Duquesne Law Review

Volume 35
Number 1 *Special Issue: A Symposium on Physician-Assisted Suicide*

Article 21

1996

Conclusion: Shaky Foundations and Slippery Slopes

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The articles contained in this volume raise a broad array of concerns about physician-assisted suicide and particularly about the conceptualization of the practice as a constitutional right. The parameters of the debate over physician-assisted suicide can only be outlined in this brief concluding article.

I. Breaking with History and Tradition

A time-honored method for determining whether a particular practice merits constitutional protection is to inquire whether the practice is "deeply rooted in this Nation's history and tradition."[1] Relying on a biased selection of historical facts and interpretations, the Ninth Circuit Court of Appeals for the United States has sought to find a basis for a right to hasten death through assisted suicide.[2] A mark of the Ninth Circuit's failure is the fact that the Second Circuit, though seeking the same result, abandoned a historical search as futile.[3]

The fact that suicide and euthanasia have been rejected by the Jewish and Christian tradition, for many centuries, and that these traditions find independent confirmation in the Hippocratic Oath, which has formed the very idea of the medical profession, is difficult to deny or downplay. Likewise, it is also difficult to deny or downplay the fact that the English common law and American legal traditions have consistently treated assistance in a suicide as a grave crime.[4]

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1. Moore v. East Cleveland, 431 U.S. 494, 504 (1977) (plurality opinion).

2. Compassion in Dying v. Washington, 79 F.3d 790, 806-10 (9th Cir. 1996) *en banc*, *cert. granted*, Washington v. Glucksberg, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 96-110).

3. Quill v. Vacco, 80 F.3d 716, 724 (2nd Cir. 1996), *cert. granted*, Vacco v. Quill, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858).

4. *See* C. Everett Koop, *Introduction*, 35 Duq. L. Rev. 1 (1996); *See also* John Dolan, *Is Physician-Assisted Suicide Possible?*, 35 Duq. L. Rev. 355 (1996); Daniel Avila,

These traditions continue into the present day not only through stands taken against assisted suicide by most major religious groups,[5] but also by specific prohibition against assisted suicide in thirty-five states, two of them, in Iowa and Rhode Island, enacted this year, and by prohibition resulting from interpretation of the common law or homicide statutes in most other states. While proponents of assisted suicide can cite the passage of one legalization measure in Oregon in 1994 in support of the practice, opponents of assisted suicide can clearly cite the defeat of similar assisted suicide proposals in many other states; and particularly such defeats occurring in fifteen states since the Oregon vote.[6] To say the least, therefore, history cannot plausibly mandate or support the legalization of the assisted suicide practice.

II. Inherent in Ordered Liberty?

It is possible that in support of assisted suicide, individuals can take a more open-ended or "progressive" view of the Constitution and claim a deeper insight into its historical implications than have more cautious ages. If the freedom to choose assisted suicide is not firmly grounded in the history and tradition of the United States, then perhaps upon a more profound reflection this freedom is among the liberties that are so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed."[7]

Notably, further reflection on this theory raises conundrums. An individual's freedom to choose assisted suicide is a strange new kind of human freedom: a freedom to extinguish life and all possibility of future freedom. If the right to live can be called the most basic right, a "right to have rights,"[8] the right of a suicidal individual to assistance in taking his or her life seems a most irreversible alienation of a supposedly inalienable right. Like the freedom to sell oneself into slavery, which has been a "liberty" barred for over a century by the Thirteenth Amendment, the freedom to have oneself killed may more properly be viewed

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Is the Constitution a Suicide Pact?, 35 Duq. L. Rev. 201 (1996); Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics, and the Future of the Medical Profession*, 35 Duq. L. Rev. 395 (1996).

5. *See* Richard Coleson, *Contemporary Religious Viewpoints* 35 Duq. L. Rev. 43 (1996).

6. *Life at Risk, A Chronicle of Euthanasia Trends in America* (National Conference of Catholic Bishops, Washington, D.C.), July/August 1996.

