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The Road to Glucksberg

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CHAPTER 1 The Road to *Glucksberg*

Carl E. Schneider

This volume contains a series of essays on the United States Supreme Court's opinion in *Washington v Glucksberg,*[1] the case that presented the question whether laws making it criminal to help a person commit suicide are unconstitutional. These essays are written by scholars in several disciplines for a broad audience that may include doctors, lawyers, ethicists, and the general public. In this opening chapter, therefore, I want to provide some background that might make these essays and the difficult legal issues they raise more accessible to such an audience.

Before *Glucksberg: Cruzan* and *Quinlan*

I begin, as a student of the common law must, with a case. In the earliest minutes of January 11, 1983, a twenty-five-year-old woman named Nancy Beth Cruzan was driving down Elm Road in Jasper County, Missouri. Her car went off the road. When a policeman arrived, he found her lying face-down in a ditch ten meters from her car. She was not breathing. Her heart had stopped. An ambulance quickly arrived. Minutes later, its medical team got Nancy's heart and breathing started again. But Nancy remained in a coma.

As the days turned to weeks, it became clear that Nancy was in a "persistent vegetative state."[2] Her brain had been deeply and permanently damaged from being without oxygen for so long. She was unconscious, able only to respond reflexively to sounds and perhaps to pain. She lay curled up, her arms and legs contracted. She could not swallow. To make feeding her easier, her husband allowed surgeons to place a tube in her stomach through which she could be given food and water.

Eventually, Nancy's husband seems to have left the picture, and it was her parents who heard the doctors predict her future. They were told that Nancy was not legally dead, since some parts of her brain still worked. Nor was she terminally ill. Indeed, she might live another thirty years. But she would never regain consciousness.

On learning this, the Cruzans told the hospital to stop feeding Nancy through the tube so that she would die. The hospital refused to obey without a court order. A Missouri trial court issued that order, saying that Nancy would have wanted to die. However, the Missouri Supreme Court reversed the trial court. It found there was not enough evidence of what Nancy would have wanted to override the state's strong policy in favor of preserving life. In

December of 1989—almost seven years after the accident—the case reached the United States Supreme Court. What should that court have done?

This is really a remarkable question. The Supreme Court can generally decide for itself what cases to hear. It does not take most cases. This case might have seemed too easy a winner for Missouri to be worth reviewing. Nancy Cruzan did not fit many of the categories that are commonly invoked to justify stopping medical treatment. She wasn't dead; she was just kept alive by machines. She was not near death; on the contrary, she had many years to live. She was apparently not in pain, much less unbearable and unending pain. She had never used any of the formal means by which she could have announced in advance a wish to have medical treatment ended. She did not need "heroic measures" or "extraordinary means" to keep her alive. Indeed, she did not need medical care. She simply needed food and water.

To understand how remarkable a question the Supreme Court presented itself with, we need one more fact about its jurisdiction. The Supreme Court is, of course, the highest federal court. As such, its task is to resolve questions of federal law about which the lower federal courts disagree. But federal law is not responsible for defining homicide or regulating medical care. That is the prerogative of the states. The Supreme Court could only reach the *Cruzan* case by considering an argument that Nancy Cruzan had rights under the federal Constitution that Missouri had somehow violated. Thus, the claim in *Cruzan* was not that good social policy justified withdrawing food and water from Nancy, but that she had a constitutional right to compel the hospital to stop feeding her. The claim, in short, was that she had a "right to die."

How had America come this far? A few decades ago, things were quite different. Legally, of course, causing someone's death is punishable as homicide, even if the victim consented. And helping someone commit suicide is a crime in about two-thirds of the states. It was generally understood that both principles applied to failures to provide or continue medical care a patient needed to stay alive. Socially, most people believed (without having thought much about it) that doctors were above all committed to keeping their patients alive.

