatever you foresee as the certain or even likely²¹ outcome of your conduct. So Judge Reinhardt derides the American Medical Association's insistence upon the distinction between giving pain killers with intent to kill and giving them with intent to suppress pain.²² He

euthanasia.) Of course, treatment is often withdrawn without any purpose of terminating life, but knowing that death will result as a more or less inevitable side-effect. The figures I have just given, where termination of life was a *purpose*, represent only a minority (about 47%) of all the cases where treatment was withdrawn and death followed. Another set of cases not noticed in the soothing official commentary is those where pain- or symptom-relief was administered with the explicit [i.e., primary] purpose of shortening life (a further 1,350 cases), or partly with that purpose (another 6,750)—cases mostly of lethal, though not instantly lethal injections. *See id.* Of these, 5,508 cases (68%) are to be added to the 1,000 cases Dworkin presumably had in mind when he said that 'doctors have given lethal injections to unconscious or incompetent terminal patients who had not explicitly asked to die'.

19. Even if one excludes all the cases where terminating life was not the doctor's *primary* intention, it remains true that nearly 1 death in 12 is accelerated precisely and explicitly with the intent to terminate life—in the United States that would be over 160,000 deaths each year, over 80,000 of them being without explicit request. In sum, using my definition of euthanasia, the only definition which really fits with the surrounding law of murder, there would be at a minimum about 160,000 and more realistically over 400,000 cases in the United States of *euthanasia*—deaths caused by decisions and courses of conduct intended to bring it about. Less than half of these would be *voluntary* and the rest, the majority, would be *non-voluntary*. And more than a third of these cases of non-voluntary euthanasia would doubtless be the killing of patients who were at that time competent to make an explicit request but did not do so.

20. Of course, these extrapolations to the United States are debatable. Holland suffered the horrors of Nazi invasion and purges, has a more effective and universally available healthcare system, and is relatively free from racial and underclass poverty. On the other hand, it has doubtless been affected more deeply than the United States by atheism and unbelief, and so by cynicism and despair.

21. *See Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 2258 (1996).

22. *See id.* at 823-24 & n.94. The distinction is firmly and ably defended by (i)

declares that doctors who respect a patient's decision to forgo life-sustaining treatment *intend* to hasten their patient's death.²³ And that the laws authorising people to refuse treatment are simply laws for authorising suicide. In a delirium of rhetoric, he even suggests that laws for preventing suicide have 'an aim' of prolonging a dying person's suffering. And so on and on—this is the key to the whole opinion.

The word 'intention' can indeed be given a special extended meaning, including foreseen likely effects, which does not do much harm in the law of torts, but has had to be carefully expelled from the law of murder by a long course of decisions and enactment.²⁴ The extended meaning was always a legal fiction. Intention is a reality, not merely a word. That's why it is synonymous, in its non-fictitious sense, with many other words and phrases: 'with the aim of', 'with a purpose of', 'trying to', 'in order to', 'with a view to', or plain 'to' (as in 'He came to Loyola to give a lecture' or 'She gave the morphine to kill the patient to let the children claim under the expiring insurance policy'). You intend your end (aim, purpose, sought-after outcome) and your chosen means. Consequences which you foresee, even as certainties, are not intended unless they are one of your ends or your means. I foresee jetlag flying the Atlantic, the hangover after the party, the fading of drapes in bright sunlight, the annoyance of people who hear my stuttering, the death of my own troops in the assault I have ordered. I intend none of those consequences, however inevitable.

No less erroneously and arbitrarily than the Ninth Circuit, the Second Circuit in *Quill v. Vacco*²⁵ wholly misrepresents both the intention of the legislative guarantees of the right to refuse medical treatment m, and the type of intentions for the sake of which such

Judge Kleinfeld, dissenting in *Compassion in Dying*, 79 F.3d at 858; and (ii) the Walton Committee: Report of the House of Lords Select Committee on Medical Ethics, HL Paper 21-I of 1993-94 (31 January 1994), paras. 242-44, reproduced in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 103-04 (John Keown ed., 1995). And see now the firm and clear statements of the Court in *Vacco v. Quill*, 117 S. Ct. 2258 (1997), especially the quotations from *United States v. Bailey*, 444 U.S. 394, 403-406 (1980) and from Judge Kleinfeld's judgment.

23. See *Compassion in Dying*, 79 F.3d at 822.

24. See *Sandstrom v. Montana*, 442 U.S. 510, 513 (1979); John Finnis, *Intention and Side-Effects*, in LIABILITY AND RESPONSIBILITY: ESSAYS IN LAW AND MORALS 32-64 (Frey & Morris eds., 1991).

25. 80 F.3d 716 (1996).

legislation was enacted: not the intention of hastening or determining the time of my death but the intention to be free from unwanted burdens and interventions on my body, even if my death is a foreseeable consequence. The legislature of course foresaw that one consequence of its enactment would be that some people would use—abuse—this right by exercising it *with intent* to hasten death. But as a legislative declaration makes clear,²⁶ that was not part of the legislature's intent—no more than we intend the guilty to escape when we grant due process of law, or intend lawyers to conspire to lie when we grant an attorney-client privilege.