7. Palko v. Connecticut, 302 U.S. 319, 325-26 (1937) (cited in *Quill*, 80 F.3d at 723).

8. Furman v. Georgia, 408 U.S. 238, 289-90 (1972) (Brennan, J., concurring).

as a self-contradiction of freedom rather than its ultimate pinnacle.[9]

Many Americans, however, including some jurists find such philosophical concerns all too abstract. The key policy issue in supporting assisted suicide is the purported benefit arising from the practice to suffering individuals. What is the cost/benefit calculus for a policy of legalization? Can society help to end the suffering of a few desperately ill patients without harming many others in the process?

It is at this point that the set of issues usually referred to as the "slippery slope" needs to be addressed. Such issues arise at two levels. On the first level, the practice of assisted suicide may place members of society on a conceptual slippery slope, so that it will be logically difficult or impossible to raise principled objections to further expansions of the idea once the basic premise is accepted. On the second level, a more empirical level, such a practice may in fact combine with various other contingent factors in society to produce massive abuse, so that this practice here and now is inadvisable. This phenomenon is perhaps better described as the "loose cannon" effect.

III. The Conceptual Slippery Slope

A policy seeking to allow physician-assisted suicide only at the voluntary request of a mentally competent, terminally ill adult has some problems of internal coherence; problems greatly magnified by any attempt to define such a right in constitutional terms. Even a seemingly simple term such as "terminal illness" becomes hopelessly complex upon closer examination. Indeed, even the Supreme Court has noted that "it is often impossible to identify a patient as terminally ill except in retrospect."[10] Medical experts have found that the term "terminally ill" is not only difficult to apply, but almost impossible to define.[11] Predictions based on a precise definition of this term, such as, a definition that includes only individuals estimated to have less than a 50% chance of living for six months, will still often be wrong. The arbitrariness of the definition will also raise concerns about its relevance and prompt new "equal protection" claims by patients who fall just outside the definition's borders. Alternatively, the precision of the definition may be abandoned, as illustrated by

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9. *See* John Dolan, *Is Physician-Assisted Suicide Possible?*, 35 Duq. L. Rev. 355 (1996).

10. United States v. Rutherford, 442 U.S. 544, 556 (1979).

11. *See* Joanne Lynn et al., *Defining the "Terminally Ill:" Insights from SUPPORT*, 35 Duq. L. Rev. 311 (1996); *See also* Eric Chevlen, *The Limits Of Prognostication*, 35 Duq. L. Rev. 337 (1996).

the Ninth Circuit's expansive acceptance of all of the definitions of "terminal illness" found in more than forty state laws.[12] In that case, however, many patients with chronic or debilitating conditions that are not "terminal" in any ordinary sense of the term will be deemed eligible for assisted suicide. Thus, either option outlined above with respect to defining the term "terminally ill" creates its own slippery slope.

Similar difficulties arise in determining the nature and scope of a terminally ill patient's "competent" and "voluntary" request for death. The application of either term to the request is problematic if suicidal individuals with terminal illness, like suicidal individuals generally and unlike individuals who refuse extraordinary life support, are almost always suffering from potentially treatable depression.[13] If an individual's terminal illness itself does not necessarily make the individual's suicidal wish more common or "rational," what is the basis for treating such a wish so differently from the wishes of patients who are not terminally ill? Could the basis for this treatment really be an independent judgment made by the state, rather than the individual, that terminally ill individuals are objectively "better off dead"? If so, why restrict the right to physician-assisted suicide solely to cases in which the patient has been able and willing to express his or her own "voluntary" wish?

The Ninth and Second Circuit decisions provide a tentative answer to this question: Once physician-assisted suicide is established as a constitutional right, courts will find a way for the practice to be exercised by others on behalf of incompetent patients as well. This is explicit in the Ninth Circuit's insistence that friends, relatives or even state-appointed guardians may make decisions for such patients so that "a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself."[14] The same result is implicit, but equally inevitable, in the Second Circuit's finding that there is no rational distinction between assisted suicide and the withdrawal of life-sustaining treatment.[15] Since the latter is routinely delegated to surrogate decisionmakers in the great

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12. After noting, for example, that the Uniform Rights of the Terminally Ill Act and many state laws define a "terminal" condition "without reference to a fixed time period," the court concludes that "*all* of the persons described in the various statutes would appear to fall within an appropriate definition of the term." *Compassion in Dying*, 79 F.3d at 831 (emphasis added).