Nevertheless, in the real world of medical practice, things were more complicated. It was probably always true that, faced with particularly desperate cases, doctors deliberately let patients die. Indeed, hints would occasionally slip out that a doctor had actively hastened a death. As medical technology developed, doctors increasingly faced genuinely confounding choices about whether to use medicine's whole armory. Eventually, it became accepted, although not invariable, practice to issue orders against trying to revive an "irreversible, terminal, pain-ridden patient" when he stopped breathing or suffered heart failure.[3]

In short, the "law on the books" and the "law in action" were quite different. The law on the books said, "You must always treat a patient." But that law was often disobeyed. Prosecutors surely knew what was going on, but they rarely brought charges. Even when they did, the defendants were often

sympathetic, and juries were reluctant to convict and judges to punish them.[4] Nevertheless, the very conflict between what the law said and what it did was widely criticized. Nor were doctors comfortable with either the moral or the legal risks they ran when they walked the line between the law on the books and the law in action.

In sum, there was real uncertainty and ambivalence about the role of both law and medicine at the end of life. This ambivalence was captured in a case from 1947—*Repouille v United States*.[5] Louis Repouille wanted to become a naturalized citizen. To do so, he had to show that he had been a person of "good moral character" for five years. However, he had had a thirteen-year-old boy who was mentally retarded, mute, and blind; who had malformed arms and legs; who could do nothing for himself; and who lived out his life in a crib. Repouille found it hard to care for the boy and his four other children, and one day he chloroformed the child. Repouille was convicted of manslaughter, but he was given a suspended sentence. (That is, he was put on probation but did not have to go to jail.) Was he a person of "good moral character"?

The court, in an opinion by Learned Hand, one of America's most admired judges, saw many moral perplexities but held "that only a minority of virtuous persons would deem the practise [of killing such a child] morally justifiable, while it remains in private hands, even when the provocation is as overwhelming as it was in this instance."[6] However, Judge Jerome Frank, another eminent jurist, dissented. Notably, he did not argue that Mr. Repouille *was* a man of good moral character. Rather, he argued that the issue was so uncertain that the court should have sought information about the general public view of such conduct.[7]

Despite this ambivalence, or perhaps because of it, the law governing the end of life came under growing pressure. Medical advances multiplied questions about when to stop or withhold treatment. Doctors had ever more reason to fear both criminal and civil liability for decisions not to treat. Furthermore, a small but convinced movement sought to liberalize the law. That movement was earnestly confident that the law was backward and barbaric, and it labored to reform it. Still, these issues were not broadly discussed, and the public remained uninformed, uncertain, and uneasy about the law at the end of life.

The first major change in both public and legal attitudes came, of course, with a case. In 1976, the New Jersey Supreme Court encountered Karen Ann Quinlan.[8] She was a twenty-two-year-old woman who had fallen into a persistent vegetative state. In other words, she lay in a coma from which doctors said she could not recover. She could not breathe on her own and was kept alive by a machine (called a respirator) that helped her breathe. She could not eat on her own and was fed by means of a tube. She was expected to die within a year, and possibly much sooner.

After prayer and consultation with priests, Karen's father asked a court to appoint him his daughter's guardian and to let him have the respirator removed so that she might die. The trial court said no, but the state supreme

court said yes. Citing *Roe v Wade,* the American abortion decision, the court held that patients have a constitutional right to refuse medical treatment. That right, the court continued, "should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice."[9] It said that "[t]he only practical way to prevent destruction of the right is to permit the guardian and family of Karen" to decide what she would have done had she been able to decide for herself.[10] Since the court had "no doubt . . . that if Karen were herself miraculously lucid for an interval" she would not want the respirator, the court authorized her father to order its removal.[11]

Why was the *Quinlan* case crucial? As I suggested, it arose when the time was ripe, when the issue was becoming more common and more problematic. Karen Quinlan unforgettably embodied the reformers' claims. She was by all accounts a lively and engaging person harshly struck down. Her father was by all accounts a decent, thoughtful, and devastated man struggling to do his best under the worst circumstances. Day after day, the Quinlans won the public's deepest attention and profoundest sympathy. Further, the case was importantly different from earlier causes célèbres. They had typically involved prosecutions of people who had already taken the law into their own hands in a "mercy killing." But in *Quinlan* the family was respectfully asking for governmental authority to end their daughter's life.

