2000

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Publication Information & Recommended Citation

Schneider, Carl E. "Making Biomedical Policy through Constitutional Adjudication: The Example of Physician-Assisted Suicide." In *Law at the End of Life: The Supreme Court and Assisted Suicide*, edited by C. E. Schneider, 164-217. Ann Arbor, Mich.: University of Michigan Press, 2000.

CHAPTER 7

Making Biomedical Policy through Constitutional Adjudication: The Example of Physician-Assisted Suicide

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Carl E. Schneider

Introduction

Throughout most of American history no one would have supposed biomedical policy could or should be made through constitutional adjudication. No one would have thought that the Constitution spoke to biomedical issues, that those issues were questions of federal policy, or that judges were competent to handle them. Today, however, the resurgence of substantive due process has swollen the scope of the Fourteenth Amendment, the distinction between federal and state spheres is tattered, and few statutes escape judicial vetting. Furthermore, Abraham Lincoln's wish that the Constitution should "become the political religion of the nation" has been granted. "We now reverently refer to the Supreme Court as the great arbiter of American moral life, as performing a 'prophetic function,' as expressing what 'we stand for as a people.'"[1] Its Justices are invoked as "moral teachers who help to shape the character of our nation."[2] How could our most perplexing ethical issues *not* be confided to such an institution?

My first purpose in this chapter is to consider that question, to ask whether constitutional adjudication is a good way to make biomedical policy. My answer—in its briefest, bluntest form—is no. I believe biomedical policy is generally better made—is better informed, better structured, more responsive, wiser, and more legitimate—when it is made by the whole range of governmental agencies (legislatures, administrative agencies, referenda, courts interpreting statutes and the common law), and semiofficial and nonofficial institutions and individuals (commissions like the New York Task Force on Life and the Law, professional associations like the American Association of Bioethicists and the American Medical Association, voluntary associations like churches, and individuals like scholars, doctors, patients, and families). These actors and agencies will not produce perfect law; they may not even produce good law. But they are likelier to do better than courts acting as interpreters of the Constitution.

My vehicle for this argument is the cases deciding whether there is a constitutional right to assistance in committing suicide, particularly the

Ninth Circuit's decision in *Compassion in Dying v Washington*[3] and the Supreme Court's reversal of that decision in *Washington v Glucksberg.*[4] My principal exhibit will be *Compassion in Dying.* It is the high-water mark of the constitutional claim and the culmination of exceptionally thorough judicial consideration: The District Court found Washington's prohibition of assisted suicide unconstitutional; the Ninth Circuit's three-judge panel reversed; and the Ninth Circuit *en banc* reversed the panel by a vote of eight to three in a long and detailed opinion. *Compassion in Dying,* in short, probably represents as considered a job as a court is likely to achieve in setting biomedical policy through constitutional adjudication. It therefore repays careful inspection.

An obvious objection to the argument against making biomedical policy through constitutional adjudication is that, for better or worse, the Constitution creates rights courts must enforce, that courts thus cannot escape making biomedical policy, and that it is thus not worth asking whether constitutional adjudication will yield sound biomedical policies. I have several answers to this objection. First, I rather quaintly doubt the Fourteenth Amendment creates a constitutional right of privacy of the kind the Court has created. This is a well-worn controversy, and I need only say here that the reasons for my doubts are conventional ones, including the interpretive leap such a right requires, the difficulties the Supreme Court has had articulating and defining that right, and the power the right gives unelected courts. Perhaps somewhat less conventionally, I also believe the problems with constitutional adjudication I will describe are relevant to whether a privacy right should be read into the Constitution.

Second, my arguments should be relevant even to someone who finds a privacy right in the Fourteenth Amendment because they speak to some unresolved issues in the law of substantive due process. For example, even if there is a privacy right, the capacity of courts to handle biomedical questions well should affect our view of the right's scope: The privacy right is a judicial creation; it should be one judges can interpret and implement effectively and intelligently. Furthermore, my arguments speak to a persistent but neglected problem in Fourteenth Amendment analysis—how governmental interests should be evaluated.[5]

Third, I will ask not just whether constitutional adjudication is a good way of making public policy, but also whether, under current constitutional doctrine, statutes that make it a crime to help someone commit suicide are unconstitutional. I will primarily contend that the state's interests are strong enough to make those statutes constitutional even if there is some kind of privacy right to assisted suicide.

In sum, this chapter serves this volume's goals in several ways. First, it asks an important question about any issue of public policy—which institutions are best entrusted with the decision? More particularly, it joins the controversy over the role of courts as an instrument of public policy.[6] Second, it contributes to the debate on the scope of the right of privacy and on how state interests should be treated in Fourteenth Amendment analysis. Third, it comments on the constitutional strength of the state's interests in making it criminal to assist in a suicide. Finally, it speaks to the question whether assisted suicide should be forbidden as a matter of public policy.

Since this chapter is lengthy, let me summarize its argument here. I will not contend that constitutional adjudication must inevitably reach the wrong result in bioethical cases. The Supreme Court in *Glucksberg* reached the right one, even though the Court was divided and several of its members—perhaps a majority—warned that somewhat different facts might have led them to a critically different result. I will argue, rather, that constitutional adjudication is ill-equipped to make good bioethical policy. This is particularly a problem where a court finds that a statute is unconstitutional, for then the court substitutes its judgment for the legislature's and ordinarily attempts to sketch a new policy.

I will argue that there is little reason to prefer a court's judgment and much reason to doubt its ability to craft sound policy. More particularly, I will suggest that the Constitution and constitutional jurisprudence are poor in guidance for making bioethical policy and that judges' training and experience hardly remedy this defect. Worse, litigation commonly fails to furnish judges the information they need for evaluating statutes intelligently. To illustrate this point, I will scrutinize the Ninth Circuit's treatment of the interests the state asserted in *Compassion in Dying*. I will then propose that these judicial handicaps are exacerbated by much in the culture of American law. I will conclude by arguing that other institutions are better placed to make—and indeed are already making—policy governing assisted suicide than are courts.

How Well Equipped Are Judges to Make Policy?

Judges interpreting the Constitution might make good policy for two reasons—because the Constitution states good principles for public policy and provides a good framework for analyzing social issues or because judges' training, experience, and procedures give them insight into what policy should be. Neither of these conditions fits matters of biomedical policy.

First, the absence of any textual commission from the Constitution means the Justices are thrown back on their own resources in making policy. In privacy law, those resources have produced a perfectly worthy desideratum—autonomy. Yet by itself autonomy is no guide to policy. Autonomy, yes. But in what quantities, in what places, and at what costs?[7] The Justices have found no satisfactory way to turn a banality into a workable principle: Autonomy is notoriously a greedy concept, but the Court cannot define its limits. Autonomy is notoriously one good among many, but the Court cannot articulate a sound method for accommodating it to other goods.

Consider the announced principles of Fourteenth Amendment analysis. First, a court decides whether a statute infringes a fundamental right. If it does, it is constitutional only if it is "necessary" to serve a "compelling" state interest. If the statute does not infringe a compelling state interest, it is constitutional if it simply serves a "legitimate" state interest. Much depends, then, on how one decides what rights are fundamental. However, even after several decades of modern substantive due process, that decision remains embarrassingly manipulable. For example, the Court ritually says it begins "by examining our Nation's history, legal traditions, and practices."[8] But everything turns on the specificity of that examination: Define the right narrowly and it will rarely look "fundamental." Justice Scalia was correct in his concurrence in *Cruzan v Director, Missouri Department of Health* when he denied that suicide had ever been thought a right[9] and in his opinion for the plurality in *Michael H. v Gerald D.*[10] when he said Americans had never imagined a right to adultery. But the Court has not always employed Justice Scalia's narrow definition of history and tradition. Had it done so in *Roe v Wade,* for example, it could hardly have derived a fundamental right to abortion.[11] Yet if one broadens one's definition of the right and asks whether there is a history and tradition of protecting autonomy or of a "right to be left alone," virtually any claim may be alchemized into a fundamental right.

This dilemma might lead us into despondency about the history-and-traditions test and toward a more conventional lawyer's approach—inferring principles from precedent and then using the principle to guide decisions. The most celebrated such attempt—one seized on by the Ninth Circuit in *Compassion in Dying*—is from *Planned Parenthood of Southeastern Pennsylvania v Casey:*

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.[12]

Perhaps this rhapsody is inspiring; it is hardly instructive. The Court in *Glucksberg* responded to it sensibly: "That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, . . . and Casey did not suggest otherwise."[13] But then what principle *should* be inferred from the cases? The Court does not try to say. And how could it? What consistent principle should be inferred from cases that hold, for instance, that private sexual activities may be criminalized[14] but that most abortions may not be?

Like the formulations for evaluating fundamental rights, the tests for assessing the state's interests are mightily manipulable. A statute that interferes with a "fundamental right" must be "necessary" to promote a "compelling" state interest. What do those Delphic terms mean? The Court never says. "Compelling" languishes in mystery, since the Court rarely uses it to decide cases. "Necessary" has meant first that there is no less offensive way of reaching the statute's goal and second that the statute is neither under- nor overinclusive. Since no statute fully meets either criterion, few statutes that infringe a fundamental right have 'scaped whipping.[15]

As privacy jurisprudence developed, it became clear that the decision whether a fundamental right had been infringed was virtually dispositive. This seemed an embarrassing betrayal of the test the Court had promulgated, and it promoted an impoverished analysis. Gradually, the Court devised an intermediate category of scrutiny less apt to predetermine a statute's fate. This answered some of the criticisms of the old two-tier system, but it has left privacy law even more befogged than before. The Court only intensified these perplexities in *Cruzan,* for there the Court seemed to abandon the language of fundamental rights to adopt the language of "liberty interests." The Court then "balanced" the liberty interest against "the relevant state interests."[16] Justices Brennan and Stevens agreed Cruzan had a fundamental right but not on how to evaluate the state interest. Justice Brennan said that "if a requirement imposed by a State 'significantly interferes with the exercise of a fundamental right, it cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests.'"[17] Justice Stevens said that, at a minimum, the statute must "bear a reasonable relationship to a legitimate state end."[18]

Is this chaos of thought and passion, all confused, merely the product of an early stage in privacy jurisprudence? Perhaps, but there are reasons to think the pattern of undefined terms, multiple tests, and manipulable standards will persist. The problems with which the Court is struggling are bitterly difficult. Autonomy is a core value, but it is so endlessly expansive and has such different costs and benefits in different situations that writing principles to promote it seems to baffle everyone. Furthermore, building doctrine by committee is awkward, particularly where the committee membership changes and the members are fractious and apparently unburdened by any sense of obligation to compromise even enough to provide guidance to lower courts, the bar, and the public. In both *Cruzan* and *Glucksberg,* for example, Justice O'Connor was part of a five-person majority but wrote concurring opinions that cast doubt on the majority's reasoning. And in *Glucksberg* the nine Justices wrote six opinions. Furthermore, the Court constructs constitutional doctrine through a common law process that looks at issues piecemeal. This makes it hard for the Court to assess any doctrine as a whole.

As we will see throughout this chapter, this brief summary hardly does justice to the problems the Court has encountered in stating a defensible autonomy principle and operationalizing it with workable tests. Thus, so much is left to the Justices' discretion that they must draw deeply on their own resources. So how well suited to making sound public policy are those resources?

Little in the training or experience of most judges fits them to make biomedical policy. Law schools primarily teach students to analyze legal documents and doctrines, to derive principles from precedents, and to apply precedents to new cases. Despite decades of criticism, judicial opinions dominate the enterprise. Even statutes are assigned cautiously, resisted by students, and taught gingerly. Students rarely read the social science that public policy should consult and regularly leave law school without encountering a serious analysis of how a legal doctrine actually works. Unhappily, scholars do not write such analyses, law teachers are often uninterested in them,[19] and authors cannot squeeze them into casebooks.

Legal practice hardly remedies these defects of legal training. Lawyers today, particularly elite lawyers, tend to specialize narrowly. And for most lawyers even a general practice is a narrow enterprise. Thus it is possible—it is common—to be appointed to the bench without ever having administered an organization, met a payroll, run a public program, stood for office, or served in a legislature. Judges' social experience is likely to be narrow as well. Most elite judges were born into, and all of them live among, the comfortable classes. As a multimillionaire jurist once lamented to me, "I'm always the poorest man in any room I'm in."[20]

Once anointed, judges become genuine generalists, assigned to resolve a breathtaking range of problems. Legislators may specialize; judges cannot. Legislators serve on specialized committees with expert staffs. Judges have only a few "clerks" who have just graduated from law school, and they cannot consult experts out of court. Some judges even try to limit their social contacts to preserve their dispassion. In their work they lead lives of quiet preparation. In sum, judges suffer the narrowness of the generalist.

All this means judges often know little about the issues of public policy they must resolve and have little experience analyzing public policy issues in any but doctrinal terms. Yet the way courts acquire and analyze information does little to ameliorate this ignorance and inexperience. The only judge who participates in finding facts is the trial judge. But trial judges have little control over what facts are discovered, for it is primarily the lawyers' responsibility to investigate the relevant facts and to introduce them into evidence.

Yet trial lawyers suffer from the same impoverished training and experience judges do. They are specialists at litigation who must educate themselves about every new case. Furthermore, their allegiance is not to the truth, but to the client, so that they typically introduce only evidence favorable to their clients. The range of opinions and information the judge hears thus depends on who the clients are. If they do not represent the full range of interested parties—and they rarely do—relevant positions will go unexplored. (Hospices, for instance, were not litigants in *Glucksberg*.) All this is troublesome enough when the question is only whether some fact occurred. It is crippling when the issue is whether some policy is wise. Such a question requires analyses of complex data that can essentially be introduced only through expert witnesses. In American litigation, these witnesses are ordinarily paid by the parties, and paid to be partisan. Finally, the quantity and quality of the information lawyers introduce depend on the (markedly variable) competence of the lawyers and the wealth of their clients (and on the rules of evidence).

In American law, appellate judges depend on the information trial courts gather. Appellate judges may not make inquiries of their own and in any event have neither time nor taste for doing so. They primarily rely on the parties' briefs and perhaps a joint appendix that reprints a few slivers of the record. (Although judges are entitled to summon the whole record, they rarely do.) Other affected parties may submit *amicus curiae* briefs, although they need not and although judges rarely read them. No judge is polymath enough to be well informed on all the kinds of cases that come before a court. Courts, in other words, make social policy on the basis of "executive summaries."

The result of all this is that appellate courts regularly fail to understand the nature of the institutions and practices for which they make rules, even when those institutions and practices are legal ones. Thus, one fascinating study of the way courts actually deal with criminals concluded that the Supreme Court's decisions "overlook (1) the nature of courts as formal organization; (2) the relationship that the lawyer-regular *actually* has with the court organization; and (3) the character of the lawyer-client relationship in the criminal court (the routine relationships, not those unusual ones that are described in 'heroic' terms in novels, movies, and TV)."[21] As another commentator puts it, "American jurists of criminal law rarely study the reality of the American criminal justice system but potter happily away in an Alice-in-Wonderland world where defendants with competent lawyers go on trial and argue strenuously about *mens rea* or the rules of evidence or the exact weight or implication of the guarantees in the Bill of Rights."[22]

Once again, the contrast with legislators is illuminating. In a well-run legislature, bills are turned over to a specialized committee. Its expert staff prepares reports and interviews witnesses who represent a range of interests and views. At hearings, legislators may ask whatever questions they wish (or are prompted to ask by their staff). Legislators may also interrogate anyone they choose about the controversy. And legislators properly heed public debates and are properly the subject of lobbying (which would be improper ex parte contact were a judge approached).