13. *See* Herbert Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation,* 35 DUQ. L. REV. 225 (1996).

14. *Id.* note 120 at 832.

15. *Quill v. Vacco*, 80 F.3d at 728.

majority of states when a patient is incompetent, there would be no rational basis for denying similar delegated decisionmaking for assisted suicide.

The residual distinction between assisted suicide and the direct killing of a patient by the administration of lethal drugs is scarcely credible once the far clearer distinction between refusing extraordinary life support and demanding lethal drugs is abandoned. The Ninth Circuit found it "difficult to make a principled distinction" between the two, particularly in the case of patients who "may be unable to self-administer the drugs."[16] Advocates of assisted suicide have gone further, arguing that failure to authorize lethal injections "unfairly discriminates against patients with unrelievable suffering who resolve to end their lives but are physically unable to do so."[17] Other advocates point out how unreliable a suicide by orally ingested drugs may be, insisting that the right to assisted death will not be ensured unless "in every instance a doctor is standing by to administer the *coup de grace* if necessary."[18]

Finally, the role of physicians in assisted suicide has far broader implications than some individuals may realize. Such a practice does not simply add one further tool to the physician's traditional black bag. Rather, assisted suicide threatens to transform the medical profession into a technical specialty equally trained to use its skills for healing or for killing.[19] This transformation seems well underway in the Netherlands, where physicians accustomed to the practice of euthanasia have developed their own idea of what kind of life merits assisted death. In many cases, these physicians have acted on that idea without bothering to consult the patient.[20] The move from healing to (initially compassionate) killing is so fundamental that by comparison, all other steps down the slope, from the terminally to the chronically ill, from voluntary request to well-meaning substituted judgment, and from supplying to administering lethal drugs, seem relatively unimportant and easily traversed.

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16. *Compassion in Dying*, 79 F.3d at 831.

17. Franklin Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. OF MED. 120 (July 14, 1994).

18. Derek Humphry, Letter to the Editors, *Oregon's Assisted Suicide Law Gives No Sure Comfort to Dying*, N.Y. TIMES, Dec. 3, 1994, at 22; M. O'Keefe, *Dutch Researcher Warns of Lingering Deaths*, THE OREGONIAN, Dec. 4, 1994, at A1.

19. *See* C. Everett Koop, *Introduction*, 35 DUQ. L. REV. 1 (1996); *See also* John Dolan, *Is Physician-Assisted Suicide Possible?* 35 DUQ. L. REV. 355 (1996).

20. *See* Herbert Hendin, *The Slippery Slope: The Dutch Example*, 35 DUQ. L. REV. 427 (1996); *See also* HERBERT HENDIN, SEDUCED BY DEATH: DOCTORS, PATIENTS AND THE DUTCH CURE (1996).

To put this concern in its most chilling terms, one may recall initial reports in the 1930's on Nazi plans "to kill incurables *to end pain*."[21] Described as "the act of providing a painless and peaceful death," euthanasia was ostensibly to be granted only when the patient "expressly and earnestly" requested it, or "in case the patient no longer is able to express his desire, his nearer relatives, acting from motives that do not contravene morals, so request."[22] Whatever monstrous dimensions the Nazi plans ultimately assumed, it has been suggested that the portentous and decisive step was taken when doctors were first authorized to take innocent human life.[23]

The present killing of incompetent patients and newborn children with disabilities in the Netherlands illustrates that ominous expansions of euthanasia and assisted suicide do not occur solely in racist and totalitarian regimes. Such expansion may be an invariant feature of an agenda that has a logic of its own.