So much for words. If we are to tell what is being said, we need not only definitions but also propositions. We must not try to make do—or do anything—with non-propositional catchphrases such as 'sanctity of life', 'death with dignity', or 'right to die'.

Take the last, 'the right to die'. Where is the proposition specifying *who* has the right, to *what* acts, by *which* persons? Is it the right of terminally ill patients? (And what is terminal illness?) Or only of those who are suffering? (And what sort and degree of sufferings?) Or of all who are suffering whether or not their illness is terminal? Is it a right only to be assisted in killing oneself, as created in the suspended Oregon law of 1995? Or also that others be permitted (or perhaps under a duty) to kill me? (When I cannot do so myself? Or also when I choose?).²⁷

Here in the United States the debate is currently fixated on assisting in suicide. But this is only a whistle stop.²⁸ The Ninth Circuit's

26. See Health Care Agents and Proxies Act, N.Y. PUB. HEALTH LAW § 2989(3) (McKinney 1993); *Quill*, 80 F.3d at 734 n.7.

27. The Dutch Supreme Court's 1984 decision exempted from criminal sanction not only euthanasia but also assisting in suicide, the subject of a different provision of the Dutch Penal Code. But assisted suicide is a minority pursuit in Holland. Against the 26,000 cases of euthanasia, only about 400 cases of assisted suicide are reported.

28. Sometimes this way station is passed through within the confines of a single statute. Thus in the Northern Territory of Australia, the world's first and (for a brief period) only operative legislative enactment in the field, the Rights of the Terminally Ill Act 1995, is presented to the public as about assistance in killing *oneself*, and has a central provision which seems to mean precisely that:

4. A patient who, in the course of a terminal illness, is experiencing pain, suffering and/or distress to an extent unacceptable to the patient, may request the patient's medical practitioner to assist the patient to terminate the patient's life.

Rights of the Terminally Ill Act 1995 (N. Terr. Austl.) § 4. But the Act's definition of 'assist' gives, at the very end of the list, 'and the administration of a substance to the patient'. *Id.* § 2. So this is a euthanasia law under colour of a law

opinion, behind its protective refusal to identify even in principle what class of people has the constitutional right it declares, made it quite clear that the court sees no relevant distinctions short of the distinction between 'voluntary and involuntary' (non-voluntary) termination of life.²⁹ And even that distinction is immediately revealed to be fuzzy: the footnote warns that the judges 'do not intimate any view' of non-voluntary or involuntary euthanasia, and that if 'a duly appointed surrogate decision maker' decides to terminate the life of a non-competent patient, that counts as 'voluntary' euthanasia.³⁰

III

People say everyone has a right to autonomy—that as an American, one has 'the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life'—the words in *Planned Parenthood v. Casey*³¹ relied upon by the Ninth Circuit in *Compassion in Dying*³² and quoted approvingly in Ronald Dworkin's new book.³³ But healthy Americans who demand assistance in suicide, or actual euthanasia at the hands of medical personnel, will find themselves being told by our reformers that, well, after all the right belongs *not* to those with an autonomy interest in defining their own concept of existence and so forth, but to people whose lives are no longer worth living—and, that means whose lives are no longer worth living in the opinion of a court, or medical practitioners, in the context of legislative criteria adopted by courts or legislatures from time to time. Even when you fall seriously ill, or become clinically depressed, you will find (if the reformers are to be believed) that your right to autonomy does not give you the right to be assisted in suicide unless you are ill *enough* or suffering *enough*, or depressed severely and incurably *enough*—in each case 'enough' in the view of somebody else, *other people*. And this of course is no surprise. For what you are proposing is not a private act, but precisely an act in which you seek assistance from someone else, or which you are asking someone else to carry out, sharing your intent to destroy your

about assisting suicide.

29. *Compassion in Dying v. Washington*, 79 F.3d 790, 832 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 2258 (1996).

30. *Id.* at 832 n.120.

31. 505 U.S. 833, 851 (1992).

32. 79 F.3d at 813.

33. See DWORKIN, *supra* note 4, at 144.

personal life. It is no more a private act than a duel or an agreement to sell myself into slavery.

So the bottom line issue becomes clearer. When should we allow some people to sit in judgment on the life of another human person, to judge that person's life worthless, and so to authorise themselves or others to carry out that person's request for death? And then, if such judgments about the worthlessness of a person's life are decisive, why not also when the judgment about insufficient or negative quality of life is the same but the request for help to terminate life cannot be made? Or has not been made?

Notice: the issue is *not* whether physicians can reasonably make the more limited assessment necessary to judge further treatment futile, or excessively burdensome, or not rewarding enough to be worth the costs in suffering, money, labour, or use of other resources. Those are difficult, inherently uncertain judgments. But they are in any case made, routinely, in countless ways in countless cases. They remain focused upon the treatment and the burdens and benefits, and fall short of the global assessment of a person's whole existence needed to warrant a decision focused precisely on terminating that existence—to undertake a course of conduct with the intent to kill (or assist in the killing of) that person, to destroy or assist in the deliberate destruction of his or her very being so far as is humanly possible.