For all the reasons I have described, then, systematic empirical information rarely intrudes itself into the labors of appellate judges. Even when it does, however, courts all too often dismiss it. As David Faigman says in his extended study of the problem, "Historically, most constitutional fact-finding depended on the Justices' best guess about the matter."[23] Faigman notes, for example, that the Court asked for research on whether excluding jurors who oppose the death penalty biases juries in favor of conviction. Nevertheless, in *Lockhart v McCree,* the Court dismissed the consequent outpouring of research on the ground that it did not meet the Court's high standards of empirical verification, a dismissal Faigman attributes in considerable part to the Court's failure to understand how social science works.[24]

Perhaps my point about the ability of courts to assimilate information may be made more concrete by being made more personal:

> In the Chambers of the justice for whom I clerked, the burden of the Court's work meant that cases were handled like this: The justice would read the parties' briefs in each case; the three clerks divided the argued cases among them. Before oral argument, the clerks and the justice would discuss the cases. The justice would listen to the oral arguments, and the Court would deliberate and vote privately. If my justice was assigned to write the opinion, the clerk who had worked on the case would draft it. He had ten days in which to do so. In that time, he continued to read briefs and to write memoranda to the justice on the petitions to hear cases that kept pouring into the Court. When the clerk was finished drafting the opinion, the justice would read it over and edit it lightly.[25]

In this section, I have been asking whether there are *a priori* reasons to think judges will make good biomedical policy. I have suggested that the Constitution is not a rich source of relevant wisdom, that the Court has not developed constitutional doctrine that provides a cogent and workable analytic framework, that little in the training and experience of judges suits them to make public policy, and that courts are poorly organized to collect the kind of information and analysis on which successful policy ordinarily rests. In short, there are excellent reasons to doubt courts will make good bioethical policy through constitutional adjudication.

Policy Analysis and the State Interests: The Example of *Compassion in Dying*

I now want to look at one ambitious judicial attempt to make bioethical policy through constitutional adjudication to see how well courts actually succeed at it: by their fruits ye shall know them. My example, of course, is the Ninth Circuit's *en banc* opinion in *Compassion in Dying v Washington.*[26] For brevity's sake, I will ignore the court's arguments about whether Washington's statute infringed some constitutional interest and concentrate on the court's analysis of the interests the state advanced to justify its statute. I will do so because the arguments deriving such a right have already been lengthily criticized while the state-interest arguments have generally been scanted and because the court's treatment of the state's interests exemplifies the judicial incapacities I have been discussing.[27]

In this part, I make two central arguments. The first is that courts typically fail to take states' interests seriously enough.[28] My second central argument is that courts often are poorly informed about the policies they are making. The Ninth Circuit analyzed *Compassion in Dying* at uncommon length. Yet it repeatedly seems to have misunderstood the facts and arguments basic to its decision. To demonstrate this, I will examine the court's treatment of each of the state's principal interests.

The First State Interest: The Unqualified Interest in Life

The Ninth Circuit began by acknowledging what the Supreme Court said in *Cruzan:* "The state may assert an unqualified interest in preserving life in general."[29] The court rejected this interest for two reasons. Its first reason was one that it returned to at several points and that was also the basis for the Second Circuit's decision in *Quill v Vacco:*[30]

> [T]he state of Washington has already decided that its interest in preserving life should ordinarily give way—at least in the case of competent, terminally ill adults who are dependent on medical treatment—to the wishes of the patients. In its Natural Death Act, . . . Washington permits adults to have "life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconsciousness."[31]

The first problem with this argument is that Washington need not have "decided" its interest in life should give way. Rather, it might only have concluded that the principle of *Cruzan* compelled it to permit people to refuse medical treatment. In other words, the state may have believed people are constitutionally entitled to resist bodily intrusions, even if those intrusions are livesaving. But the state might still have retained an interest in preserving life that it wished to assert in any permissible way.

The second problem with the court's argument lies in its view of doctors' motives: "In disconnecting a respirator, . . . a doctor is unquestionably *committing* an act; he is taking an active role in bringing about the patient's death. In fact, there can be no doubt that in such instances the doctor intends that, as the result of his action, the patient will die an earlier death than he otherwise would."[32] The court is—characteristically—confident, but it is wrong. The doctor need not intend anything of the kind, often will intend nothing of the kind, knows that predictions about disconnecting respirators are perilous (as the case of Karen Ann Quinlan famously demonstrated), and may hope the patient will survive. Nor is it obvious that patients—who often cling to the wispiest hopes—want to die when they refuse treatment.

The court thought it was "not possible to distinguish prohibited from permissible medical conduct" in a second way: "[D]octors have been supplying the causal agent of patients' death for decades. Physicians routinely and openly provide medication to terminally ill patients with the knowledge that it will have a 'double effect.'"[33] The doctrine of double effect is the principle "that a single act having two foreseen effects, one good and one harmful (such as death), is not always morally prohibited if the harmful effect is not intended."[34] The doctrine is commonly invoked to justify providing medication to relieve pain even though the medication is also likely to cause death as long as "the physician's provision of medication . . . [is] intended to relieve grave pain and suffering and [is] not intended to hasten death."[35]

The Ninth Circuit surely was not required to accept the doctrine of double effect. But it was required to understand it and the consequences of rejecting it. Nevertheless, the court rushed headlong from the possibility that a doctor's action may cause death to the certainty that death must be the doctor's goal: "To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other."[36] The court does not seem to grasp that a doctor may know death is a risk without being certain it will happen or wanting it to. The court's misunderstanding may flow partly from its medical naiveté. As one physician (and proponent of assisted suicide) writes, "[C]aregivers experienced in hospice settings know that it is extremely difficult to produce a fatal overdose by increasing the amount of opioid administered to a patient suffering pain. This is especially true when the agent is titrated with care and when the patient has been receiving an opioid long enough to build up tolerance."[37]

Not only does the court misperceive the motives doctors and patients must have in terminating medical treatment or in seeking relief from pain, it seems not to have considered the consequences of equating those acts with suicide. If *any* refusal of treatment that might prolong life is suicide, a person or state that opposes suicide must undergo or demand extremes of treatment no one would think sensible. And if pain relief that runs some risk of causing death were called murder, how many doctors would treat pain adequately? No wonder an observer as sober and serious as John Arras calls the court's rejection of the doctrine of double effect "reckless and counterproductive." He explains, "[M]any physicians would sooner give up their allegiance to adequate pain control than their opposition to assisted suicide and euthanasia. If they are convinced by the judge's reasoning, many will be reluctant to practice adequate pain control techniques on their dying patients."[38]

The court also depreciated the state's general interest in life because that interest "is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die without further medical treatment. . . ."[39] But the court failed to explain satisfactorily why the state's interest is diminished by someone's decision to die, and the Supreme Court did not agree that it is: "As we have previously affirmed, the States 'may properly decline to make judgments about the "quality" of life that a particular individual may enjoy . . . '. . . . This remains true, as *Cruzan* makes clear, even for those who are near death."[40]

The court acknowledged that the state might be deterred from permitting assisted suicide by the difficulty of defining "terminally ill." However, the court so confidently assumed a workable definition is easily devised:

> We acknowledge that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is sometimes impossible to say for certain whether a borderline individual is or is not mentally competent. However, we believe that sufficient safeguards can and will be developed by the state and medical profession . . . to ensure that the possibility of error will ordinarily be remote.[41]

This implies that the problem is that doctors may apply the definition of terminally ill inaccurately. That is certainly a concern, given the relentless uncertainty of medical predictions and the notorious variability of medical practice. But the problem lies not just in applying the definition—it lies in devising it. The court scoffs at the "purported definitional difficulties" on the grounds that they "have repeatedly been surmounted."[42] The court's evidence is that states have enacted definitions of "terminal" into law. But that is no answer if the definitions are bad ones. Unfortunately, there is a reason to doubt the present state of knowledge permits reliable definition. One well-informed study reports that

> every criterion has very serious problems and complexities, even in a population for whom good models for predicting survival is available. The number of long-term survivors increases when more inclusive criteria are applied while the number of very early deaths increases when more restrictive criteria are used. No statistical criterion seems to capture only the population which was really intended.[43]

Thus this study concluded, "Deciding who should be counted 'terminally ill' will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide. Allowing physicians (or anyone else) to decide who is terminally ill without standards or guidance will result in uneven application with unjustified variations across diseases, across physicians, and across regions."[44] In short, the Ninth Circuit seems to have been unaware of the evidence that "[h]ighly accurate predictive models of survival are difficult to create, harder to apply, scanty in number, flawed in practice, and impossible in theory."[45]

The Second State Interest: Preventing Erroneous Decisions

The Ninth Circuit conceded that "the state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated."[46] However, the court said that "that interest . . . is substantially diminished in the case of terminally ill, competent adults who wish to die."[47] Here the Ninth Circuit apparently misunderstood both the state's argument and the world of the dying. The court seemed to think the state was simply trying to prevent suicide. But the state was arguing that a decision to commit suicide made under the influence of mind-warping pressures is not autonomous.[48] In other words, the state interest at issue was not a general interest in preventing suicide, but a more particular interest in preventing suicides that result from "decision defects."[49]

Although its opinion turns on the principle of autonomy, the court is largely indifferent to the problem of decision defects. Yet that problem is severe for all patients and crucial for terminally ill patients contemplating suicide. Thus Herbert Hendin, a leading student of suicide, writes, "Like other suicidal individuals, patients who desire an early death during a serious or terminal illness are usually suffering from a treatable mental illness; most commonly a depressive condition or alcoholism."[50] Depression is notoriously unrecognized by its sufferers and those around them, particularly when, as for the dying, it is easy to identify a reason for sorrow. Worse, "depression is underdiagnosed and often inadequately treated. Although most people who kill themselves are under medical care at the time of death, their physicians often fail to recognize the symptoms of depressive illness or to provide adequate treatment for the illness."[51]

More broadly, the court seems afflicted with a naive view of human motivation, one that does not appreciate how complex, ambiguous, and ambivalent people's motives commonly are. The motives of the seriously ill have all those characteristics and are further roiled by the fatigue, fear, pressures, and disorientation disease wreaks on its sufferers.[52] All these problems are exacerbated by the confrontation with mortality. Thus Hendin writes, "Clinicians and researchers working with patients who request assisted suicide during an illness have described the patients as having the same intense emotions, such as hopelessness, despair, anxiety, rage and guilt, seen in suicidal patients without physical illness."[53] These emotions conduce to ill-considered decisions. Thus Stengel comments that many "suicidal attempts and quite a few suicides are carried out in the mood 'I don't care whether I live or die,' rather than with a clear and unambiguous determination to end life. . . . Most people, in committing a suicidal act, are just as muddled as they are whenever they do anything of importance under emotional stress."[54]

In addition, requests for suicide may be motivated by desires that can be less harshly satisfied. Hendin, for instance, suggests that losing their sense of control drives some patients to try to fix the time and circumstances of their deaths.[55] If so, providing them with other kinds of power may satisfy their wish for control.[56] Similarly, Hendin reports, "The vast majority of patients who request assisted suicide or euthanasia are motivated primarily by the dread of what will happen to them in the dying process rather than by their current pain or suffering. . . . When these fears are dealt with by a caring, sensitive physician, the patient's requests for death usually disappear."[57] Hendin also believes patients requesting help committing suicide, "like other suicidal individuals, are often testing the affection and care of others. The overwhelming number of patients drop the request to die, however, if their anxieties are dealt with sensitively and effectively."[58]

If these are the kinds of reasons patients request help committing suicide, it is unsurprising that the "desire for death is variable over time even for patients who are terminally ill. This is true even among the small number of terminally ill patients expressing a persistent wish to die. When interviewed two weeks later, two-thirds of these patients show a significant decrease in the extent of the desire to die."[59] It is commonly observed that, "once patients are confronted with illness, continued life often becomes more precious; given access to appropriate relief from pain and other debilitating symptoms, many of those who consider suicide during the course of a terminal illness abandon their desire for a quicker death in favor of a longer life made more tolerable with effective treatment."[60] Such changes of heart are experienced by patients of all kinds, not just the dying. For example, one patient—Wilfrid Sheed—learned that "cancer, even more than polio, has a disarming way of bargaining downward, beginning with your whole estate and then letting you keep the game warden's cottage or the badminton court; and by the time it has tried to frighten you to death and threatened to take away your very existence, you'd be amazed at how little you're willing to settle for."[61]

In sum, there is much evidence that a disturbing number of terminally ill patients considering suicide are not making truly autonomous decisions. Depression is a predominant motive for seeking assistance in suicide even among the terminally ill. It is generally treatable, but it is often not diagnosed by doctors. People seeking suicide are often in the grip of emotions they do not understand and are pursuing goals that can be met in less drastic ways. The wish to commit suicide is often inconstant. In short, decision defects plague decisions to die. Perhaps all this evidence is not incontrovertible. But it is the kind of evidence a state might reasonably adduce to support the interests it advances. Just such evidence in fact influenced the New York State Task Force on Life and the Law to recommend that assisted suicide not be legally permitted.[62]

Had the court accorded this evidence the respect it warranted, the court would not just have taken the decision-defects argument more seriously. It might also have understood how challenging the state's argument was to the court's view of the case. For the state was not just invoking a paternalistic interest in protecting its citizens. Rather, it was asserting an interest in promoting its citizens' autonomy, in protecting people from being led into making decisions that are not autonomous. In its strongest form, the state's argument was that on balance prohibiting assisted suicide serves autonomy better than permitting it. This would be true if—put crudely—more people would be kept by the prohibition from nonautonomously committing suicide than would autonomously decide to commit suicide were it legal. In short, the court's crucial premise—that the choice was between autonomy and paternalism—was wrong. Rather, the choice was between two views of how to promote autonomous decisions.

But why was the court—which elsewhere in its opinion was shocked at any interference with autonomy—so indifferent to the state's arguments on behalf of it? While the court acknowledged that "many suicides are committed by people who are suffering from treatable mental disorders,"[63] it implied that suicides by the terminally ill are different: "In the case of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless. . . ."[64] And the court said that should an error "in medical or legal judgment" occur (a possibility the court thought "remote"[65]), it would be "likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most desirable."[66] Apparently, then, the court thought suicide the rational response to terminal illness.

The court, in other words, appears to espouse the view I suspect many people credit—that suicide is a normal response to terminal illness and that the terminally ill who want to commit suicide thus differ sharply from other suicidal people. This may be a common view, but there is good reason to doubt it (particularly if you do not assume, as the court seems to, that every terminally ill person who wants to commit suicide is in unbearable, untreatable pain). As I have been suggesting, even terminally ill people who consider suicide often change their minds when some of their other problems are ameliorated. And "only a small percentage of terminally ill or severely ill patients attempt or commit suicide."[67]

But even if suicide were the rational response to terminal illness, it would still be surprising that the court could be so unconcerned about decision defects. A standard argument for patient's autonomy is exactly that people's views of rationality differ, and that each person's view should be respected. Is, then, the court concerned for autonomy, or is it animated by a view of how the dying should act?[68]

The Third State Interest: Preventing Undue Influence

The third state interest the Ninth Circuit acknowledged was protecting the dying from arbitrary, unfair, or undue influence. The court dismissed the possibility of two kinds of danger. First, it jeered at the argument that prohibiting assisted suicide is necessary "to protect the disadvantaged."[69] The court, however, hardly bothered to explain why that argument is "disingenuous," "fallacious," and "meretricious," and it rushed on to say "there is far more reason to raise the opposite concern—that the poor would be denied 'the assistance that would allow them to end their lives with a measure of dignity.'"[70] The court expressed itself obscurely, but it apparently reasoned that assisted suicide is a medical service, that the poor get fewer medical services than the rich, and that therefore the poor will have less access to help in committing suicide. The state's argument, however, was that those caring for the poor will be too ready to acquiesce in their suicide because (a) they regard the lives of the poor as less valuable than other lives and (b) helping the poor die is cheaper than keeping them alive. The court never grapples with (a) and seems never to grasp (b).