IV. Euthanasia in the U.S. Health Care System: Loose Cannon on a Foundering Ship?

To those individuals aware of Dutch euthanasia abuses, perhaps the most damning comment on American plans for legalizing assisted suicide is that Dutch euthanasia practitioners reject such an experiment on American soil as too dangerous. Notably, as one such Dutch practitioner said to an American visitor, "I wouldn't trust myself as a patient if your medical profession, with their commercial outlook, should have that power."[24]

While such criticism seems paradoxical in light of the evidence of nonvoluntary killing in the Netherlands, it underscores a final ambiguity and danger in the efforts to allow a "free choice" for assisted suicide: choices may only be superficially free, because, while sincerely expressed by the patient, the patient is heavily influenced and even coerced by the forces in his or her environment. Whatever else it may be, the freedom to provide certain persons with lethal drugs for suicide presents an extremely convenient means for solving many other people's problems.[25]

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21. Associated Press, *Nazis Plan to Kill Incurables to End Pain; German Religious Groups Oppose Move*, N.Y. Times, Oct. 8, 1933, at 1 (emphasis added).

22. *Id.*

23. One commentator notes: "At the heart of the Nazi enterprise . . . is the destruction of the boundary between healing and killing." Robert Jay Lifton, The Nazi Doctors 14 (1986).

24. J. Keown, *Dutch Slide Down Euthanasia's Slippery Slope*, Wall St. J., Nov. 5, 1991, at A18.

25. On efforts to evade that fact and even to evade the reality of killing involved in the practice, see Rita Marker & Wesley Smith, *The Art of Verbal Engineering* 35 Duq. L. Rev. 81 (1996).

Economic pressures in a financially pressed health care system present the most obvious example of these dangers. These pressures are amply illustrated by Oregon's Medicaid rationing scheme, which denies some life-sustaining treatments to indigent terminally ill citizens because they are not deemed cost-effective, but reimburses the cost of providing assisted suicide in all cases.[26]

More subtle but equally powerful pressures can be expected from social prejudices against individuals who are old, disabled and unproductive in a society oriented toward youth, vigor and visible achievement. It would be naive in the extreme to imagine that consent to assisted suicide on the part of debilitated and vulnerable patients would not be manipulated by others, as such patients internalize the feelings of those around them that they are a burden on family and community. The very act of establishing assisted suicide as a new "right" for these patients may invite the judgment that those in poor health who fail to choose the assisted suicide option are acting arbitrarily and even selfishly.[27]

These pressures and prejudices are not figments of the imaginations of individuals who oppose assisted suicide in principle; they are the bases upon which open-minded study groups have concluded that legalized assisted suicide is a risky and unwise gamble with helpless and marginalized individuals' lives. For example, the twenty-five members of Governor Mario Cuomo's Task Force on Life and the Law disagreed on the abstract ethics of assisted suicide, but unanimously agreed to oppose legalization of the practice:

> The Task Force members concluded that the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved. The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary.[28]

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26. *See* D. Postrel, *State could cover assisted suicide*, SALEM STATESMAN JOURNAL, Dec. 6, 1994, at A1.

27. *See* Marshall Kapp, *Old Folks On The Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 DUQ. L. REV. 443 (1996); *See also* Herbert Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 DUQ. L. REV. 285 (1996).

28. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT, 120 (1994).

The conclusion independently reached by the American Bar Association's Commission on Legal Problems of the Elderly is strikingly similar:

> Proposals in favor of personal autonomy and voluntary choice are framed and limited by the options available to people. To argue that the principle of personal autonomy includes euthanasia in a country such as the United States which does not recognize a universal legal right to access to quality care is near-sighted at best. At worst, it is a serious danger to those without adequate care options, for they may be subtly or not so subtly encouraged to "opt out" of life via aid in dying precisely because they lack decent care alternatives or because they may become serious financial burdens on their families.[29]

These concerns were brushed aside by Judge Reinhardt of the Ninth Circuit with the comment that providing universal access to health care is a legislative task from which the federal judiciary is "compelled to stand aside."[30] Surely, however, the judiciary is not required to ignore the social pressures and inequities which will drive the implementation of its own call for access to assisted suicide. Proclamation of a "free choice" for death, when no other choice is accessible, is no victory for freedom. Furthermore, if euthanasia is defined by the courts as a valid aspect of health care, it may be too late for new legislative health care initiatives designed to alleviate the social pressures toward euthanasia, for such court rulings would be used to exert pressure toward *including* euthanasia among the health care options newly promoted to the marginalized.