IV

We should not try to estimate the impact of changing the law by looking at its new permission while holding steady and unchanged everything else in the picture. Ronald Dworkin has given the British public good advice: When considering the impact of introducing a justiciable Bill of Rights, do not for a moment assume that it will be interpreted and enforced by lawyers and judges with today's attitudes. A whole *new breed* of lawyers and law teachers and judges will rapidly come into existence to give effect to the new regime.³⁴

34. See RONALD DWORIN, A MATTER OF PRINCIPLE 31 (1985). H. L. A. Hart, a passionate liberal reformer, never ceased to support the legislation of 1967 which legalised so-called therapeutic abortion in Britain. But in the 1970s he noted that its effects had been *greatly underestimated* by those who brought about the change. What had been envisaged by many as simply a permission, recognising an area of liberty in place of prohibition, had proved to be the introduction of a vast structure of new relationships, institutions, funding, professional obligations, and so forth, involving changes in the ethics, practices, and dispositions of doctors, midwives, social workers, psychiatrists, and people at large. See H. L. A. Hart, *Abortion Law Reform: The English Experience*, 8 MELB. U. L.

So do not think of the euthanasia law being administered by today's medical practitioners and nurses and hospital administrators, whose codes of ethics exclude killing as a treatment and management option. If the law of murder were changed in the way proposed, and especially if it were changed by decision of the Supreme Court declaring what is every American's right as part of the very meaning of liberty, the ethics of all those professions and classes would—and would be bound to—change. The change would be very rapid, hastened along by the not too gentle spur of the law of torts.

Don't be distracted here by conscience clauses. The question is not about the right of the few orthodox Catholics and Jews and other mavericks to opt out. It is about the bulk of ordinary decent professionals,³⁵ equipped with new 'treatment options' which would greatly simplify the management of difficult cases, by the elimination of the human being causing the trouble.

Our doctors have always had the power to kill us. And to disguise their deed. This time last year I watched my father die of cancer. The doctor who gave him morphine towards the end had the power to decide to terminate his life under the guise of deciding what would quell his pain. In many, many situations, nothing prevents the doctor deciding to kill save an ethic which simply excludes that option—the ethic derided by the Ninth Circuit for insisting upon the very same difference as the law of murder: between intending to kill and accepting death as a side-effect (possibly welcome but still unintended) of something done with no such intent. Now change the law and the professional ethic. Killing with intent becomes a routine management option. Oh yes, there are restrictions, guidelines, paperwork. Well meant. Not utterly irrelevant. But as nothing compared with our doctors' change in heart, professional formation and conscience.

So our doctors would enter our sickrooms as men and women trained to be willing to kill on the occasions of their choosing, guided we trust by new professional and legal standards which shift to and fro searching for the bright *line* lost with the majoritarian judicial or

REV. 388, 408-09 (1972).

35. Like, for example, all who massively opposed the introduction of Great Britain's Abortion Act 1967 as a violation of the profession's age-old ethics, whose Medical Defence Union told them in 1968 that changing the criminal law entailed changing their civil law duties of care in tort, and who within a few years became massively opposed to any reform that might slightly reduce the treatment options that had become available to them. See JOHN KEOWN, *ABORTION, DOCTORS AND THE LAW: SOME ASPECTS OF THE LEGAL REGULATION OF ABORTION IN ENGLAND FROM 1803-1982* 84, 84-109 (1988).

legislative overthrow of the line between intending to kill and intending to heal, treat, alleviate, palliate

A new zone of silence. Can I safely speak to my physician about the full extent of my sufferings, about my fears, about my occasional or regular wish to be free from my burdens? Will my words be heard as a plea to be killed? As a tacit permission? And why does my physician need my permission, my request? The Dutch guidelines, insisted upon in court pronouncements, and described in the Dutch press and literature with robotic, mantra-like regularity as 'strict' and 'precise', demand that euthanasia be preceded by an explicit request. But within five years *most* Dutch medical killings are without any explicit request whatever. And though reporting is required by the guidelines, and non-reporting is a criminal offense, 87% are not reported. In a famously law-abiding country.

Another zone of fearful silence. Outside the door are the relatives. What will they be telling the doctor about my condition and my wishes? What is it prudent to tell them about my suffering, my depression, my wishes? Are they interpreting my state of mind just as I would wish? Are their interests in line with mine? Many people will find that their nearest and dearest are less and less near, and less and less dear.³⁶

Dutch doctors give the official (anonymous) enquiries two main reasons why they almost always violate the Guidelines and the criminal law by falsifying the death certificate and reporting that death was from 'natural causes'. One is to avoid the fuss of legal investigation. The other, almost equally strong, is the desire to protect relatives from official inquiry.³⁷

Ronald Dworkin's new book responds to such concerns. Even now, he says, 'doctors sometimes deliberately give dying patients large enough doses of pain-killing drugs to kill them'.³⁸ He ignores the question of their intent in doing so, and says that this is a 'covert

36. See Roger Scruton, *Not Mighty But Mundane*, *The Times* (London), May 30, 1996, at 41, a sympathetic review of BERT KEIZER, *DANCING WITH MR D* (1996), by a sensitive and philosophically inclined ex-Catholic Dutch euthanasiast doctor who recounts his experiences in killing his patients, the astonishing ease with which one gets and uses this licence to kill, the rapid informality of the actual killing (a speed and informality necessary to maintain the sense that this is a *medical* event), and the frequently blasé attitude of the relatives. In Scruton's final words: '[A]s atheism, cynicism and the practice of euthanasia spread, your nearest and dearest will be less and less near, and less and less dear'. Scruton, at 41.