The court did admit there is reason to worry "that infirm, elderly persons will come under undue pressure to end their lives from callous, financially burdened, or self-interested relatives, or others who have influence over them."[71] The court said it did "not minimize the concern."[72] Perhaps not, but neither did it evince much understanding of it. The concern, of course, is that debilitated and desperate people are suggestible: "[D]emoralization and lack of assertiveness are likely to make the terminally ill patient more vulnerable to the suggestions of others. . . ."[73] The primary point is not (as the court implies) that patients will be hustled off by hard-hearted or grasping doctors and relatives. It is more centrally that "[w]ell-meaning and discreet suggestions, or even unconscious changes in expression, gesture, and tone of voice, can move a dependent and suggestible patient toward a choice for death."[74] It is that families—wearied financially, psychologically, and morally by the trials of caring for someone gravely ill—might yearn for the patient to ease them of their burden. In this light, it is disturbing that, according to one study of the Dutch experience "more euthanasia requests came from the families of patients than the patients themselves. The investigator for the study concluded that the families, the doctors and the nurses were involved in pressuring the patients to request euthanasia."[75]

This is troubling, of course, on autonomy grounds. The rationale for a right to assisted suicide is deference to the patient's choice, but that rationale is defeated where the patient was pressured into committing suicide. But it is troubling on another ground as well, for families' distress can sometimes be satisfied less drastically: "A 1989 Swedish study revealed that when chronically ill patients attempted suicide, their overburdened families often did not want them resuscitated. When social services stepped in and relieved the family's burden by sending in home care helpers, most patients wanted to live and their families wanted them to live as well."[76]

The changing structure of American medical care provides additional reason to worry about pressures to choose death. American health care is being transformed by the rise of managed care and cost containment. We are thus moving from a system in which it was generally in doctors' financial interest to overtreat patients toward one in which doctors have incentives to undertreat them. Both systems have their failings, and it is hardly obvious that the old system was better for patients.[77] But any decision to permit assisted suicide needs to consider that the new system gives doctors direct financial reasons to persuade their patients to die.[78] Once again, however, the Ninth Circuit was either ignorant or indifferent.

The Ninth Circuit did, however, have another string to its bow. Its principal response to concerns that people might be pressured into committing suicide, as to concerns about whether patients might commit suicide improvidently, was that doctors will regulate these decisions. So crucial is this argument that it deserves quoting at length:

> We believe that most, if not all, doctors would not assist a terminally ill patient to hasten his death as long as there were any reasonable chance of alleviating the patient's suffering or enabling him to live under tolerable conditions. We also believe that physicians would not assist a patient to end his life if there were any significant doubt about the patient's true wishes. To do so would be contrary to the physicians' fundamental training, their conservative nature, and the ethics of their profession. In any case, since doctors are highly-regulated professionals, it should not be difficult for the state or the profession itself to establish rules and procedures that will ensure that the occasional negligent or careless recommendation by a licensed physician will not result in an uninformed or erroneous decision by the patient or his family.[79]

It is hard to know where to start analyzing this astonishing statement. Perhaps we may begin by observing that the court does not trouble to provide evidence for it.[80] But evidence is acutely needed, for the court's propositions are, at best, suspect. Even the court's colorable assumption that doctors are "highly-regulated professionals" is dubious. Doctors certainly feel tightly regulated, and bitterly many of them resent it.[81] When doctors talk of assisted suicide, they often assert some kind of entitlement to do what *they* believe is best for their patients and are incredulous when told the law might claim to influence their judgment. But is medicine "highly regulated"? The very definition of a profession is that it is crucially self-regulating, and few professions have been as concerned to preserve that prerogative or as triumphant in doing so as medicine.[82] Law is ordinarily tamely respectful of that prerogative.[83] When it regulates medicine—medical malpractice doctrine is a crucial example—it generally accepts medicine's own standards. Even where the law has powerful reasons to regulate—for example, when disciplining incompetent doctors—it is notoriously feeble. Courts have been particularly loath to be saddled with decisions at the end of life and have preferred to set broad standards rather than adjudicate individual cases.

The Ninth Circuit's assumption that doctors are highly regulated is especially odd in an area where doctors have so flagrantly violated the law with such impunity. When Timothy Quill admitted in a preeminent medical journal that he had helped a patient commit suicide, he was investigated but not prosecuted.[84] A few miles down the road from where I write, Jack Kevorkian's toll has now passed one hundred. He was thrice prosecuted for assisting with suicides but never convicted.[85] Only when he delivered a tape of himself in flagrante delicto to *60 Minutes* and stripped himself of legal counsel was he convicted of murder. Oh law, where is thy sting?

The Ninth Circuit might have recalled that the law's enforcement problem is old and ubiquitous, that people do not obey just because the law commands.[86] The enforcement problem is harshest in cases like those involving medical decisions—where an activity occurs in private, where the people the law wants to influence feel the decision is theirs to make,[87] where the only person keeping records is the person regulated, and where the victim is dead and cannot complain.[88]

The Ninth Circuit explains its sang-froid about improvident decisions to commit suicide partly by saying concern about undue influence "is ameliorated in large measure because of the mandatory involvement in the decision-making process of physicians, who have a strong bias in favor of preserving life. . . ."[89] Here the court appears to accept an increasingly outmoded version of doctors' attitudes toward treating the dying. It was long regretted that doctors would strive officiously to keep patients alive. But this criticism is becoming anachronistic. More and more it is doctors who start discussions of stopping treatment, and understandably.[90] Horribly ill people who cannot improve are rarely rewarding patients. And the treatments that keep them alive often distress all concerned.

But the court need not have rested its decision on how much doctors are regulated or how resolutely they wish to keep patients alive, for there are many concrete factors it could have consulted and much evidence it might have evaluated. The court professed to be "aware of the concern that doctors become hardened to the inevitability of death and to the plight of terminally ill patients, and that they will treat requests to die in a routine and impersonal manner, rather than affording the careful, thorough, individualized attention that each request deserves."[91] But those concerns are much more specific and troubling even than this. What the court asks of doctors is more challenging than the court realizes. For example, "the detection of judgment-impairing confusion among dying people is surprisingly difficult. . . . [O]ne researcher concluded that 'our clinical observations miss profound confusional episodes in [20%] of our patients.'"[92] Not only do "physicians and nurses regularly overstate dying patients' decision-making competence," but there is currently "inadequate experience or research data to design reliable safeguards to ensure the lucidity of dying patients who might claim a right to assisted suicide."[93]

Bluntly phrased, the question the court should have asked was this: If doctors will supervise suicides so well, why do they so often treat the dying so badly? As Howard Brody writes, "It has been exhaustively documented that medical management of terminal suffering is currently inadequate."[94] Indeed, he says there is "compelling evidence that the status quo is far below optimal, if not actually scandalous."[95] More specifically, it is notorious that too many doctors are poorly trained to recognize depression, that they often undertreat pain, and communicate badly with patients. And most relevantly, who believes doctors do an exemplary job of learning and heeding the wishes of dying patients? The Ninth Circuit

> apparently assumes that clinicians faithfully adhere to patients' wishes in treatment decisions, including end-of-life care. But there is disturbing evidence that this is not so. . . . [In the] SUPPORT [study,] . . . fewer than one-fourth of treating physicians had ever reviewed the patient's preferences, even when these were explicitly written down in an advance directive. Even when patients' preferences were known, they were frequently simply ignored.[96]

Doctors fail in the duties they already owe dying patients and seem fated to fail as guardians of patients' decisions to die for many—often understandable—reasons. Routine dulls sympathy, as Rousseau knew long ago: "When we have seen a sight it ceases to impress us, use is second nature, what is always before our eyes no longer appeals to the imagination, and it is only through the imagination that we can feel the sorrows of others; this is why priests and doctors who are always beholding death and suffering become so hardened."[97] The frustrations and irritations of unresponsive and unrewarding patients can defeat even dedicated doctors, for "physicians do in fact get tired of treating patients who are hard to cure, who resist their best efforts, who are on their way down—especially when they have had no long-term relationship with them over many years. 'Gorks,' 'gomers,' and 'vegetables' are only some of the less-than-affectionate names such patients receive from the interns and residents."[98] Finally, the delicate decisions the Ninth Circuit wants from doctors are especially elusive when doctors are intensely busy—as many chronically are.

Hardening of sympathies is an unavoidable problem even under good circumstances. But what happens when suicide becomes a right doctors are commanded to respect? The court expects doctors to find the elusive line between honoring the patient's "right to die" and ensuring patients do not make "unfree" decisions. But the lessons of reform are rarely learned in such subtle ways. As I once wrote, "People can usually follow the letter of a new rule, but its spirit is harder to capture."[99] Many doctors learn only crude lessons from bioethics—tell patients the truth (always); accede to patient's decisions to withdraw treatment (always). Doctors who have so long been castigated for their paternalism thus seem likely to err on the side of deferring to assertions of the right to die. The court expects doctors to spot defective decisions because suicide now seems so heterodox. But as it became routine and blessed by the authority of a constitutional right it would become normal and would evoke less anxiety and scrutiny.

Even the most sensitive doctor may be perplexed at the task of supervision the court blithely imposes. For how should a doctor answer when a patient asks for help committing suicide? How hard, if at all, should a doctor try to dissuade the patient? Is dissuasion an improper attempt to manipulate what should be an autonomous decision? A way of helping patients evaluate their situation more intensely and thus of enhancing patients' autonomy? Or is it a way of making sure the patient's decision is free, informed, and irrevocable? And when, if at all, should a doctor propose, or even mention, assisted suicide?[100] Is proposing it a duty commanded by the doctrine of informed consent every time the patient is eligible for it? Is any mention of it inherently a suggestion? What implications would that suggestion have? That the patient's life is not worth living? That the patient is a burden? That the case is hopeless? That the doctor wants to give up? Should the burden always be on the patient to make the first suggestion?

The court's faith that doctors will prevent improvident or pressured decisions to commit suicide ignores yet another problem. Any time the medical profession is made the gatekeeper to something people want and feel entitled to (abortions, draft deferments, letters verifying an employee's disability) a few doctors will be driven by ideology or economics to provide it, often uncritically and even zealously. Only a few such doctors are needed to make the service widely available. Jack Kevorkian is a gruesome example, but Hendin observes, "Although Kevorkian may seem eccentric, it is worth knowing that in the Netherlands, a small number of physicians are attracted to euthanasia and do a great number of cases."[101]

This brings us to our most direct evidence about how well doctors might supervise assisted suicide—Holland. As Hendin notes, "The Dutch model and Dutch guidelines have been accepted as models for the Oregon law and most of the state laws being considered in this country to legalize assisted suicide and euthanasia."[102] Reliable information about the Dutch experiment is elusive, and interpretations of it differ. Nevertheless, there is reason to fear that Dutch doctors regulate these decisions poorly, that "[v]irtually every guideline established by the Dutch, whether it be a voluntary, well-considered, persistent request; intolerable suffering that cannot be relieved; consultation; or the reporting of cases, has failed to protect patients or has been modified or violated with impunity."[103]

One homely test of the doctor's role as supervisor of suicide comes from a model case of assisted suicide—the story of how Timothy Quill helped his patient "Diane" to die.[104] Quill is a prominent exponent of assisted suicide (indeed, he is the Quill of *Quill v Vacco*). His account of Diane's story has widely been thought to exemplify what laudable medical care would be like were assisted suicide legal. That account describes a sorrowful physician yielding to his patient's exercise of her autonomy. Yet in a penetrating and disturbing study of that account, Patricia Wesley shows in some detail how dubious it is. She concludes that "[f]ar from being the neutral reflector and facilitator of Diane's desires that he believes himself to be, Dr. Quill in fact powerfully and directly shapes those desires."[105]

I have been suggesting that one reason the Ninth Circuit was confident doctors could safeguard decisions to commit suicide is that it did not understand what it was asking doctors to do or how they would react. There may be another reason—the court did not have to write the regulations for the new regime. Instead, it could airily say, "Any of several model statutes might serve as an example of how these legitimate and important concerns can be addressed effectively."[106] Perhaps it is only when an institution must actually develop (and administer?) regulations that it realizes their perplexities. The Ninth Circuit could spare itself that burden and hence the trouble of clearer, harder thought.

In sum, the Ninth Circuit would make doctors the guardians of the decision to commit suicide. Why, then, did it not ask the old question, *Quis custodiet ipsos custodes?* We ask that question not because the guardians are untrustworthy (although some will be), but because we recognize the difficulty of their job. It is that difficulty with which the court declines to grapple.

The Fourth State Interest: Protecting the Integrity of the Medical Profession

The Ninth Circuit did "not believe that the integrity of the medical profession would be threatened in any way by the vindication of the liberty interest at issue here." On the contrary, "it is the existence of a statute that criminalizes the provision of medical assistance to patients in need that could create conflicts with the doctors' professional obligations and make covert criminals out of honorable, dedicated, and compassionate individuals."[107] The court reasoned, "The assertion that the legalization of physician-assisted suicide will erode the commitment of doctors to help their patients rests both on an ignorance of what numbers of doctors have been doing for a considerable time and on a misunderstanding of the proper function of a physician."[108]

The court's reference to what doctors are already doing is a restatement of the court's belief that doctors are helping patients commit suicide (are killing patients?) when they withdraw treatment needed to prolong life. I have already criticized this argument, so we need now say only that this is not what doctors or patients understand doctors to be doing and that those understandings speak to the state's argument about the integrity of the medical profession. For the state's argument is that doctors who think they are assisting in their patients' suicide will regard those patients differently from doctors who believe they would never do so and that patients who believe their doctors would never assist in their suicide can trust their doctors more freely than patients who are denied that confidence.

The court's explanation of "the proper function of a physician" is obscure. Perhaps most mystifying is its statement that "experience shows that most doctors can readily adapt to a changing legal climate. Once the Court held that a woman has a constitutional right to have an abortion, doctors began performing abortions routinely and the ethical integrity of the medical profession remained undiminished."[109] This is mystifying on two levels. First, not everyone would agree that the ethical integrity of the medical profession is undiminished. Kass and Lund, for example, see

> good reasons to argue the contrary. Massive numbers of abortions are now being performed, far beyond what was originally expected, and for reasons not originally regarded as appropriate. Moreover, physician acceptance of abortion may in fact be partly responsible for recent weakenings in the professions's repugnance to cause death. . . . [O]ne of the arguments offered twenty-five years ago against allowing doctors to perform abortions was that it would inevitably lead to doctors performing euthanasia.[110]

Second, the question is not whether doctors will "adapt to a changing legal climate." It is whether that changing climate will be regrettable. First, how will patients regard doctors with a license to kill? Ours is an age of distrust. It is also an age when we must trust even strangers. As medical care is bureaucratized, our doctors become such strangers, strangers to whom we confide our health and even our lives. In these circumstances, one assurance patients may value is the knowledge that doctors will not, cannot, kill.