V. Stepping Back: What Was the Question?

Anyone who spends time exploring the depths and dangers of the euthanasia agenda may begin to wonder: If assisted suicide was supposed to be the answer, what was the question?

There is evidence that the question posed by elderly and seriously ill individuals is something quite different from, "how do I more easily get assistance in suicide?" A recent study notes that cancer patients experiencing significant pain are less likely than the general public (or their own physicians) to favor assisted suicide; what these patients really want is better relief for their pain.[31] Some disability rights leaders have become quite vocal in their opposition to an agenda that they view as reinforcing prejudices against the worth of a life with a permanent disabil-

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29. American Bar Association Commission on Legal Problems of the Elderly, *Memorandum of* Jan. 17, 1992, *reprinted in* 8 Issues in L. & Med. 117, 121 (1992).

30. *Compassion in Dying*, 79 F.3d at 826.

31. E. Emanuel et al., *Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public*, 347 The Lancet 1805 (1996).

ity.[32] On a larger scale, numerous polls show strong opposition to legalizing assisted suicide among senior citizens, and disproportionately strong support for the practice among young, white, affluent males.[33] Is assisted suicide the answer sought by its supposed beneficiaries, or just the solution that the able-bodied have assumed would be best for all concerned?

Appeals for less dangerous alternative solutions, such as improved pain control and care for dying patients, better access to supportive services, and so on, are likely to be greeted with the response that such care is currently inadequate. This, however, seems to argue for a renewed commitment to solve these inadequacies. Medical experts, including those represented in this volume, universally agree that there is an enormous gap between the "state of the art" in modern pain control and the actual practice of most physicians and hospitals in the United States. These inadequacies of care help to drive the demand for assisted suicide. It may be equally true that a leap to the "quick fix" of assisted suicide will short-circuit any true commitment to make this care as good and humane as it can be. The most basic premise behind any effort to improve the conditions of life for any class of individuals is the firm conviction that individuals' lives really *matter*. Twist, turn and evade it as one might, this basic premise is thrown into question when a particular class of individuals is proposed as offering good candidates for "assistance" in suicide.[34]

When a car is not running well, no individual in his or her right mind drops the car off at the junkyard without making sure that it does not simply need an oil change or a full tank of gas. The real problems of seriously ill patients in our society, to say the least, deserve as much responsible attention. Clearly, this is especially so if the alternative is a long drive down a slope that increasingly resembles a vertical drop.

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32. *See* K. Wolfe, *Disabled Activists Fight Assisted Suicide*, THE PROGRESSIVE 16 (Sept. 1996); H. Gallagher, *Slapping Up Spastics: The Persistence of Social Attitudes Toward People with Disabilities*, 10 ISSUES IN L. & MED. 401 (1995).

33. *See Life at Risk: A Chronicle of Euthanasia Trends in America*, Oct. 1994, at 3-4; *See also id.*, June/July 1995, at 1; *Id.*, June 1996, at 3. The Hemlock Society's own polling indicates that "the younger the person, the more likely he or she is to favor this legislation" allowing assisted suicide. Hemlock's newsletter notes that "this is somewhat at odds with how Hemlock views its membership." *See Poll Shows More Would Support Law Using Gentler Language*, TIMELINES 9 (Jan.-Feb. 1994).

34. On the differences between genuine compassion and the view that a life of suffering lacks human dignity, *see* Courtney Campbell, *Suffering, Compassion, and Dignity in Dying*, 35 DUQ. L. REV. 109 (1996).