37. See Keown, *supra* note 11, at 281.

38. DWORKIN, *supra* note 4, at 145.

decision much more open to abuse than a scheme of voluntary euthanasia would be'.³⁹ He neglects to note that, whatever the 'scheme of voluntary euthanasia would be', the power and opportunity of doctors to administer lethal doses of pain-killers would remain absolutely unfettered. But that same power and opportunity will be in the hands of a 'new breed of doctors' (like Dworkin's projected 'new breed' of lawyers and judges for Britain), doctors directed to regard *intentional killing* as a therapeutic option, something good doctors quite often do. And now the 'covert decision' to use lethal doses of pain-killers will be a readily available end-run around the law's paperwork requirements for legal voluntary euthanasia—an end-run for those doctors who don't wish to use the alternative end-run employed by Dutch doctors in 7 out of 8 cases of plain euthanasia—ignore the paperwork. Either way: avoid fuss. Don't involve the relatives in tiresome legal process.⁴⁰

In his evidence before the Walton Committee (the British Parliamentary Committee on euthanasia in 1993), Dworkin was asked again and again about these problems. His answers can be fairly summarised in one quotation. This sort of bad consequence of legislation—

is not an argument for caution, because it would be wrong to harm a lot of people [by keeping the present law against euthanasia] just because we feel that in some instance a decision might be made on the wrong basis. Those in charge of these decisions, and the doctors would be to the frontline, would simply have to be very careful to observe the kinds of conditions that the model Uniform Statute on Living Wills ... directs doctors to attend to.⁴¹

But of course, doctors would simply *not* 'have to', and the Committee unanimously rejected his reassurances.

His response in his new book is equally unconvincing: 'states plainly have the power to guard against requests influenced by guilt, depression, poor care, or economic worries'.⁴² Nearly everyone who

39. DWORKIN, *supra* note 4, at 145.

40. Most of the non-reporting Dutch doctors gave two reasons for violating their clear legal duty to report: avoid the fuss of legal investigation; protect the relatives from judicial inquiry. See Keown, *supra* note 11, at 281.

41. Report of the House of Lords Select Committee on Medical Ethics, HL Paper 91-vii of 1992-93 (29 June 1993) 162, para. 452.

42. DWORKIN, *supra* note 4, at 144.

has thought seriously about this has concluded that the power is practically empty.

Be that as it may, it is very important to see what's going on here. *Suppose* for a moment that there is a right (moral or constitutional) to choose when to die, i.e., to choose precisely to hasten one's death. Even more evidently there is a right to choose *not* to be killed. The question is which legal framework will *take those rights most seriously*. That is a largely empirical question. It is a question which Dworkin accepts, but has wholly failed to answer plausibly. Here, at the nub of the debate, we are not dealing with a legal theorist's vision of what our constitution requires as a matter of integrity, or with a Herculean grasp of the principles of an entire legal system and its history. We are all dealing with a question on which ordinary folk have as good a grasp as anyone: In the new world of medical law and ethics, what conceivable legislative pronouncements, elegant preambles, government pamphlets, elaboration of hospital paperwork, physician reporting, official enquiries and all that, could remove or even appreciably diminish the patient's subjection to the pressure of the thought that my being killed is what my relatives expect of me and is in any case the decent thing to do, even though I utterly fear it and perhaps perceive it as the uttermost and ultimate indignity, an odious, devastating subjection to the needs and will of others? And likewise with the other sources of tyranny, the new power, opportunity, and ethic of doctors, and the real and novel power of the relatives.

At this point in his new book Dworkin terminates his brief response to such concerns. 'These slippery-slope arguments', he declares, 'are very weak ones; they seem only disguises for the deeper convictions that actually move most opponents of all euthanasia'.⁴³ To represent these convictions of *most people who oppose euthanasia* he takes care to select a Catholic priest who links euthanasia with contraception! But it is my colleague Ronald Dworkin's own assessment of those effects and implications that is truly 'very weak'. The Walton Committee of thirteen members included only one Catholic, and a spread of liberal and secular opinion—medical, legal, philosophical—representative of worldly, secular British society. They heard him, read his book, took a mountain of other evidence, visited Holland for discussions with the Dutch medical and legal authorities. They unanimously recommended against changing the law defining

43. *Id.* at 145.