The justice of these fears is suggested by a second concern—that doctors may be disquieted and even corrupted by the power and practice of euthanasia. The Ninth Circuit was sanguine about the effect of assisted suicide on the profession because doctors already participate in their patients' deaths. But this is all the more reason for concern. Conscientious doctors worry deeply about their power, about how it hardens and distances them, about their own motives; bioethicists have warned for years about the arrogance of power. Assisted suicide would inflame such concerns: "One physician who has worked for many years in a hospice caring for dying patients put the matter most convincingly: 'Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.'"[111] And in this light it is troubling to read Hendin's report:

> A number of Dutch euthanasia advocates have admitted that practicing euthanasia with legal sanction has encouraged doctors to feel that they can make life or death decisions without consulting patients. Dutch euthanasia practitioners ask themselves the following question: Would I want to live if I were the patient? The question not only implies that a physician has a right to make decisions about whose life is

> worth living, it also ignores considerable research that has shown that doctor's [*sic*] consistently underestimate patient perceptions as to their quality of life.[112]

The Fifth State Interest: The Slippery Slope

Finally, the Ninth Circuit evaluated the state's slippery-slope argument—the argument that legalizing assisted suicide will lead down a spiral of unintended consequences toward what the court invidiously refers to as "a parade of horribles."[113] The court contemns this suggestion: "This same nihilistic argument can be offered against any constitutionally-protected right or interest. . . . In fact, the Court has *never* refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly."[114] It is hard to understand why the slippery-slope argument is "nihilistic." Nihilism is the belief that all arguments are meaningless; people who invoke the slippery slope are saying that one argument is bad and that others are not. Nor is it a compliment to the Supreme Court to say it has been indifferent to slippery slopes. Part of making good policy is considering where a policy might lead and how it might be misused. In addition, concerns about slippery slopes *have* helped lead the Supreme Court to decline to announce a constitutional right.[115] In short, the Ninth Circuit should have asked whether legalizing assisted suicide would cause intolerable slippery-slope problems. That should have led it to examine the three kinds of slippery slopes.

The first slope is the possibility that people who did not qualify for help with suicide would nevertheless receive it. This could happen in two principal ways. First, doctors might try but fail to distinguish between qualified and unqualified candidates. Second, doctors might not try to distinguish among candidates. This is a familiar process. Legislatures once attempted to permit only those abortions necessary to protect a woman's life or health. That line did not hold and in some places was breached almost overnight. Similarly, even judges in a state as Catholic as Massachusetts declined to make the inquiries the Supreme Court contemplated when it established rules in *Bellotti v Baird*[116] governing the ability of minors to obtain abortions.[117] Likewise, states long sought to make divorce available only on fault grounds, but judges widely flouted that rule.[118]

Lines are fragile for many reasons. Not everyone will sympathize with a line, and some who dislike it will breach it. Even people who approve of a rule may find it easier to say yes than no or may find cases at the margin hard to manage. The process of deciding a series of cases tends to shift the line, since the most extreme case decided in the past tends to become the standard for the present. Furthermore, routine domesticates: a case that once seemed uncomfortable soon becomes too familiar to justify attention. The regulations that sustain lines are particularly susceptible when they challenge a constitutional right, for such rights have so much moral force and usually evoke so much judicial solicitude that they are hard to resist. As John Arras remarks, "We have actually seen this script played out before in the context of abortion law. . . . One regulatory constraint that had been placed on women's choice in some jurisdictions was mandatory review by a hospital-based committee. . . . [T]his regulatory mechanism, along with a host of others, was unceremoniously discarded by the Supreme Court. . . ."[119]

In short, there are good reasons to wonder how durable any line limiting assisted suicide would be. And there are special reasons to fear for the line limiting it to competent, terminally ill adults who have made a free and determined decision. These are the reasons we reviewed when we examined the difficulties of defining "terminally ill," of ascertaining whether a patient was competent to make a considered decision, of preventing patients from choosing suicide under undue influence, and of making doctors the guarantors of regularity. To these excellent *a priori* reasons to doubt the line will hold we must add the evidence that in Holland—the only jurisdiction with real experience of such a line—it has been widely breached.

The first slippery-slope problem, then, is that the rules governing assisted suicide might be applied unsoundly. The second slippery slope is the possibility that the principle the court employed to justify assisted suicide will be more capacious than is necessary to accord competent, terminally ill patients a right to the help of a doctor in committing suicide.[120] In other words, we must ask whether the principle of *Compassion in Dying* leads beyond that limit and would justify a constitutional right to voluntary euthanasia, or to nonvoluntary euthanasia, or even to involuntary euthanasia. The answer is all too likely to be yes. As Justice Holmes said, "All rights tend to declare themselves absolute to their logical extreme."[121] And the Ninth Circuit recruits a notoriously "greedy"[122] right, what is broadly if imprecisely called a right to "privacy," a right "whose core principle seems endlessly expansive."[123] What is more, the Ninth Circuit interprets that right aggressively. For example, the court seemed to believe there is a fundamental right to make all "decisions that are highly personal and intimate, as well as of great importance to the individual,"[124] and it invoked the Supreme Court's most rapturous flights of rhetoric—like the celebrated passage from *Casey* I quoted earlier.

In sum, the second kind of slippery-slope argument suggests that the Ninth Circuit's principle was too strong. It is thus strange that the court says, "The question whether that type of physician conduct may be constitutionally prohibited must be answered directly in future cases, and not in this one."[125] Courts may not decide cases not before them, but they should at least peer down the road to see what lies ahead. This, after all, is why the common law uses hypotheticals so lavishly—to accelerate the process of litigation to test a principle's force and valence.[126]

The third kind of slippery slope raises the possibility that as courts interpret a new right, it will expand beyond its original justification. This process operates by small steps, often without judicial recognition that "rights creep" is occurring. It is easy to imagine ways the right to assisted suicide might slide down this slope. First, we would hear that anything that limits the right is improper. In the zeal to prevent that impropriety, the scope of the right itself would swell. Second, there would be equal protection arguments that people not eligible for assisted suicide were just as deserving as those who were.[127] It would be said, for example, that there are only trivial differences between the seriously and the terminally ill, or between the physically ill and those suffering other kinds of miseries. It would be said that people who are terminally ill but unable to kill themselves should not be denied a right other terminally ill people have. It would next be proposed that people who were terminally ill but not mentally competent should have the benefit of the right to commit suicide. If this seems far-fetched, one should recall that in *Cruzan* Justice Brennan argued that if Cruzan could not exercise her "right to die" someone should exercise it for her.[128]

Justice Brennan's position in *Cruzan* and Justice Stevens's as well exemplify how an idea can be unloosed from its moorings and slide in astonishing directions. The "right to die" was born as an expression of autonomism and antipaternalism. But that rationale could be transformed in a blink into paternalism itself. Justice Brennan, for example, wanted to transmute Cruzan's right to make a decision for herself into her family's entitlement to guess what her decision would have been had she made one. And Justice Stevens wanted to transmute Cruzan's right to make a decision into her family's entitlement to do what they thought would be best for her.[129] These may be good policy choices, but *not* because Cruzan had an autonomy right. Stripped of their autonomy language, these two opinions represent arguments for treating Cruzan benevolently, paternalistically.[130]

One might respond to the state's slippery-slope arguments by saying that such arguments are logically dubious. If a first step is right, it is right even though the second step is wrong. If the second step is wrong, it simply should not be taken. But that should not prevent taking the first step, since there is no logical reason the second step must be taken just because the first one was. Indeed, there is a logical reason to stop before reaching the bottom, since the whole argument assumes that the top of the slope is crucially different from the bottom.[131]

Logically, this refutation of the slippery-slope argument seems convincing. But as Justice Holmes famously said, "The life of the law has not been logic; it has been experience." And the American experience of law at the end of life confirms the hazards of the slippery slope. This should not be surprising. First, slippery slopes are dangerous whatever the logic because of the common law's method. The common law reasons from precedents. It asks whether each new case is essentially the same as some precedent. If so, it is decided in the same way. But if you decide a series of cases in the same way because each case is *almost* the same as its predecessor, the end of the series may wind up far distant from the beginning.

Second, slippery slopes operate psychologically, not logically. "[T]hey work partly by domesticating one idea and thus making its nearest neighbor down the slope seem less extreme and unthinkable."[132] Yet a third reason we slide down slippery slopes is that people are pushing us. Some Americans ardently want to change the law at the end of life. They well know that the public is afraid of the bottom of the slope; they have consciously calculated how to move us down it by small steps.

Experience justifies the state's slippery-slope arguments. Over the past few decades, the United States has moved from a reluctance even to withdraw medical treatment to serious proposals for active euthanasia, with assurances all along the way that each step was the last. My colleague Yale Kamisar rightly asks, "If, as has been well said, 'the history of our activities and beliefs concerning the ethics of death and dying is a history of lost distinctions of former significance,' what reason is there to think that the history will end when we sanction assisted suicide for the terminally ill?"[133] Holland's experiment with assisted suicide suggests that the American slide would continue further than we might like: "Over the past two decades, Dutch law and Dutch medicine have evolved from accepting assisted suicide to accepting euthanasia, from euthanasia for terminally ill patients to euthanasia for chronically ill individuals, from euthanasia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to the practice and conditional acceptance of nonvoluntary and involuntary euthanasia."[134] The Ninth Circuit's opinion itself exemplifies the slippery-slope problem. That court says to Washington, you have slid thus far down the slope, therefore it would be unconstitutional not to go much further. That court refuses to consider just where the end of the slope might be. If the court could not look at our history, or Holland's, it could at least have looked to itself to see why it should not have dismissed the state's slippery-slope argument.

On Collective State Interests

The Ninth Circuit, I have been saying, had trouble with all the state's interests. However, it, like most courts, particularly scanted interests that do not operate in a direct and obvious way on individual people, but that affect people collectively. Indeed, the court said: "If broad general state policies can be used to deprive a terminally ill individual of the right to make that choice, it is hard to envision where the exercise of arbitrary and intrusive power by the state can be halted."[135] This is perverse. Broad and general policies often promote basic and genuine social interests.[136]

The Supreme Court does seem to recognize the importance of such interests. It believes, for example, that states may have "an 'unqualified interest in the preservation of human life,'" an interest which "is symbolic and aspirational as well as practical."[137] Unfortunately, it is not clear what the Court means by a "symbolic and aspirational" interest or why it is important. Let me suggest one possibility. Sometimes law cannot achieve its goals through direct regulations because effective law enforcement is not practicable. Law has "expressive" resources that may then be recruited. Law's expressive function, that is, seeks "not so much to influence behavior by requiring or forbidding people to perform a particular act, but to influence behavior by encouraging people to think in a particular way."[138]

Assisted-suicide statutes exemplify this expressive use of law. Killing cannot be prevented solely through regulation, for people are not always deterred simply by fear of punishment, particularly when they have lively motives for killing. Rather, they must be led to internalize a norm against killing. Given the forces opposing it, that norm must be exigent. The classic example of a deeply internalized, exigent norm is a taboo. A taboo is a prohibition without exception, to which exceptions are unthinkable. Taboos work for that reason. As soon as they are subject to rational analysis, as soon as qualifications and exceptions become permissible, their social, psychological, and perhaps even moral force begins to crumble:

> Taboos do not work rationally; they work by inducing reactions of horror and disgust at the prohibited practice. Rational analysis of taboos is not only likely to miss this point, but even itself to weaken the taboo. Once you begin to think[, for example,] about which kinds of incest-like activities lack particular identifiable harmful consequences for particular identifiable participants, you begin to think about the unthinkable and about why some "incest" is harmless incest. As this process continues, the emotional force of the taboo, its force as a general deterrent, is eroded.[139]

"Thou shalt not kill" is a core taboo. As we begin to consider when it is good deliberately to end a life without even the cloak of the justification that it is the disease that is causing the death or that the death is an inadvertent and undesired side effect of treating pain, the taboo against killing begins to erode. When we begin to say killing is a question of each individual's values, the erosion worsens.

Recent developments have already troubled the borderland between life and death. For example, withdrawing medical treatment is today not only normal, it is becoming virtuous. The rise of abortion as a right has altered views about whether each abortion is some kind of killing. We have redefined death to suit our need for transplantable organs by adopting a brain-death standard. We are beginning to contemplate using higher-brain death. In the midst of such disruptions of our understanding of death, the state may be particularly concerned to preserve the core understanding that killing is not just wrong, but unimaginable.

This taboo is not aimed just at attitudes toward killing oneself and others. It is directed particularly at a group with extraordinary power that resists regulation—doctors. Thus Kass and Lund invoke "a centuries-old taboo against medical killing, a taboo understood by many to be one of the cornerstones of the medical ethic."[140] They explain,

> Medical students, interns, and residents are taught—and acquire—a profound repugnance to medical killing, as a major defense against committing—or even contemplating—the worst action to which their arrogance and/or their weaknesses might lead them. At the same time, they are taught not always to oppose death. . . . But in order to be able to keep their balance, physicians have insisted on the absolute distinction between deliberate killing and letting die. Non-medical laymen (including lawyers and judges) may not be impressed with this distinction, but for practicing physicians it is morally crucial.[141]

The state's interest in the taboo against killing, then, helps explain the apparently arbitrary lines between killing and letting die of which the Ninth and Second Circuits complained. Arbitrary they may in some ways be, but they reflect and affirm social understandings on which crucial taboos rest.

The state's "symbolic and aspirational" interest in human life has a second element. The principal problem with suicide is not that a few dying people have trouble committing it, but that many people—particularly young people—commit it who have not made a wise, or even competent, decision.[142] Criminal prohibitions of suicide are so futile they have long since been abandoned, and thus the state's challenge is again to promote a social environment that deters suicide. Dignifying suicide by medicalizing it and calling it a constitutional right seems likely to corrupt that environment.

I would even make—if cautiously—a third argument—that the state has an interest in helping patients respond well to the shock and horror of mortal illness. When people encounter any new and daunting situation, they rarely wish to work out from first principles how to cope with it. Rather, they often wish to consult common practice. As Alan Wolfe writes, "When people make decisions, they tend to look not to a mathematical formula to determine what is to their best advantage, but to what others do, to what they have traditionally done, or to what they think others think they ought to do."[143] The sick particularly need this social assistance in making decisions, not just because their situation is often so unfamiliar, but because it is so frightening. Thus one student of the memoirs people write about illness observes, "Perhaps one reason why the work of dying seems so difficult today is that the individual is expected not only to face his or her death—in itself a task arduous enough—but also create a way of dying out of the fragments of ideologies and religious sentiments that our culture provides us."[144] This does not tell us, of course, which social practices might most comfort and sustain the dying. But I think the state may decide that in general they will benefit most from practices that do not make suicide a standard resort, which encourage the dying to maintain their ties with the living and to seek the rewards life has yet to give them.[145]

Here I do not think the Ninth Circuit is helpful. The right it announced was rooted in the view that dependence must be deplorable and undignified. The court, for instance, says "a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease" might do so partly "to avoid . . . a humiliating death."[146] But why must such a death be humiliating? As Callahan acutely says, "What Reinhardt has done, in effect, is to bless a trivial, even demeaning, notion of dignity. What could be more mischievous than a view of dignity that requires we be clean, alert, and able to take care of ourselves?"[147]

The Ninth Circuit might have argued that all three of these state interests are illegitimate because in promoting them the state makes itself directly interested in people's preferences. However, the state is not seeking to override those preferences, only to shape them, or even to shape the forces that shape them. Some of these preferences—like not wanting to kill—the state is not just entitled but is even obliged to shape. But the state may legitimately shape the forces that influence other preferences. We will always be shaped by our environments. We maximize our autonomy by shaping the environments that shape us. But many of those environments—including the hospitals in which American deaths today occur—are virtually impervious to us unless we use that one great tool, government. Seen in this way, government is not just a threat to autonomy, but a device we recruit to protect ourselves from other threats to our autonomy. For example, Kamisar asks, "In a climate in which suicide is the 'rational' thing to do, or at least a 'reasonable' option, will it become the unreasonable thing *not* to do? The noble thing *to* do?"[148] And David Velleman suggests that the dying might sometimes prefer not to have the choice to commit suicide so that they might escape any sense of duty to do so.[149] Since a truly neutral environment seems impossible, citizens may (within important limits) properly employ the state's power to protect themselves from unfavorable environments.

The "collective" state interests extend beyond the expressive function. For example, instituting a right to assisted suicide might well reduce the presently strong incentive to create better ways to help the sick and dying. Consider the hospice movement. It has helped transform palliative care and provide decent and dedicated care for dying patients who have decided to abandon their struggle for a cure. But as Kass and Lund fear, "Because the quick-fix of suicide is easy and cheap, it will in many cases replace the use of hospice and other humanly-engaged forms of palliative care, for there will be much less economic incentive to continue building and supporting social and institutional arrangements for giving humane care to the dying."[150] Hendin believes this has already happened in Holland, where "the easy solution of euthanasia or assisted suicide has led to a third kind of slippage: a diminution in the quality of and pressure for palliative care, which became one of the first casualties of euthanasia. Hospice care has indeed been virtually non-existent in the Netherlands."[151]

Had it thought about what I am calling the state's collective interests, the Ninth Circuit would no doubt have objected to them. It would have said that it is hard for courts to evaluate them because taboos do their work indirectly, because preferences are shaped in labyrinthine ways, because social institutions are born of many forces. No doubt. But these are reasons courts should judge collective interests perceptively and shrewdly, not reject them out of hand. Such state interests matter, and a jurisprudence too crude to respect them is poorly suited for making bioethical policy.

Assessing the State's Interests

In *Compassion in Dying,* Washington asserted a number of interests, none of which struck the Ninth Circuit as weighty. I have suggested that the court was hostile to the state's account of its interests for two reasons: because of the structure of Fourteenth Amendment analysis, which typically scants state interests, and because the court was ill-informed about the bases for the state's claim. I suspect the Fourteenth Amendment tradition of dismissing state interests helps account for the court's abrupt treatment of many of Washington's asserted interests, particularly what I have called collective interests. And in *Compassion in Dying* that abrupt treatment was particularly easy because the court was so poorly informed. The list of its misperceptions is long. The court did not seem to understand: the doctrine of double effect and how doctors and patients regard it; the inescapable imprecision of "terminally ill"; the extent to which depression motivates the suicide even of terminally ill people; the difficulty of diagnosing depression; how doctors and patients interact; how patients make decisions; why terminally ill people want to commit suicide; how the disadvantaged make choices at the end of life; the effects of changes in American health care on decisions to die; the difficulty of writing effective regulations in this area; the modest capacity of doctors to prevent unwise decisions to commit suicide; the Dutch experience; or the probable effects of assisted suicide on doctors.

My point has not been that the state's interests require it to prohibit assisted suicide, for I do not believe they do. Nor is my primary point that the state's interests justify the state's statute, although I believe they do. What I have argued, rather, is that the Ninth Circuit seems to understand the state's interests so poorly and to dismiss them so facilely as to cast doubt on the court's capacity to make good public policy at least for this bioethical issue.

Making Policy by Weighing Rights and Interests

Once the individual rights and the state interests at stake in a case have been surveyed, standard Fourteenth Amendment jurisprudence calls for the court to judge whether the latter are strong enough to justify the statute's infringement of the former. This is surely a necessary step in making wise policy. But it is not one a court is well equipped to take.

The problems begin at the theoretical level. First, the Supreme Court has been unable to specify what standard to use in evaluating competing rights and interests.[152] Its failure is disconcerting but understandable, since the personal right and the state interest are incommensurable. This awkwardness might be avoided if a court only needed to decide if the right and the interests had each attained some specified standard, and this is what the Court for some time tried to require. Its system, however, proved too rigid, and the Court's categories proliferated and now seem to have collapsed. The Ninth Circuit's response to this defeat was to try to "balance" the right and the interests. But this simply returned it to the core problem of incommensurability—that there is no scale on which rights and interests can be weighed. And this revived the old problem of substantive due process—that it requires judges to make so many poorly guided choices that it invites them to read their own policy preferences into constitutional law.

Far from acknowledging these problems, the Ninth Circuit said proudly,

> Weighing and then balancing a constitutionally-protected interest against the state's countervailing interests, while bearing in mind the various consequences of the decision, is quintessentially a judicial role. Despite all of the efforts of generations of courts to categorize and objectify, to create multi-part tests and identify weights to be attached to the various factors, in the end balancing entails the exercise of judicial judgment rather than the application of scientific or mathematical formulae. No legislative body can perform the task for us. Nor can any computer. In the end, . . . we must rely on our judgment, guided by the facts and the law as we perceive them.[153]

This passage seems wrong-headed at every turn. First, far from being "quintessentially a judicial role," weighing and balancing constitutional rights against the state's interests is at the beginning a task the legislature can and should undertake every time its acts implicate a constitutional right.[154] Second, the judicial failure to "categorize and objectify" critically erodes the court's authority to override the legislature's balance. One condition for granting power to unelected courts is that they must explain the source of their authority and the logic of their decision. Third, the court seems to concede at the end of this passage that it is essentially relying on its own "judgment." It never explains what makes its judgment worthier of respect than the legislature's or even why its judgment might yield good policy. On the contrary, the court unnervingly intimates that it can rely first and primarily on its own judgment and only need have that judgment guided by "the facts and the law as we perceive them."

But even a court less insouciant than the Ninth Circuit would face disabling problems balancing rights and interests in a case like *Compassion in Dying*. Consider what it would take to develop a genuinely informed policy about assisted suicide. Historically, courts have been content to announce an individual interest of some specified weight and ask if the state has a countervailing interest of some specified strength. But in making policy, other questions are relevant. First, how many people would want to exercise the right? This matters, since good policy asks what a statute's total benefit and total harm are.

The Ninth Circuit has no idea how many people would actually assert the right. Perhaps swayed by the plaintiffs' stories, the court insistently says "many."[155] But it never tells us what "many" means or how accurate it is. The court needs to answer these questions because "many" may well be wrong. A good estimate should start with everyone who is terminally ill and mentally competent. From this group must be subtracted all those—clearly the huge majority—who do not want to commit suicide.[156] From the remaining patients must be subtracted all those who can die by refusing medical treatment. Then one must subtract those who have been unduly pressured into committing suicide or who have improvidently decided to do so.[157] Then should be subtracted those who could achieve their goals by a means other than suicide—for example, by entering a hospice or securing proper pain medication. From those (few?) who are left must be subtracted those who could commit suicide satisfactorily without help, for what is at issue is not the right to commit suicide (which is nowhere criminal) but the right to help in doing so. As Campbell writes, "Patients already have access to information about how to end their lives, and 'stockpiling' of medications has in many instances given them access to the means to end life."[158] And perhaps one should also subtract those who will have assistance whatever the law says, for "press reports and polls suggest that some physicians already respond to their patients' requests for help by prescribing medication or providing a lethal injection."[159] Finally, one must subtract those patients for whom even physician-assisted suicide would not provide the deliverance they sought.[160] Perhaps this leaves "many" candidates, but a good policy maker would at least be on notice to inquire in some serious way.

So the first thing we would need to know in weighing the costs and benefits of making assisted suicide a right is how many people would want to exercise it. Second, we would want to know how much worse off these people would be were they denied suicide instead of being relegated to their next choice. This is another inquiry the court seems quite uninterested in, even though it is quite possible that the marginal benefits of assisted suicide would turn out to be quite low. Third, we would want to know what collateral benefits suicides might bring (to families relieved of the burden of caring, paying, and sorrowing for their ill; to society saved the costs of medical care; to dying people in general, who might find comfort in knowing they could escape their travail).

Such calculations would begin to give us a sense of the benefits of a right to assisted suicide. We would also, of course, calculate the benefits of prohibiting it. We would ask first how many people would make a nondefective decision to commit suicide, would be deterred by a statute prohibiting it, and would be glad they had been deterred. Second, we would ask how many people would make a defective decision to commit suicide. Third, we would ask how many friends or family members would benefit should a suicide be prevented.

The preceding paragraphs suggest how complex the court's task would be even if it simply tried to specify the numbers of people who might be injured or helped by a regime of assisted suicide. These are not inquiries at which courts are likely to excel or even attempt. Courts specialize in determining what happened in some past event, not in trying to predict who might be affected by a reform that has not even been instituted. Yet even if the court could make these predictions, it would still need some way of assigning a weight to each kind of benefit and burden. And this is without even considering the perplexities of measuring what I have called the state's collective interests, its interests in attitudes and institutions. In short, as Justice Brandeis wrote,

> Merely to acquire the knowledge essential as a basis for the exercise of this multitude of judgments would be a formidable task; and each of the thousands of these judgments would call for some measure of prophecy. Even more serious are the obstacles to success inherent in the demands which execution of the project would make upon human intelligence and upon the character of men. Man is weak and his judgment is at best fallible.[161]

The standard response substantive-due-process jurisprudence makes to these onerous inquiries is to accord precedence to the individual rights at stake. As I once explained:

> Ordinarily, we talk in terms of what I have called the Mill paradigm: "That is, we think in terms of the state's regulation of a person's actions. In such conflicts, we are predisposed to favor the person, out of respect for his moral autonomy and human dignity."[162] That predisposition also rests on our assumption that the state can bear any risks of an incorrect decision better than the individual can.[163]

Such is the Ninth Circuit's approach: "The consequences of rejecting the as-applied challenge would be disastrous for the terminally ill, while the adverse consequences for the state would be of a far lesser order."[164] However, the Mill paradigm works only where the contest is between an individual's rights and the interests of the state. That is not this case. Rather, this is a contest between some individuals who want to commit suicide and other individuals who have an interest in being protected from making a defective and incompetent decision to commit suicide. These interests conflict. We cannot favor the individual against the state, because some individuals will be harmed whatever we do. The Mill paradigm leads us to worry more about limiting individual rights than injuring the state's interests because the state can take its lumps better than individuals. But here individuals will suffer either way, and their autonomy interests will be injured either way. In other words, part of the problem is that the court's categories—individual rights and state interests—obscure the social realities it confronts.

The Ninth Circuit boasts that "balancing" individual rights and the state's interests is "quintessentially a judicial task." In this section, I have suggested that the court's faith in its skill seems to rest on its underestimate of the challenges of that task. The court does not seem to appreciate how many identifiable groups stand to lose or gain from a regime of assisted suicide, how hard it is to predict the number of members of each group, how tricky it is to evaluate their interests (in health, in life, in happiness), how perplexing it is to assign weights to the state's collective interests, and how impossible it therefore is to balance all the interests involved. To be sure, these problems will harass *any* institution that must evaluate assisted suicide. But what makes the court think itself so excellently suited to handle them?

The Culture of the Case

I have suggested that their training, experience, and resources poorly equip judges for making bioethical policy, and I have tried to show how truncated the analysis in even the court's lengthy opinion in *Compassion in Dying* was. I now want to examine these problems from a different angle. American judges and lawyers live in what we may call the culture of the case. That culture makes the case the focal point of law. That view grows out of our common law system (in which law is made by judges in cases) and out of the American legal faith that even statutes and the Constitution find their meaning only when interpreted by courts in cases. American legal education too reflects the culture of the case, for we teach law primarily through books that compile cases. Cases are thus central to American law, and the culture of the case shapes the way courts think and act. It does so in ways that may perhaps promote the efficient settlement of disputes but that impede making wise policy. This is largely because a system developed to resolve disputes between two individuals or enterprises ordinarily promotes neither the attitudes nor the practices that conduce to making good social policy.

First, the culture of the case leads judges to believe they need historical, not social facts. "*Historical facts* are the events that have transpired between the parties to a lawsuit. *Social facts* are the recurrent patterns of behavior on which policy must be based."[165] Courts tend to believe that social facts may be inferred from historical facts, that the litigants before them represent the facts needed to make policy. This is rarely true in cases of social importance. Anyone might become terminally ill, and the circumstances of the dying differ enormously, but lawyers will present to the court only a few litigants whose vivid but unrepresentative stories are virtually intended to mislead the court about the social problem.[166] People who might be injured by a right to assisted suicide, on the other hand, are likely to be invisible to the court. This is partly because they are hard to identify individually, especially in advance. As Arras writes, "The victims of legalization, . . . will be largely hidden from view: they will include the clinically depressed eighty-year-old man who could have lived for another year of good quality [and] . . . the fifty-year-old woman who asks for death because doctors in her financially stretched health maintenance organization cannot or will not effectively treat her unrelenting but mysterious pelvic pain. . . ."[167] Furthermore, the state appears before the court only in the drab person of a government attorney, not as a suffering individual. Thus the court never puts a human face on those who might be rescued from suicide or who might wrongly be led into it. Yet in my experience judges often grow impatient with Brandeis briefs that try to provide systematic information about social facts. As an eminent jurist once said to me when I suggested there might be systematic information on a legal problem: "I know other people live differently from the way I do, and I'm not interested." One result is the superficial treatment of social facts I catalogued earlier in the third section of this chapter.

The second feature of the culture of the case is that it draws judges toward what I call "hyper-rationalism." Hyper-rationalism may be both methodological and substantive. As a method, it "is essentially the substitution of reason for information and analysis. It has two components: first, the belief that reason can reliably be used to infer facts where evidence is unavailable or incomplete, and second, the practice of interpreting facts through a [narrow] set of artificial analytic categories."[168] Hyper-rationalism, in other words, tempts us to believe we can understand how people think and act merely by reasoning, without investigating.

Methodological hyper-rationalism, then, offers a rationale for a way of understanding and writing about social problems. Substantive hyper-rationalism furnishes the assumptions about how people think and act that stand in for the information that might be garnered from empirical work. In bioethics, as in many other areas of human thought, these assumptions tend to see people as operating in remarkably rational ways. They hold that people deliberate explicitly about their situations, that they do so in predominantly rational terms, that they are autonomy maximizers, and that they have well-worked-out agendas that they need autonomy to implement. These assumptions see people primarily as makers of decisions reaching out for control over their lives. Finally, while these assumptions do not entirely abstract people from their social contexts, they tend to simplify those contexts deplorably.[169]

Courts succumb to hyper-rationalism because they share the common belief that things are generally what they seem and because the alternative is a daunting empirical inquiry.[170] Hyper-rationalism is a shortcut that permits judges to cope with their workload. In addition, hyper-rationalism permits courts that have become committed to a result to reach it without having to explain away awkward evidence. It is hard to say which of these motives most influenced the Ninth Circuit, but it is easy to point to examples of its hyper-rationalism. For example, the court wrote airily,

> We believe that most, if not all, doctors would not assist a terminally ill patient to hasten his death as long as there were any reasonable chance of alleviating the patient's suffering or enabling him to live under tolerable conditions. We also believe that physicians would not assist a patient to end his life if there were any significant doubt about the patient's true wishes. To do so would be contrary to the physicians' fundamental training, their conservative nature, and the ethics of their profession.[171]

This passage purports to describe how doctors behave. It does so not by proffering evidence, but rather by positing that doctors have a nature that predictably governs their behavior. Just as boldly, the court assumes that doctors do what they are trained to do and what their professional ethics command. This requires us to believe that the court correctly describes doctors' training, nature, and ethics and—improbably—that doctors will not be subject to forces (like cost-conscious HMOs, or overwork, or importunate patients, laziness, or a bad temper) that lead them to ignore their training, nature, and ethics. The court hardly tries to substantiate its assumptions, and I have argued that many of them are unlikely.

As it has developed, the culture of the case has a third defect. American lawyers tend to see each case as standing for one primary idea. They commonly ask what the holding in a case is, or what its principle is. This is significant for two reasons. First, it implies that sound results can be reached purely through the analysis of principles. Second, it suggests that the core problems of a case can usually be solved by a single principle.[172] The Ninth Circuit, for example, essentially thought that *Compassion in Dying* could be decided by adumbrating the principle of autonomy. Often, however, good policy arises not out of applying a single principle, but by reconciling many conflicting principles. And often the problem is not to derive principles but to understand complex empirical realities.

This leads us to the fourth problem the culture of the case presents in constitutional litigation: it leads to piecemeal resolution of issues that are closely related and that should be resolved together with an eye to the costs and benefits of each choice. As Michael McCann puts it, "judicial authorities are largely bound to episodic case-by-case remedies for complex social problems at odds with the long-term supervisory capacities necessary for effective means-oriented planning."[173] Both the Ninth and Second Circuits centrally argued that since the state permitted people to die by refusing treatment, it must also permit assisted suicide. These courts seemed to feel that if the risks of one were tolerable, so must be the risks of the other.[174] However, good policy would consider the cumulative effects of practices, not the effects of each practice separately. Presumably we must tolerate some improvident decisions to die, but eventually their sum may begin to seem too great.