murder or assisted suicide. They judged unanimously that 'any change' in the prohibition of *intentional killing* is to be rejected because it 'would have such serious and widespread repercussions'.⁴⁴ '[W]e do not think it possible to set secure limits on voluntary euthanasia [I]t would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalized'.⁴⁵ And so on, to the conclusion that 'any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address'.⁴⁶

The insinuation that most of those who state such deeply informed judgments are disguising their real convictions is even more vividly refuted by the 1994 report of the New York State Task Force on Life and the Law, entitled *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*.⁴⁷ If you want a single, up to date and American work as a basis for your reflections on the whole question, this is the one. The 24 members of the Task Force, set up in 1984 by Governor Mario Cuomo, were perhaps even more representative, secular, liberal, than the Walton Committee. Some of them think suicide and euthanasia morally acceptable in conscience.⁴⁸ After considering a mass of evidence (including Ronald Dworkin's work, to which they carefully reply),⁴⁹ with the aid of consultants at

44. Report of the House of Lords Select Committee on Medical Ethics, HL Paper 21-I of 1993-94 (31 January 1994), para. 237. Excerpts reproduced in *Keown, supra* note 11, at 102.

45. Report of the House of Lords Select Committee on Medical Ethics, HL Paper 21-I of 1993-94 (31 January 1994), para. 238. Excerpts reproduced in *Keown, supra* note 11, at 103.

46. Report of the House of Lords Select Committee on Medical Ethics, HL Paper 21-I of 1993-94 (31 January 1994), para. 238. Excerpts reproduced in *Keown, supra* note 11, at 103.

47. See TASK FORCE, *supra* note 13.

48. See *id.* at xii-xiii, 119-20.

49. See *id.* at 74 n.112:

Advocates of legalized assisted suicide or euthanasia often fail to engage in [the] crucial balancing process. For example, Ronald Dworkin suggests that, because "[t]here are dangers both in legalizing and refusing to legalize" euthanasia, society has an obligation to carve out a middle ground. See R. Dworkin, *Life's Dominion* 198 (New York: Knopf, 1993) ("[O]nce we understand that legalizing *no* euthanasia is itself harmful to many people ... we realize that doing our best to draw and maintain a defensible line ... is better than abandoning those people altogether"). Dworkin's argument loses much of its force once it is recognized that the number of people genuinely harmed by laws prohibiting euthanasia or assisted suicide is extremely small, and that legalizing euthanasia or assisted suicide for the sake of these few—whatever safeguards are written into the law—

least one of whom is strongly pro-euthanasia, they 'unanimously concluded that legalizing assisted suicide and euthanasia would pose profound risks to many patients', especially 'those who are poor, elderly, members of a minority group, or without access to good medical care The clinical safeguards that have been proposed to prevent abuse and errors would not be realized in many cases'.⁵⁰ These and their other reasons for unanimously recommending that there be no change in the law forbidding euthanasia and assistance in suicide are carefully argued with full documentation over about 200 pages.

The Task Force took at face value the Dutch figures for 'euthanasia' in 1990 as given in the soothing and misleading official commentary, overlooking the overwhelmingly greater numbers revealed in the Tables behind that commentary.⁵¹ But even the massaged Dutch figures, extrapolated to the United States (36,000 cases of voluntary euthanasia and 16,000 non-voluntary per annum), were judged by the members of the Task Force to be an 'unacceptable' risk, a risk of abuse which, they added, 'is neither speculative nor distant, but an inevitable byproduct of the transition from policy to practice in the diverse circumstances in which the practices would be employed'.⁵²

The bottom line: the secular, highly experienced and sophisticated members of the Walton Committee and the New York Task Force judge that if euthanasia were legalised at all, the right *not* to be killed would be catastrophically nullified for very many more people than the few whose supposed right to die is compromised by present law. The Ninth and Second Circuits' countervailing judgment, by comparison, seems sophistical, naive and careless.

would endanger the lives of a far larger group of individuals, who might avail themselves of these options as a result of depression, coercion, or untreated pain.

See id. Dworkin's argument loses the rest of its force when one notices that he has entirely neglected to offer any account of a 'defensible line' that might be drawn and maintained. He suggests that if he were to offer a 'detailed legal scheme' it would include rules for deciding 'when doctors may hasten the death [soft words!] ... of unconscious patients who cannot make' the choice to die. DWORKIN, *supra* note 6, at 216. For the rest he contents himself with attacking the 'tyranny' of the existing law—'the jackboots of the criminal law'. *Id.* at 15.

50. TASK FORCE, *supra* note 47, at xiii; *see also id.* at 120.

51. *See supra* text accompanying notes 18-20.