The culture of the case is problematic in a fifth, related, way. Because courts consider problems one case at a time, they slide easily down slippery slopes. Courts too readily ask what the right result in *this* case is without investigating where the new precedent might lead. Anticipating the future is a problem for all policy makers. But it is particularly a problem for courts, which are commanded to decide only actual cases and controversies. The problem becomes insuperable where courts, like the Ninth Circuit, refuse even to consider what might lie ahead.

The culture of the case has other effects. Not least, it leads courts to ignore questions not framed by the doctrine under which suit was brought and answers that are not doctrinally available. A court, for instance, is unlikely to say that the best response to the desperation of the dying is to improve palliative care, for no constitutional doctrine points in that direction or gives courts good tools for effectuating such a judgment. Furthermore, the culture of the case tempts courts to twist problems into forms for which judicial remedies *are* available. For example, it might for several reasons be desirable to legalize assisted suicide but not to make it a right. However, the only way the Ninth Circuit could legalize assisted suicide was by making it a right, and that was what it tried to do.

Some Institutional Considerations

In the preceding sections, I have argued that courts are poorly equipped to analyze the issues bioethical policy presents. In this section, I contend that a number of institutional considerations make it desirable that courts not become the arbiters of that policy. These considerations speak not just to judicial disadvantages but to the advantages of other governmental and nongovernmental agencies.

First, a clarification. Where the Constitution commands courts to enforce rights, courts must surely do so. There are many areas in which the Constitution is uncontroversially understood to issue just such commands (even if the substance of each decision may be controversial). However, as I argued earlier, assisted suicide is not such a case. And where there is some reason to think affected people have been excluded from democratic institutions, even rights skeptics may want courts to be specially alert for violations of the Fourteenth Amendment. But here there are no "discrete and insular minorities." There is no reason to think some group or some point of view has been barred from the ballot box or the legislature's hall's. On the contrary, *everyone* risks being in the position of the plaintiffs in *Compassion in Dying,* or their families, or their friends.[175]

But even if courts are not constitutionally commanded to act, do they not at least have institutional advantages? Perhaps so, but probably fewer than courts assume. In choosing an institution to make bioethical policy in general and assisted-suicide policy in particular, one criterion should be an institution's flexibility and its ability to promote—or at least tolerate—social experimentation. Experimentation is desirable for two reasons. First, assisted suicide is terra incognita. Much will depend on our ability to regulate it. If we can regulate it well, many of the objections to it will evaporate. However, failures of regulation are likely to reveal themselves only slowly. For example, we are worried about the extent to which routinization will dull the regulatory ardor of physicians, and routine develops gradually. We are worried about slippery slopes, but we slide down them gradually and unwittingly. Not only will pathologies grow slowly, but they will be hard to detect and to measure. All this means we must be free to reverse our course whenever serious problems become evident.

The second reason we should value flexibility is that medicine at the end of life is a dynamic area in which change is constant and in which law must change with change. For example, progress in pain management or treating depression would vitiate the rights claim by weakening the argument that only suicide could offer the patient relief from misery. On the other hand, better techniques for diagnosing depression might calm our worries that the clinically depressed were being inadvertently helped to die. Similarly relevant are the seismic shifts in the structure and financing of American medical care. Even apparently fundamental professional attitudes may change. For instance, it used to be a commonplace that doctors were too eager to keep patients alive, that they were so determined to keep metabolism going, so enthusiastic about technology, and so loath to fail that they would prolong life even at the cost of kindness. Today, doctors' attitudes have altered strikingly, and the visitor to the ICU will often see doctors counseling patients and families to begin to consider withdrawing treatment.[176]

If flexibility is our goal, constitutional adjudication should not be our tool. For one thing, constitutional rights inhibit the experimentation our federal system is supposed to promote. Justice Brandeis's statement of the point is not just familiar, it is right: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."[177] Were the Court to make assisted suicide a constitutional right, all the country would have to permit it, and permit it in the specific forms the Court felt were consonant with the right.

Worse, once courts announce a constitutional opinion, they commonly resist changing it. And not without good reason. *Stare decisis* is crucial to a system of case law. Yet courts dislike reconsiderations for less admirable reasons as well. Judges, like the rest of us, resist admitting error. Once we have made up our minds, we usually have a framework of interpretation into which we fit new evidence. With that framework, we can be wonderfully ingenious in interpreting new data to prove that we were right in the first place. As Bacon put it: "The human understanding, once it has adopted opinions, either because they were already accepted and believed, or because it likes them, draws everything else to support and agree with them. And though it may meet a greater number and weight of contrary instances, it will, with great and harmful prejudice, ignore or condemn or exclude them by introducing some distinction, in order that the authority of those earlier assumptions may remain intact and unharmed."[178] Hence the natural conservatism of the decision maker.

What is more, courts, with their contempt power, readily—and to some extent properly—regard resistance as an affront to judicial dignity and to justice itself. Once a court announces not just an order, but a constitutional right, disagreement looks even more like a perfidy that must be met firmly and even sternly. As a matter of judicial psychology, the judge who has announced "the law of the land" tends to become perturbed and then insistent when states persist in resisting. When thwarted, courts tend to ask "How can these people disobey a lawful order of our court?" instead of "Why are people not doing what we expected and wanted?"

This leads to my next point. I have catalogued ways courts are badly equipped to make bioethical policy. But do not judges bring special virtues to their work? Perhaps, but those virtues have their own vices and are too often absent. One of these virtues is that courts—unlike legislatures—must justify their conclusions in principled terms. And so they should. But in *Compassion in Dying* those principled terms often seem ill considered. And Kamisar, a cautious and careful scholar even if a zealous partisan, strikingly invokes the words of Louis Henkin to describe even the Supreme Court's work: "'Some of the Court's unacceptable lines just happen. To avoid difficult questions, to support a result dictated by intuition or sympathy, perhaps to achieve a majority for that result, the Justices seize a rationale that comes to mind, without asking where it leads and whether they are prepared to go there.'"[179]

But I would also argue that sometimes a purely principled resolution is not the best one. Where people deeply disagree over basic principles (as they do about many matters of bioethical policy), there is much to be said for delaying any kind of final decision until there has been a thorough social examination of the issue and the reasons for disagreement about it.[180] And even where such a process has been carried on as long as is fruitful, compromise may be morally legitimate and practically desirable. Where reasonable and decent people vehemently disagree, it is hard to say who is right. And the political and social cost of unresolved disagreement is likely to be painfully high, as *Roe*'s sequelae attest.[181] So a compromise of the conflicting principles may be necessary. Unfortunately, courts often cannot find a legal basis for such a compromise, predict which compromise might work, or commit the antagonists to accepting it.

Assisted suicide seems an attractive case for compromise. Many and perplexing are the moral and practical issues it presents. Good-hearted and thoughtful are the adversaries. Indeed, we may already be moving toward compromises. One developing pattern is to make assisted suicide a crime but not prosecute it. And Kamisar argues that we have already achieved another kind of compromise, since "the line between letting die and actively intervening to bring about death represents a cultural and pragmatic compromise between the desire to let seriously ill people carry out their wishes to end it all and the felt need to protect the weak and the vulnerable."[182]

Detachment and dispassion are also said to be virtues judges have and others lack.[183] Of course, commitment and passion may be good responses to hard problems. But even when detachment and dispassion are desirable, judges too often spurn them. The Ninth Circuit has much to regret on this score, for its opinion is written in strangely extravagant language. For example, the court lauds itself as a barrier to "arbitrary and intrusive" exercises of state power.[184] Perhaps Washington's statute is unwise. Perhaps it is unconstitutional. But it is not arbitrary. It is a kind of statute many states—indeed, many countries—have long had that plausibly attempts to abate undoubted evils. The Ninth Circuit contends the statute balances the competing interests unwisely, but it hardly attempts to show the statute is arbitrary. (And it is odd to call a statute that prohibits a doctor from delivering fatal drugs to a patient intrusive.)

Perhaps we should not repine at such immoderation. But what is surely dismaying is the court's harsh and vituperative spirit. The court characterizes arguments with which it disagrees—even when they are the arguments of other judges—as "disingenuous," "fallacious," "meretricious," "ludicrous," "nihilistic," "inflammatory," and "disastrous." Yet the court is also sanctimonious, self-serving, and self-satisfied. After slurring those impertinent enough to believe the Washington statute is constitutional and jeering at their opinions and arguments, the court piously concludes by saying,

> Given the nature of the judicial process and the complexity of the task of determining the rights and interests comprehended by the Constitution, good faith disagreements within the judiciary should not surprise or disturb anyone who follows the development of the law. For these reasons, we express our hope that whatever debate may accompany the future exploration of the issues we have touched on today will be conducted in an objective, rational, and constructive manner that will increase, not diminish, respect for the Constitution.[185]

Judicial care and caution are missing not just from the language but the substance of *Compassion in Dying,* as many commentators have noted. Arras says that "[w]ithin the blink of an eye, a seemingly unmovable consensus within the medical profession, the judiciary, the bioethics community, and the general public was unceremoniously overturned."[186] Burt writes that "the rulings by the Second and Ninth Circuit overturning state laws explicitly forbidding physician-assisted suicide were not merely novel exercises of constitutional authority. These rulings startlingly impose a legal result that was without precedent in any prior state or federal legislative action."[187] Kamisar concludes that those two cases "shattered a general consensus that withholding or withdrawing life-saving treatment constitutes neither suicide nor assisted suicide nor homicide. . . . '[T]he moral significance of the distinction has been subjected to periodic philosophical challenge,' but the distinction 'has remained a basic tenet of health care law and mainstream medical ethics.'"[188] The Supreme Court itself said, "To hold for respondents [as the Ninth Circuit had done], we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State."[189]

I have argued that constitutional adjudication is a poor way of making bioethical policy. Is there a better way? I believe so. I would certainly not argue that *any* human institution will reliably produce admirable results, and I would certainly agree that no other branch of government can meet *all* the high standards for making policy against which I have measured courts. But the alternative to constitutional adjudication is not any single institution. Rather, it is the whole set of governmental and nongovernmental organizations that influence policy where they have not been preempted by constitutional adjudication.

The debate over assisted suicide has been conducted in many venues. The issue has perhaps been discussed most profoundly in the private conversations the dying, their doctors, and their families have had.[190] Doctors have pondered it in private conversations and professional meetings, and their professional groups have developed formal opinions about it. Suicide and euthanasia have for years been a staple of debates among bioethicists. Many kinds of private associations, from religious groups to organizations like Compassion in Dying, have become involved. Journalists have covered these activities and many more, and newspaper stories, television reports, magazine articles, and books continue to proliferate. Left to their own devices, these unofficial conversations are likely to contribute to a set of unofficial social practices not inevitably inferior to judicial edict.

Legal institutions of various kinds have likewise been active. Commissions to investigate assisted suicide—notably the New York Task Force—have been appointed and have written thoughtful reports. Legislative hearings and debates have been conducted.[191] Criminal trials and appeals have been held. Five referenda in four states have been placed before the voters. In all these ways the processes of democracy have been vigorously and usefully at work.

Nor is assisted suicide the only bioethical topic democratic and private institutions have handled actively without the benefit of constitutional adjudication. The President's Bioethics Commission drafted a three-volume report that had wide influence, and many state commissions performed similar services. The definition of death was expanded to include brain death in a quiet but effective process in which professional groups presented care-fully considered proposals to legislatures to be enacted into law. The legal doctrine of informed consent developed through common law adjudication. Doctors' attitudes toward withdrawing medical treatment have been considerably moderated through purely private, hardly noticed means. Courts deciding end-of-life cases have even moved away from the constitutional reasoning the court used in *Quinlan* in favor of reasoning based on statutes and the common law.

Each of these institutions has advantages as a bioethical policy maker. Together they have many. Most of these institutions have a flexibility courts interpreting the Constitution cannot have, for they are generally not bound by their previous decisions nor by a particular method. Many of them bring expertise to the issue. Commissions are primarily composed of people who are already expert or who become so during their work, and they employ expert staffs. Professional associations are composed of and employ experts. Even legislatures usually can find within their ranks a few specialists and can hire knowledgeable staffs and recruit expert witnesses.

These institutions can also control the timing of their decisions; they can act when the moment is propitious. Courts, on the other hand, must generally act when litigants arrive. For example, one can imagine the Supreme Court reaching a different result in *Glucksberg* had it arisen after several years of a successful experiment in Oregon with assisted suicide. Many institutions can address issues much more broadly than courts. This is partly because some of them command or influence resources that can be used in many ways. A legislature, for example, can allocate funds for many kinds of programs; courts are essentially confined to a few due process remedies.

Not least, these institutions represent, can speak directly to, or can bind the disputants in a way courts cannot. Thus these institutions are better placed to shape a discussion that leads to effective resolutions of disputes. Some of these institutions have been admirably creative in trying to do so. For example, the Michigan legislature passed a statute criminalizing assisted suicide but provided that the statute would have effect only until a commission with broad representation had examined the problem.

In sum, courts have a number of institutional disadvantages in making bioethical policy. Constitutional adjudication tends to inhibit the flexibility policy needs in a dynamic area both by setting a standard states cannot escape and by cementing judges in decisions they have reached. The judicial virtues of principled reasoning, detachment, and dispassion—even when they are useful virtues—are not always practiced assiduously, and certainly were not in *Compassion in Dying*. No single institution does possess all the virtues a good policy maker needs. But the other branches of government, along with the many interested private organizations, are better placed to consider issues expertly and thoroughly, to act at the right moment, to reach compromises, to develop complex answers to complex problems, and to respond flexibly to the continuing course of change.

Conclusion

I have argued that constitutional adjudication is a poor way to make bioethical policy. My reasons have been several. First, little in the training or experience of judges prepares them to make good public policy in most areas, including this one. Second, little in the text or even the history of the Fourteenth Amendment helps judges make good bioethical policy. Nor has the Court been able to develop doctrine that has a convincing rationale or that seems to help it formulate wise policy. Such a doctrine would require that the Court be able to explain the principles it was consulting, would specify the limits on those principles, would state workable tests to employ in applying them, and would use those tests reasonably and predictably. Such a doctrine remains elusive.

Third, constitutional litigation is a poor way to gather the social facts necessary for making good public policy, and many judges even doubt they need them. This has meant courts have not demonstrated that they understand the issues assisted suicide raises. For example, the Ninth Circuit seems not to have grasped how doctors and ethicists have understood the doctrine of double effect nor the consequences of rejecting that doctrine. It seems not to know where the problem in defining "terminally ill" lies nor how hard it is to do so. It appears not to have understood how common depression is among the suicidal, how often it goes undiagnosed, or how treatable it is. It seems to have a naive view of human motivation generally, of the motives of the ill particularly, and yet more particularly, of the motives of the suicidal. It seems not to realize why people worry about the disadvantaged in a world where assisted suicide is a constitutional right. It does not seem to perceive the ways new economic concerns and new organizational structures create new incentives to hasten the dying along their way. It seems oddly optimistic about how well doctors might regulate the process of suicide. The court seems ignorant of the contemporary ethos of medicine, of the way medical decisions are made, of how doctors deal with patients, of the reasons for the origins of bioethics, and of the regulatory problems Holland has yet to solve. Nor does much in the court's information prepare it to speculate intelligently about how a new regime will work out in practice.

What is more, judicial formulas systematically underweight the state's interests. Some of those interests, as I just said, courts seem not to understand. Less concrete but still important factors—the state's "collective" interests—courts abruptly dismiss. And courts are not equipped to evaluate the cumulative costs of the rights it and other institutions create. Furthermore, the Court has found no principled way to gauge the heft of the individual's right or the state interests so as to weigh the two against each other. On the contrary, the balance is unduly weighed in favor of the individual's rights by the judicial tendency to apply the Mill paradigm, to treat every contest as one between the individual and the state rather than as a conflict among individuals with divergent interests.

In the end, it should not be surprising that courts are so limited as an agency of public policy. They are the institution ultimately responsible for allocating power among the branches of the federal government and the states; defining free speech; structuring religious liberty; setting the boundaries of criminal procedure; deciding when regulations exceed the government's power to take property without compensation; specifying the minimal procedural rights governmental agencies must accord clients; writing some of the basic rules for resolving problems of race; interpreting every federal statute; and much, much more. Responsible for so much, courts can understand only a little. The government of courts must be the government of amateurs.

In sum, the institutions of democracy—public, semipublic, and private—have been working together to shape our policies toward assisted suicide. They are reaching plausible conclusions. Together, they are placed to make better bioethical policy than a court acting as the interpreter of the Fourteenth Amendment. Together they are actually writing better policy than the federal courts when they have tried to write it. (The Supreme Court's success was to decline the invitation.) These institutions have yet another advantage. They are the voice of democracy. That voice is not pure; it is not unflawed; it is not infallible. But assisted suicide is an issue that can affect anyone, that everyone can speak to. In fact, it is an issue as to which an exceptionally large proportion of the population has an opinion.[192] We value democratic government partly because it allows the people affected by a decision to help make it. When courts take decisions away from democratic institutions, courts should be able to advance convincing reasons and to assure us that their job will be done well. I have argued that courts can offer no such assurances when they take bioethical policy into their own hands.

NOTES

I am grateful to Yale Kamisar and Marc Spindelman for their characteristically acute readings of an earlier version of this chapter.

1. Carl E. Schneider, *Bioethics in the Language of the Law,* 24 Hastings Center Report 16, 16 (July/Aug 1994). As McCann puts it, "Courts are to a large extent educational bodies, some activists suggest, and judges the teachers throughout the government and society." Michael W. McCann, *Taking Reform Seriously: Perspectives on Public Interest Liberalism* 120 (Cornell University Press, 1986).
2. M. Cathleen Kaveny, *Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law,* 27 Hastings Center Report 29, 29 (Sept/Oct 1997).
3. 79 F3d 790 (1996).
4. 117 S Ct 2258 (1997). For a description and analysis of that case, see Sonia M. Suter, *Ambivalent Unanimity: An Analysis of the Supreme Court's Holding,* in this volume.

5. For attempts to redress the neglect, see Carl E. Schneider, *State-Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues,* 51 Law & Contemporary Problems 79 (Winter 1988); Carl E. Schneider, *The Channelling Function in Family Law,* 20 Hofstra Law Review 495 (1992); Carl E. Schneider, *State-Interest Analysis and the Channeling Function in Privacy Law,* in Stephen E. Gottlieb, ed., *Public Values in Constitutional Law* (University of Michigan Press, 1993).
6. Two landmarks in that controversy are Donald L. Horowitz, *The Courts and Social Policy* (Brookings, 1977), and Gerald N. Rosenberg, *The Hollow Hope: Can Courts Bring About Social Change?* (University of Chicago Press, 1991).
7. For a detailed examination of the problems with making autonomy the preeminent principle of bioethical policy, see Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford University Press, 1998).
8. *Glucksberg,* 117 S Ct at 2262 (citations omitted).
9. 497 US 261, 293 (1990).
10. 491 US 110 (1989).
11. Justice Blackmun did try to mount a kind of historical argument, but the fact remained that abortion had long been regulated through the criminal law and that at the time of *Roe* most states still criminalized abortion.
12. 505 US 833, 851 (1992).
13. 117 S Ct at 2271 (citations omitted).
14. Bowers v Hardwick, 478 US 186 (1986).
15. For criticisms of this and other "technical" deficiencies of state-interest analysis, see Schneider, *State-Interest Analysis,* L & Contemporary Problems at 82–96 (cited in note 5); Robert F. Nagel, Note, *Legislative Purpose, Rationality, and Equal Protection,* 82 Yale Law Journal 123 (1972).
16. 497 US at 278–79, 280–84.
17. Ibid. at 303 (Brennan, J., dissenting) (citation omitted).
18. Ibid. at 344 (Stevens, J., dissenting) (citations omitted).
19. For a deplorable example of this attitude, see Carl E. Schneider, *Definition, Generalization, and Theory in American Family Law,* 18 University of Michigan Journal of Law Reform 1039 (1985). For a recantation, see Carl E. Schneider, *On the Duties and Rights of Parents,* 81 Virginia Law Review 2477 (1995). For a full-scale analysis of the attitude, see Carl E. Schneider & Lee E. Teitelbaum, *Life's Golden Tree: The Case for Empirical Scholarship in American Law* (unpublished manuscript).
20. To which I replied, "Not here you're not." He was not amused.
21. Abraham S. Blumberg, *The Practice of Law as Confidence Game: Organizational Cooptation of a Profession,* 1 Law & Society Review 15, 38–39 (June 1967).
22. Graham Hughes, *The Great American Legal Scholarship Bazaar,* 33 Journal of Legal Education 424, 429 (1983).
23. David L. Faigman, *"Normative Constitutional Fact-Finding": Exploring the Empirical Component of Constitutional Interpretation,* 139 U Pennsylvania L Rev 541, 545 (1991).
24. See ibid. at 589–95 for criticism of the Court's approach.
25. Carl E. Schneider, *Making Sausage,* 27 Hastings Center Report 27, 27–28 (Jan/Feb 1997).
26. 79 F3d 790 (1996).
27. My views about the constitutional right asserted in these cases are well captured by, e.g., Yale Kamisar, *Are Laws against Assisted Suicide Un-*

constitutional?, 23 Hastings Center Report 32 (May/June 1993); Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There* No *Constitutional "Right to Live"?*, 25 Georgia Law Review 1203 (1991). Some of my own views are expressed in Cruzan *and the Constitutionalization of American Life,* 17 Journal of Medicine & Philosophy 589 (1992).

28. It is hard to know how seriously the Supreme Court took the state interests in *Glucksberg,* since the Court's conclusion that there was no fundamental right to assisted suicide meant that the state had to meet only a light burden of proof.
29. 79 F3d at 817.
30. 80 F3d 716 (1996).
31. *Compassion in Dying,* 79 F3d at 817. This argument may reflect a common strategy among courts evaluating state-interest claims—to imply that the state actually does not believe in all the interests it asserts, that the state is being hypocritical. But states do not think. Furthermore, the state is not a human being, and it is not capable of hypocrisy. Hypocrisy is thinking one thing and doing something else. But the state may act in ways that seem to be conflicting without hypocrisy exactly because ours is a system of divided powers in which policy is supposed to change with elections. In addition, of course, hypocrisy is in the eye of the beholder. The Ninth Circuit may think it hypocritical to permit patients to refuse medical treatment but to deny them the help of a doctor in committing suicide; most commentators do not.
32. 79 F3d at 822.
33. 79 F3d at 823.
34. Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 206 (4th ed., Oxford University Press, 1994) (footnote omitted).
35. Ibid. at 206–7.
36. 79 F3d at 824.
37. Howard Brody, Compassion in Dying v Washington: *Promoting Dangerous Myths in Terminal Care,* 2 BioLaw S:154, S:156 (Special Section, July/Aug, 1996).
38. John Arras, *News from the Circuit Courts: How* Not *to Think About Physician-Assisted Suicide,* 2 BioLaw S:171, S:187, n23 (Special Section, July/Aug, 1996).
39. 79 F3d at 820.
40. *Glucksberg,* 117 S Ct at 2272.
41. 79 F3d at 824 (footnote omitted).
42. Ibid. at 831.
43. Joanne Lynn et al, for the SUPPORT Investigators, *Defining the "Terminally Ill:" Insights from SUPPORT,* 35 Duquesne Law Review 311, 322 (1996).
44. Ibid. at 334.
45. Eric Chevlen, *The Limits of Prognostication,* 35 Duquesne Law Review 337, 353–54 (1996).
46. 79 F3d at 820.
47. Ibid.
48. As one standard definition puts it, an autonomous decision is one in which "a patient . . . with substantial *understanding* and in substantial *absence of control* by others *intentionally authorizes* a professional to do something." Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 76 (cited in note 34).
49. On which, see Peter Hammer, *Assisted Suicide and the Challenge of Individually Determined Collective Rationality,* in this volume.
50. *Suicide and the Request for Assisted Suicide: Meaning and Motivation,* 35 Duquesne Law Review 285, 286 (1996).
51. Ibid. at 288 (footnotes omitted). "In one study . . . fewer than 15 percent of depressed residents had correctly been diagnosed by the nursing home physician. . . . [Another] study noted that only 15 percent of the alert and

oriented patients with depression received treatment." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 32–33 (no publisher, 1994).

52. See Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford University Press, 1998), particularly ch 3.
53. Hendin, 35 Duquesne Law Review at 296 (footnote omitted).
54. Quoted ibid. at 291.
55. Ibid. at 290–91.
56. See Schneider, *The Practice of Autonomy,* particularly ch 4 (cited in note 52).
57. Hendin, 35 Duquesne Law Review at 290 (footnote omitted).
58. Ibid. at 293 (footnote omitted).
59. Ibid. at 293 (footnote omitted).
60. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* xiv (no publisher, 1994).
61. *In Love with Daylight: A Memoir of Recovery* 14 (Simon & Schuster, 1995). On the ways people adjust to distressing circumstances, see Philip Brickman, Dan Coates, & Ronnie Janoff-Bulman, *Lottery Winners and Accident Victims: Is Happiness Relative?,* 36 Journal of Personality & Social Psychology 917 (1978).
62. *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (no publisher, 1994).
63. *Compassion in Dying,* 79 F3d at 820.
64. Ibid. at 820–21.
65. Ibid. at 824.
66. Ibid.
67. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 9 (no publisher, 1994).
68. For the argument that substantive reforms are often cloaked in the language of autonomy, see Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford University Press, 1998), especially ch 6.
69. 79 F3d at 825.
70. Ibid.
71. Ibid. at 826.
72. Ibid.
73. Hendin, 35 Duquesne Law Review at 288.
74. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession,* 35 Duquesne Law Review 395, 407 (1996) (footnote omitted).
75. Herbert Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review 427, 428 (1996) (footnotes omitted).
76. Hendin, 35 Duquesne Law Review at 300–301 (1996) (footnotes omitted).
77. For a careful study of many of these issues, see Bradford H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals* (Harvard University Press, 1991).
78. This argument is extensively developed in Susan M. Wolf, *Physician-Assisted Suicide in the Context of Managed Care,* 35 Duquesne Law Review 455 (1996).
79. 79 F3d at 827.
80. Indeed, in the entire section on unduly influenced decisions to commit suicide there is only one footnote, and it proffers only more assumptions, not evidence.
81. See, e.g., Grace Burdrys, *When Doctors Join Unions* (Cornell University Press, 1997).
82. See, e.g., Eliot Freidson, *Medical Work in America* 178–205 (Yale University Press, 1989).
83. See, for example, *Roe v Wade,* 410 US 113, 163 (1973), where the Court becomes so confused about whose rights it is protecting that it

says that "the attending physician, in consultation with his patient, is free to determine, without regulation by the state, that, in his medical judgment, the patient's pregnancy should be terminated."

84. Timothy E. Quill, *Death and Dignity: Making Choices and Taking Charge* 9–22 (W. W. Norton, 1993).
85. Yet "[i]n some of Kevorkian's cases, the push for the patient's death came from relatives; in others no medical pathology was found upon autopsy, and in virtually no case were any possible alternatives to assisted suicide adequately explored." Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review at 441 (1996). This difficulty obtaining convictions is not a recent development. It appears that "eleven physicians have faced criminal charges in connection with the killing of a patient or family member, but none has yet been imprisoned." Judith F. Daar, *Direct Democracy and Bioethical Choices: Voting Life and Death at the Ballot Box,* 28 University of Michigan Journal of Law Reform 799, [825] (1995). It also appears that "[t]here have been no reported convictions to date [for assisting in a suicide of a terminally ill patient], despite the fact that physician-assisted suicide is known to occur in practice." T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States,* 16 Journal of Legal Medicine 481, 507 (1995).
86. See Carl E. Schneider & Margaret F. Brinig, *An Invitation to Family Law: Principles, Process, and Perspectives* 148–50, 1157–58 (West, 1996).
87. A typical opinion comes from one of the physician-plaintiffs in *Glucksberg:*

    > Although medical professionals must be accountable for their practices, most physicians believe medical decisions and practices are an intensely private matter in which the state does not and should not intrude. Physicians are likely to dislike or detest state regulation of end-of-life practices because of deeply held professional and philosophical views, as well as pragmatically seeing it as limiting patient options and subverting optimal patient care.
    >
    > Thomas A. Preston, *The Case for Privacy in Dying: A Solution from the Supreme Court,* 76 King County Medical Society 9, 13 (Nov 1997).

88. It is often argued that regulation would actually be easier if assisted suicide were legal. Perhaps. But it is hardly reassuring that, "[d]espite changes in the law that ensure Dutch doctors will not be prosecuted if they follow guidelines, 50% of Dutch doctors do not report their euthanasia cases. Further, 20% of the doctors say that they will not do so under any circumstances." Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review at 430 (1996) (footnotes omitted).
89. 79 F3d at 837.
90. See note 176 and accompanying text.
91. 79 F3d at 826–27.
92. Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?,* 35 Duquesne Law Review 159, 172 (1996) (footnote omitted).
93. Ibid. at 174.
94. Compassion in Dying v Washington: *Promoting Dangerous Myths in Terminal Care,* 2 BioLaw S:154, S:155 (Special Section, July/Aug, 1996) (footnotes omitted). "Numerous barriers hamper the delivery of pain relief and palliative care, including a lack of professional knowledge and training, unjustified fears about ad-

diction among both patients and health care professionals, inattention to pain assessment, and pharmacy practices." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 35 (no publisher, 1994).

95. *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice,* in this volume.
96. Margot White & Marc Spindelman, *Ninth Circuit Ignores Medical Experience at Our Peril,* 2 BioLaw S:159, S:167 (Special Section, July/Aug, 1996) (footnote omitted). See Support Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT),* 247 Journal of the American Medical Association 1591 (1995), and *Dying Well in the Hospital: The Lessons of SUPPORT,* a special supplement in the Hastings Center Report of Nov/Dec 1995.
97. Jean Jacques Rousseau, *Émile* 192 (E. P. Dutton, 1950).
98. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession,* 35 Duquesne Law Review 395, 418 (1996).
99. Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* 185 (Oxford University Press, 1998).
100. Hendin reports that "more than half of Dutch physicians consider it appropriate to introduce the subject of euthanasia to their patients." *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review at 428 (footnote omitted).
101. Ibid. at 441.
102. Ibid. at 440.
103. Hendin, *The Slippery Slope,* 35 Duquesne Law Review at 428. Criticisms along these lines are also reported in Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* 23 (W. W. Norton, 1997); John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope?,* in John Keown, ed., *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* 261 (Cambridge University Press, 1995); Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (Free Press, 1991).
104. The article is reprinted in Timothy E. Quill, *Death and Dignity: Making Choices and Taking Charge* 9–16 (W. W. Norton, 1993).
105. Patricia Wesley, *Dying Safely,* 8 Issues in Law & Medicine 467, 480 (1993). To like effect, see Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure* 26–30 (W. W. Norton, 1997).
106. 79 F3d at 833 (footnote omitted).
107. 79 F3d at 827.
108. 79 F3d at 827–28.
109. 79 F3d at 829–30. It is a little hard to see this as an example of adapting to a changed legal climate, since "[b]y 1967 [six years before *Roe*], . . . some 87 percent of American physicians favored a liberalization of the country's anti-abortion policies." James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy* 256 (Oxford University Press, 1978).
110. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession,* 35 Duquesne Law Review 395, 403–4 (1996) (footnotes omitted).
111. Kass & Lund, 35 Duquesne Law Review at 418 (footnote omitted).