52. TASK FORCE, *supra* note 47, at 134.

V

As the fraud lawyers say, *Follow the money*. Who can doubt that if assisted suicide is introduced by judicial fiat, it will be followed if not accompanied by voluntary euthanasia, and that the *subsequent*, inexorable course of litigation (whose outcome seems to be forecast in the Ninth Circuit's footnote)⁵³ to establish that these autonomy rights must be exercisable for and on behalf of the incompetent would be litigation substantially funded by healthcare financial interests? Who can doubt that meanwhile, in the words of the New York Task Force,

Limits on hospital reimbursement based on length of stay and diagnostic group, falling hospital revenues, and the social need to allocate health dollars may all influence physicians' decisions at the bedside Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process.⁵⁴

No one's pain, delirium, or other physical distress is untreatable.⁵⁵ In a tiny proportion of cases the treatment might have to extend to keeping the patient unconscious.⁵⁶ But the care-providers may well have an objection to that: the cost of care.

VI

And we should be *looking out for the will to power*. Any permission of euthanasia, voluntary or involuntary, will obviously be a huge accession of power to physicians and healthcare personnel. Dutch doctors not only regularly and with effective impunity kill non-consenting patients. With equal freedom they refuse thousands of requests for euthanasia. Patients are radically dependent and, in

53. See *Compassion in Dying v. Washington*, 79 F.3d 790, 832 n.120. (9th Cir.), cert. granted *sub nom.* *Washington v. Glucksberg*, 117 S. Ct. 2258 (1996).

54. TASK FORCE, *supra* note 47, at 123.

55. My Oxford colleague, Dr Robert Twycross (not a Catholic), who has treated thousands of patients dying of cancer over the past 20 years, gives reasons for thinking that the proportion of such cases where mastery of pain is difficult for skillful practitioners is of the order of 1%, and the proportion where nothing less than complete sedation will suffice is much less than 1%. See Robert G. Twycross, *Where There Is Hope, There Is Life: A View From the Hospice*, in *EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES* 141, 141, 147-49, 165-66 (John Keown ed. 1995).

56. See *id.* at 165-66.

the Task Force's words, 'generally do what their doctors recommend.'⁵⁷ As they also say:

Physicians who determine that a patient is a suitable candidate for assisted suicide or euthanasia may be far less inclined to present treatment alternatives, especially if the treatment requires intensive efforts by health care professionals.⁵⁸

And much more in the same vein, persuasively spelt out and documented by the Task Force.

The Task Force speaks on the basis of wide, hands-on medical and other relevant practical experience. From my quite different position let me just suggest another possible relevance of the will to power. Ronald Dworkin's theory of the right to euthanasia—a theory in which there is indeed something to admire, especially his account of 'critical interests' and his rejection of scepticism⁵⁹—is a theory driven by a conception that it is reasonable (and, he insinuates, right) to regard one's life as a narrative of which one is the author, so that when one ceases to be in *command* of the plot one's remaining life—denounced as mere biological life—is valueless if not indeed 'indecent' and contemptible. And here he quotes with evident approval passages in which Nietzsche fiercely attacks those who do not choose to die 'when it is no longer possible to live proudly'.⁶⁰ Whatever Dworkin's own views, there is much to reflect upon hereabouts—not least Nietzsche's passionate contempt for the weak, and for compassion with them. Nietzsche's conception of morality as a kind of aesthetics—the aesthetics of a self-created life, indeed a self-narrated life, and in that way a life of noble, authorial power—deeply and pervasively misunderstands morality and thus the very foundations of human rights. A theme I cannot pursue here.

VII

The Ninth Circuit ransacks the language to describe the 'unrelieved misery or torture' from which its decision will rescue people. The judgment's last words are 'painful, protracted, and agonizing deaths'.⁶¹ But as Dr Peter Admiraal, leading Dutch exponent

57. TASK FORCE, *supra* note 47, at 122.

58. *Id.* at 124.

59. See DWORKIN, *supra* note 6, at 201-07.

60. See DWORKIN, *supra* note 6, at 212.

61. *Compassion in Dying v. Washington*, 79 F.3d 790, 814, 839 (9th Cir.), *cert. granted sub nom. Washington v. Glucksberg*, 117 S. Ct. 2258 (1996).

and practitioner of euthanasia, said in the mid-1980s, pain is never a legitimate reason for euthanasia because methods exist to relieve it,⁶² indeed in most cases it can be adequately controlled without adverse effect on the patient's normal functioning.⁶³ An expert committee of the World Health Organisation concluded in 1990: 'now that a practicable alternative to death in pain exists, there should be concentrated efforts to implement programs of palliative care, rather than yielding to pressure for legal euthanasia'.⁶⁴ Though Dworkin toys with talk of 'terrible pain'⁶⁵ and 'prolonged agony',⁶⁶ his primary argument for wanting legalisation of euthanasia lies elsewhere, so far as I can see—in the view that it is reasonable to have a quasi-Nietzschean, aesthetic hatred of dependence and loathing for the spectacle of (say) Sunny von Bulow, wholly unconscious for years but visited daily by her hairdresser. 'Really obscene' he told the Walton Committee.⁶⁷

It is indeed hard for people like judges, professors, classical scholars, and so forth—used to mastery, achievement, and control—to accept the prospect of becoming or being subject to great deprivation and more or less complete dependence. They—we—are understandably but misguidedly tempted to view such a state as spoiling their 'narrative'. The view is radically mistaken: the narrative of which they can (where they rightly can) be proud is a narrative which ends when their actual ability to carry out choices ends. Beyond that point, as (in one's earliest years) before it, there is life which is real, human, and personal, but without a story of which to be proud or ashamed. An utterly common human condition. Aesthetic objections to being reduced to this equality of dependence and powerlessness are, I suggest, no adequate basis for imposing on the many the grave injustices—the terror of being put to death and the reality of coerced and unrequested extinction—inherent in any working regime of euthanasia.