112. Herbert Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review 427, 436 (1996) (footnote omitted).
113. 79 F3d at 830.
114. Ibid. at 830–31.
115. See, e.g., *Bowers v Hardwick,* 478 US 186 (1986), and *Michael H. v Gerald D.,* 491 US 110 (1989).
116. 443 US 622 (1979).
117. Robert H. Mnookin et al., *In the Interest of Children: Advocacy, Law Reform, and Public Policy* 149–264 (W. H. Freeman, 1985).
118. See Herbert Jacob, *A Silent Revolution: Routine Policy Making and the Transformation of Divorce Law in the United States* (Chicago University Press, 1988).
119. John Arras, *News from the Circuit Courts: How* Not *to Think About Physician-Assisted Suicide,* 2 BioLaw S:171, S:179–80 (Special Section, July/Aug, 1996).
120. Whether this is technically a slippery-slope argument is difficult to say because there is no technical definition of that kind of argument. At least, however, it shares with a slippery-slope argument the danger that a rule contended for may lead further than was anticipated.
121. *Hudson County Water Co. v McCarter,* 209 US 349, 355 (1908).
122. Paul Freund, *Privacy: One Concept or Many,* in J. Roland Pennock & John W. Chapman, eds., *Privacy* (Nomos XIII) (Atherton Press, 1971).
123. Carl E. Schneider, *State-Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues,* 51 Law & Contemporary Problems 79, 87 (Winter 1988).
124. 79 F3d at 813 (footnote omitted).
125. 79 F3d at 831.
126. It was a similar failure that led Kamisar to say, "With all deference, this author finds it hard to believe that the *Quill* [*v Vacco*] court thought through where its rationale would lead and whether it was prepared to go there." *The "Right to Die": On Drawing (and Erasing) Lines,* 35 Duquesne Law Review 481, 487 (1996).
127. As Kamisar notes, "What the *Quill* Court did, in effect, was to lubricate the 'slippery slope' with the Equal Protection Clause." Ibid. at 487.
128. See *Cruzan,* 497 US at 328. As Kass and Lund observe, "the vast majority of candidates who 'merit' an earlier death cannot request it for themselves. Persons in a so-called persistent vegetative state; those suffering from severe depression, senility, mental illness, or Alzheimer's disease; infants who are deformed; and retarded or dying children—all are incapable of requesting death, but are equally deserving of the new humane 'aid-in-dying.'" Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession,* 35 Duquesne Law Review 395, 412 (1996).
129. See *Cruzan,* 497 US at 331.
130. Similarly, Hendin reports a case proffered by an attorney for the Dutch Euthanasia Society as an illustration of why it was often necessary for doctors to end the lives of competent patients without discussion with them. The attorney spoke of a doctor who had terminated the life of a nun a few days before the nun would have died, because the nun was in excruciating pain and her religious convictions did not permit her to ask for death. Herbert Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review 427, 435–36 (1996).

131. For a careful analysis of slippery-slope arguments, see Frederick Schauer, *Slippery Slopes,* 99 Harvard Law Review 361 (1985).
132. Carl E. Schneider, *Rights Discourse and Neonatal Euthanasia,* 76 California Law Review 151, 168 (1988).
133. *Are Laws Against Assisted Suicide Unconstitutional?* Hastings Center Report 32, 40 (May/June 1993), citing Thomas Mayo, *Constitutionalizing the "Right to Die,"* 49 Maryland Law Review 103, 144 (1990).
134. Herbert Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review 427, 427 (1996).
135. 79 F3d at 837.
136. I develop this argument at some length in Carl E. Schneider, *State-Interest Analysis and the Channelling Function in Privacy Law,* in Stephen E. Gottlieb, ed., *Public Values in Constitutional Law* 97 (University of Michigan Press, 1993).
137. 117 S Ct 2272 (1997) (footnote omitted).
138. Carl E. Schneider & Margaret F. Brinig, *An Invitation to Family Law: Principles, Process, and Perspectives* 161 (West, 1996).
139. Carl E. Schneider, *State-Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues,* 51 Law & Contemporary Problems 79, 98 (Winter 1988). I develop this argument at greater length ibid. at 97–106. See also Guido Calabresi, *Reflections on Medical Experimentation in Humans,* 98 Daedalus 387 (1969).
140. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession,* 35 Duquesne Law Review 395, 401 (1996).
141. Ibid. at 419–20. Lest these fears seem too timorous, we should recall the evidence that for years doctors orchestrated the deaths of newborns whose lives they regarded as not worth living. See, e.g., Raymond S. Duff & A. G. M. Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery,* 289 New England Journal of Medicine 890 (1973). Cf. Martin S. Pernick, *Eugenic Euthanasia in Early Twentieth-Century America and Medically Assisted Suicide Today: Similarities and Differences,* in this volume.
142. "The major studies all agree in showing that the fraction of suicide victims struggling with a terminal illness at the time of their death is in the range of 2% to 4%." David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities,* 8 Issues in Law & Medicine 147, 151 (1992).
143. *Whose Keeper? Social Science and Moral Obligation* 43 (University of California Press, 1989).
144. Anne Hunsaker Hawkins, *Reconstructing Illness: Studies in Pathography* 124 (Purdue University Press, 1993).
145. For a defense of this kind of argument in constitutional terms, see Carl E. Schneider, *State-Interest Analysis and the Channeling Function in Privacy Law,* in Stephen E. Gottlieb, ed., *Public Values in Constitutional Law* (University of Michigan Press, 1993).
146. 79 F3d at 821.
147. Daniel Callahan, *Assisted Suicide Is a Power Too Far,* 2 BioLaw S:125, S:126 (Special Section, July/Aug, 1996). I discuss this problem at some length in ch 5 of Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and*

Medical Decisions (Oxford University Press, 1998).

148. Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?,* 23 Hastings Center Report 32, 39 (May/June 1993).
149. J. David Velleman, *Against the Right to Die,* 17 Journal of Medicine & Philosophy 664 (1992).
150. Leon R. Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession,* 35 Duquesne Law Review 395, 406 (1996). See also Courtney S. Campbell, Jan Hare, & Pam Matthews, *Conflicts of Conscience: Hospice and Assisted Suicide,* 25 Hastings Center Report 36 (May/June 1995).
151. Herbert Hendin, *The Slippery Slope: The Dutch Example,* 35 Duquesne Law Review 427, 430 (1996) (footnotes omitted).
152. On the Court's confusion, see Carl E. Schneider, *State-Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues,* 51 Law & Contemporary Problems 79, 82–95 (Winter 1988).
153. 79 F3d at 836.
154. As Cardozo wrote,

    > If you ask how [the judge] is to know when one interest outweighs another, I can only answer that he must get his knowledge just as the legislator gets it, from experience and study and reflection; in brief, from life itself. Here, indeed, is the point of contact between the legislator's work and his. The choice of methods, the appraisement of values, must in the end be guided by like considerations for the one as for the other. Each indeed is legislating within the limits of his competence.
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    > Benjamin N. Cardozo, *The Nature of the Judicial Process* 113 (Yale University Press, 1975). It is worth noting that here Cardozo was speaking of a court exercising common law authority.

155. E.g., "By prohibiting physician assistance, it bars what for many terminally ill patients is the only palatable, and only practical, way to end their lives. Physically frail, confined to wheelchairs or beds, many terminally ill patients do not have the means or ability to kill themselves in the multitude of ways that healthy individuals can. Often, for example, they cannot even secure the medication or devices they would need to carry out their wishes." 79 F3d at 832. "The testimony produced by the plaintiffs shows that many terminally ill patients who wish to die with dignity are forced to resort to gruesome alternatives because of the unavailability of physician assistance." Ibid. at 834. "Next, the plaintiffs produced testimony showing that many terminally ill patients are physically or psychologically unable to take their lives by the violent means that are almost always their only alternatives in the absence of assistance from a physician." Ibid. at 835.
156. "Studies indicate that for many patients with severe pain, disfigurement, or disability, the vast majority do not desire suicide. In one study of terminally ill patients, of those who expressed a wish to die, all met diagnostic criteria for major depression." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 13 (no publisher, 1994). "Among older persons, for whom chronic painful illnesses are not uncommon, only 0.5% of male deaths and 0.2%

of female deaths are attributable to suicide." David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities,* 8 Issues in Law & Medicine 147, 160–61 (1992).

157. "The wish to end life by killing oneself is almost always a serious symptom arising from a temporary psychiatric illness." David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities,* 8 Issues in Law & Medicine 147, 163 (1992).
158. Courtney Campbell, *Sanitizing Suicide in the Culture of Death: "So, Go Back, Jack, Do It Again,"* 2 BioLaw S:121, S:122 (Special Section, July/Aug, 1996). White and Spindelman even write, "Most would-be suicides are quite capable of concocting or consuming a death-inducing potion, or of otherwise ending their lives without a doctor's assistance." Margot White & Marc Spindelman, *Ninth Circuit Ignores Medical Experience at Our Peril,* 2 BioLaw S:159, S:162 (Special Section, July/Aug, 1996).
159. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 4 (no publisher, 1994).
160. There is evidence, for example, that Dutch doctors have found that "even if a physician knows the proper drugs and dosage, in one out of four cases, prescribed use does not result in a quick, efficient death, but instead induces a coma that lingers for several days." Courtney Campbell, *Sanitizing Suicide in the Culture of Death: "So, Go Back, Jack, Do It Again,"* 2 BioLaw S:121, S:124 (Special Section, July/Aug, 1996).
161. *New State Ice Co. v Liebmann,* 285 US 262, 310 (dissenting).
162. Schneider, *Rights Discourse and Neonatal Euthanasia,* 76 California Law Review at 157 (cited in note 132).
163. Carl E. Schneider, *Bioethics and the Family: The Cautionary View from Family Law,* 1992 Utah Law Review 819, 838.
164. 79 F3d at 837.
165. Donald L. Horowitz, *The Courts and Social Policy* 45 (Brookings, 1977) (footnote omitted).
166. On the ways people are misled about the likelihood of events by vivid recent experiences, see Richard Nisbett & Lee Ross, *Human Inference: Strategies and Shortcomings of Social Judgment* 17–62 (Prentice-Hall, 1980).
167. John Arras, *News from the Circuit Courts: How* Not *to Think About Physician-Assisted Suicide,* 2 BioLaw S:171, S:184–85 (Special Section, July/Aug, 1996).
168. Carl E. Schneider, *Lawyers and Children: Wisdom and Legitimacy in Family Policy,* 84 Michigan Law Review 919, 932 (1986).
169. These two paragraphs are roughly borrowed from Carl E. Schneider, *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* (Oxford University Press, 1998), ch 1 of which discusses hyper-rationalism at some length.
170. Law schools should not escape their share of the blame. Not only is their teaching done through cases, but the cases are appellate cases, where the facts have already been winnowed and sifted and cannot be challenged. Complicated cases with complex facts are either not presented (because such cases are pedagogically awkward) or are edited so severely that the complexity seeps away. Legal scholars, who ought to be doing empirical research, resist it, even though it has been persuasively advocated for

most of this century. See Carl E. Schneider & Lee E. Teitelbaum, *Life's Golden Tree: The Case for Empirical Scholarship in American Law* (in manuscript).

171. 79 F3d at 827.
172. Of course, this is not a necessary attribute of a common law system; it is just the way ours has evolved.
173. Michael W. McCann, *Taking Reform Seriously: Perspectives on Public Interest Liberalism* 226 (Cornell University Press, 1986).
174. E.g., "Given the possibility of undue influence that already exists, the recognition of the right to physician-assisted suicide would not increase that risk unduly." *Compassion in Dying,* 79 F3d at 826.
175. At oral argument, counsel for the respondents in *Glucksberg* argued that because "ours is a culture of denial of death," she had "some concern that the political process would not be expected to work in a usual fashion." Quoted in Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases,* in this volume. It is difficult to know whether to take this argument seriously. For one thing, the cliché that "ours is a culture of denial of death" seems to me simply wrong. Death is honored by its own section at Border's Books & Music, books on it become best-sellers, and death has become an academic subculture. More to the point, our supposed denial of death has not in fact kept "the political process" from prolonged and vigorous discussion of assisted suicide.
176. See Robert Zussman, *Intensive Care: Medical Ethics and the Medical Profession* 104–15 (University of Chicago Press, 1992); New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 4 (no publisher, 1994). Thus one study reports that "family members tended to err on the side of providing resuscitation for the patient whereas physicians tended to err on the side of not providing the intervention." Allison B. Seckler et al., *Substituted Judgment: How Accurate Are Proxy Predictions?,* 115 Annals of Internal Medicine 92, 95 (July 1991).
177. *New State Ice Co. v Liebmann,* 285 US 262, 311 (dissenting).
178. Francis Bacon, *Novum Organum,* Peter Urbach & John Gibson, translators & eds., 57 (Open Court, 1994).
179. Yale Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines,* 35 Duquesne Law Review 481, 481 (1996), quoting Louis Henkin, *Foreword: On Drawing Lines,* 82 Harvard Law Review 63, 65–66 (1968).
180. For this argument applied specifically to bioethics, see Amy Gutman & Dennis Thompson, *Deliberating About Bioethics,* 27 Hastings Center Report 38 (May/June 1997).
181. For an argument that abortion was the kind of issue that could best have been resolved through political compromise, see Carl E. Schneider, *State-Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues,* 51 Law & Contemporary Problems 79, 113–14 (Winter 1988).
182. Yale Kamisar, *In Defense of the Distinction Between Terminating Life Support and Actively Intervening to Promote or to Bring about Death,* 2 BioLaw S:145, S:148 (Special Section, July/Aug, 1996).
183. Describing the views of what he calls "public interest liberals," McCann writes, "Judges, above all

else, are praised as independent, neutral, and impartial in ways that bureaucrats cannot be." Michael W. McCann, *Taking Reform Seriously: Perspectives on Public Interest Liberalism* 117–18 (Cornell University Press, 1986).

184. 79 F3d at 837, 839.
185. 79 F3d at 838–39.
186. John Arras, *News From the Circuit Courts: How Not to Think About Physician-Assisted Suicide,* 2 BioLaw S:171, S:171 (1996).
187. Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?,* 35 Duquesne Law Review 159, 163 (1996).
188. Yale Kamisar, *The "Right to Die": On Drawing (and Erasing) Lines,* 35 Duquesne Law Review 481, 490 (1996) (footnote omitted).
189. 117 S Ct at 2269 (citations omitted).
190. See Arthur Frank, *From Story to Law: Euthanasia and Authenticity,* in this volume.
191. Professor Kamisar reports "that in the last decade bills to legalize PAS have been introduced in more than twenty states" but not enacted and that in that period sixteen bills prohibiting it have been enacted. Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases,* in this volume. Recently, the flood has continued unabated. See Susan M. Wolf, *Physician-Assisted Suicide: Facing Death After* Glucksberg *and* Quill, 82 Minnesota Law Review 885, 890 n32. Even the federal government has entered the fray to prohibit the use of federal funds for assisted suicide. Federal Assisted Suicide Funding Restriction Act of 1997, Pub L 105–12, 111 Stat 23 (codified as amended 42 USC §§ 14401 et seq). This activity is described in some detail in Henry R. Glick, *The Right to Die: Policy Innovation and Its Consequences* (Columbia University Press, 1992).
192. Henry R. Glick, *The Right to Die: Policy Innovation and Its Consequences* 56 (Columbia University Press, 1992).