62. See Twycross *supra* note 55, at 141.

63. See Pieter V. Admiraal, *Justifiable Euthanasia*, 3 *ISSUES IN LAW & MED.* 361, 362 (1988).

64. World Health Organization, *Cancer Pain Relief and Palliative Care* (1986). In the background is the WHO's breakthrough *Method for Relief of Cancer Pain*. See *id.* at 43-70.

65. DWORKIN, *supra* note 6, at 209.

66. Ronald Dworkin, *Sex, Death, and the Courts*, N.Y. REV. BOOKS, Aug. 8, 1996, at 44, 47.

67. Report of the House of Lords Select Committee on Medical Ethics, HL Paper 91-vii of 1992-93, 162 (29 June 1993). See also DWORKIN, *supra* note 6, at 210.

VIII

What I have said about pain is one explanation why I have said so little about the realities of suffering which tempt people to commit suicide or seek assistance in doing so or demand that doctors be legally authorised to kill them. Another reason is this. For every harrowing case you can depict or report which would fall within any legalisation of euthanasia seriously defended in public debate today, there can be found dozens of cases quite comparably harrowing which fall on the other side of any such line. Read the euthanasiast, confused, but (it seems) honest Dr Lonny Shavelson's *A Chosen Death*.⁶⁸ Of the half-dozen harrowing cases he describes, only one or two would fall within any plausible euthanasia campaigner's script (and one of those, an AIDS patient who kept moving his 'line in the sand', dies naturally). Read accounts of the experience of long-time physicians in hospices for the dying.⁶⁹

The hard cases, the real sufferings of real people, are not to be shuffled away in our deliberations about euthanasia. We need to ponder them, not least to ask ourselves what we should be doing about pain and depression and other relievable sources of misery. But we also should look for the line, any line seriously proposed, and ask the line-drawers what sense they can make of distinguishing between the cases on each side of it—in matters so important as autonomy, oppression, and existence itself.

In his latest publication on euthanasia, Dworkin describes the right he contends for as 'the basic right of citizens to decide for themselves whether to die *at once* or after prolonged agony'.⁷⁰ But 'once' what? Decide to die *when*? The great majority of people who request euthanasia in hospices change their minds and come to value their last months or weeks of illness, severe though this often is. Few of those who are *dying* of AIDS request euthanasia; most of the many suicides of AIDS patients are by rather healthy people fairly soon after being told of their prognosis.⁷¹ Those who hang on very often find that their hope is eventually transferred from living on to dying well—albeit in extremities of disfigurement and debility—dying affirmed and not abandoned by their relatives or friends. These many, many people, having left behind the falsely exclusive

68. LONNY SHAVELSON, *A CHOSEN DEATH: THE DYING CONFRONT ASSISTED SUICIDE* (1995).

69. See, e.g., Twycross, *supra* note 55, at 141-68.

70. Dworkin, *supra* note 66, at 47 (emphasis added).

71. See Twycross, *supra* note 55, at 152-54.

and dominating ethic or aesthetic of control, mastery, and achievement, have found a deeper, more humble but more human understanding of the worth of simply being, with what remains of what one was given.

IX

Last but by no means least, we should wish to remain uncorrupted by the terrible euthanasiast confusion between *being in an undignified situation or condition* and *lacking human dignity*. Mindful of the Nazi horror, most American and English euthanasiasts have not yet turned their talent for rhetorically demeaning the dying or the comatose—'vegetables', and so forth—to doing the same for the mentally handicapped. What reason of principle have they for this abstention?

The deepest mistakes in Ronald Dworkin's approach to euthanasia are encapsulated in the favour which *Life's Dominion* suggests he has for the view that nurses who care for the permanently comatose, and who believe that they are doing it for a comatose person, are in fact caring only for a 'vegetating body with ... the ultimate insult: the conviction that they do it for *him*'.⁷² He does not explain how it could be reasonable to think that a body supposed to be merely vegetative and no longer personal could be insulted by respectful and loving care. And he does not defend the incoherent person-body dualism⁷³ involved in declaring the nurses erroneous in their belief that they are acting for a person, albeit one in the extremities of illness and disability. Like the nurses, and the whole tradition of respecting radical human equality, I think we should judge, and act on the basis, that: Persons keep their radical dignity until death—all the way through.

As the Walton Committee, immediately after setting out Dworkin's thesis, expressed the essential point: the 'prohibition of intentional killing ... is the cornerstone of law and social relationships. It protects each one of us impartially, embodying the belief that all are equal'.⁷⁴ The Committee had seen through the arguments

72. DWORKIN, *supra* note 6, at 212.

73. See, e.g., JOHN FINNIS, ET AL., NUCLEAR DETERRENCE, MORALITY AND REALISM 304-09 (1987); John Finnis, *A Philosophical Case Against Euthanasia*, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 32 (John Keown ed. 1995).

74. Report of the House of Lords Select Committee on Medical Ethics, HL Paper 21-I of 1993-94 (31 January 1994) paras. 236-37. Excerpts reproduced in

from autonomy and pluralism: unless doctors are to be permitted to kill anyone and everyone who makes a 'stable and competent' request for death, they are going to have to proceed on a classification of lives as 'worth living' or 'not worth living'. Benign as its present authors and promoters doubtless generally are, such a classification would create in our society a new structure of radical inequality, with implications of the most sinister kind.⁷⁵

Keown, supra note 11, at 102.

236. [W]e gave much thought too to Professor Dworkin's opinion that, for those without religious belief, the individual is best able to decide what manner of death is fitting to the life which has been lived.

237. Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing.

See id. No other person is distinguished by name in the Committee's long report.

75. These implications are readily discerned by members of disfavoured and vulnerable groups. I have in my files three reports to the legislative committee responsible for Aboriginal affairs in the legislature of the Northern Territory of Australia, dated 28 June, 9 July, and 23 July 1996, by Mr Chips Mackinolty, the consultant commissioned by the Northern Territory Government to explain to Aboriginal communities throughout the Northern Territory of Australia the meaning, limits, and benefits of the Territory's euthanasia statute. *See supra* note 28. Despite his support for the principles of the statute, Mr Mackinolty's experience of the fear and opposition of the Aboriginal communities—opposition which grew rather than diminished as they heard his explanations—has led him to advise the Northern Territory legislature to repeal the statute.

The level of fear of and hostility to the legislation is far more widespread than originally envisaged While it was expected that Aboriginal people out bush would be opposed and would be highly unlikely to avail themselves of the Act, opposition to its existence must be viewed as near universal One central Australian community, after hearing out some of the education program, became extremely angry at the legislation's existence. ('[I]t might be all right for that man in Darwin to kill his mother, but we don't do that here!'), and asked us to leave It has been expressed to us by a number of individuals that euthanasia is seen by some as a further method of genocide of Aboriginal people Conversely, there has been genuine interest from health workers and community leaders in finding out exactly what is in the legislation (albeit with a sense of trying to work out what these crazy whitefellas are up to now!) As expected there has been considerable interest in Palliative Care, which has been seen by all as 'the Aboriginal way'.

Report by Chips Mackinolty to the Northern Territory of Australia Legislative Committee for Aboriginal Affairs (June 28, 1996) (on file with author).

Going on from the previous report, I would reiterate in the strongest possible terms the comments made previously with regard to Aboriginal attitudes to the legislation and the damage it is causing Territory Health Services' reputation and standing out bush.

Report by Chips Mackinolty to the Northern Territory of Australia Legislative Committee for Aboriginal Affairs (July 9, 1996) (on file with author).

I would love to report some sort of epiphany on the road to the ROTI [euthanasia] legislation, but it just hasn't happened. If anything I feel

Dworkin now argues that there must be no 'official orthodoxy' about what makes human life of value. He says that 'no one can treat [the values in question] as trivial enough to accept other people's orders about what they mean'.⁷⁶ He says that '[w]hatever view we take ... , we want the right to decide for ourselves, and so we should therefore be ready to insist that any honorable constitution, any genuine constitution of principle, will guarantee that right for everyone'.⁷⁷ But the guarantee he proposes is worthless. While exposing almost everyone to violations of a true right (not to be deliberately killed), it would secure for few the supposed 'right to decide for themselves' but for many more would transfer to doctors the discretion to grant or withhold autonomy itself. And in exercising their discretion, the doctors, like those petitioning them for their lethal attentions, would be proceeding on a radically false valuation of the value and dignity of human life. We should not treat 'the values in question' as 'trivial enough' to allow doctors, judges, and other powerful people to impose this false valuation by whittling down and circumventing the law of murder.

Do we hear this talk of 'official orthodoxy' when it comes to matters like slavery or pedophilia? A just society cannot be maintained, and people cannot be treated with the equal concern and respect to which they are all entitled, unless we hold fast to the truth—or, if you will, the axiom—that none of us is entitled to act on the opinion that the life of another is not worth living. To trash this truth—or axiom—as a mere, unconstitutional 'official orthodoxy' is to discard the very foundations of just and *equal respect* for persons in their liberty, their pursuit of happiness, and their life.

a bit more gloomy about the whole business and its impact on the Health Department The greatest fear and reluctance about the legislation would appear to be coming from Aboriginal Health Workers themselves [F]eelings about the legislation are far more widespread than originally envisaged, that is, they are not limited to those communities who have strong "Church" followings

Report by Chips Mackinolty to the Northern Territory of Australia Legislative Committee for Aboriginal Affairs (July 23, 1996) (on file with author).

76. DWORKIN, *supra* note 6, at 217.

77. *See id.* at 239.