Ultimately, then, *Quinlan* legitimated discussion about the issues it raised. More, it confirmed the respectability of the Quinlans' position. And, in legal terms, it held not just that patients could refuse even lifesaving treatment, but that they had a constitutional right to do so, a right that survived even their ability to exercise it. By phrasing the issue in constitutional terms at this early stage in public discussion, the court gave the reformer's position special moral and legal authority.

Nevertheless, *Quinlan* did not liberalize the law as much as another case might have. First, its issue was whether to withhold medical care, not to withhold food and water or actively to kill the patient. Second, the medical care being withheld could have been called "extraordinary" or "heroic." Third, the court assumed that Karen Quinlan was dying anyway, so that the question could be not whether to cause her to die, but whether her death should be prolonged.[12] Finally, *Quinlan*'s dramatic message was dulled by an ironic fact. When her father ordered the respirator removed, Karen Quinlan confounded the doctors by not dying. Indeed, she lived on for nine more years.

Whatever *Quinlan*'s direct effects, it initiated a period of vigorous legal activity and public discussion. A series of judicial decisions stated a "right to refuse treatment," even where that treatment had kept the patient alive. This right was both constitutional and based on the common law principle that a doctor could not treat a patient unless the patient gave "informed consent." In 1976, the date of *Quinlan,* California enacted a law authorizing what came to be called "living wills." Living wills are documents in which a person states that, should he become irrevocably incompetent while fatally ill, his doctors should (under specified circumstances) withdraw any treat-

ment designed to keep him alive. Some states have also created the "durable power of attorney." This document allows its signer to appoint someone to make medical decisions—including withdrawal of treatment—for him if he becomes incompetent. By 1990, forty states had enacted living will statutes, and thirteen permitted durable powers of attorney.[13]

These statutory developments dissatisfied many reformers because most people never use them. But where were the reformers to turn next? In the American federal system, the easiest way of getting national action is through a ruling by the U.S. Supreme Court. Further, when Americans think about a social issue, they think in terms of rights. These facts brought the reform movement to the case with which I began, the case of Nancy Cruzan. Although Missouri provided for living wills, Nancy had not written one. Did she nevertheless have and exercise a constitutional "right to die"?

A majority of the Supreme Court appears to have held in *Cruzan* that a competent person has a constitutional right to refuse "unwanted medical treatment."[14] But, by a vote of five to four, the Court held that Missouri could prevent Nancy's parents from withdrawing treatment. The Court said that the constitutional right was a right to choose, and Nancy had never chosen to refuse treatment and now was physically incapable of making any kind of choice at all: "[A]n incompetent person," the Court said, "is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right."[15]

The Court did seem to say that Nancy need not have expressed her choice formally, in a living will. But Missouri could insist that evidence of any informal choice be "clear and convincing." The evidence of Nancy's choice lay in a "'somewhat serious [1/2 hr.] conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally. . . .'" The United States Supreme Court agreed with the Missouri Supreme Court that this testimony was not clear and convincing evidence that Nancy would truly have wanted to be denied food and water in her present circumstances.

The majority's opinion provoked two angry dissents. Justice Brennan wrote for himself and two other Justices. He insisted that Nancy had a "fundamental right" to "be free from unwanted medical attention." This meant "a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to the intrusion."[16] The fact "that Nancy Cruzan is now incompetent," Justice Brennan thought, could not "deprive her of her fundamental rights."[17] True, she could not personally exercise her right to "choose to die with dignity."[18] But the Court was constitutionally obliged to try to decipher what she would have done had she been conscious. And in doing so, it was obliged to look to all the available evidence, even if it was not "clear and convincing."

Justice Stevens wrote a lone dissent. He agreed with Justice Brennan that Nancy had a fundamental right. But it was not, as the majority and Jus-

tice Brennan believed, a right to choose. It was a right to a decision in her best interests. Since there was "no reasonable ground for believing that Nancy Beth Cruzan ha[d] any *personal* interest in the perpetuation of what the State has decided is her life,"[19] her parents should have been allowed to order the hospital to stop feeding her.

On its face, *Cruzan* appeared to be a setback for the reformers. After all, the Court decided against Nancy's parents. Nevertheless, on balance *Cruzan* has been a trumpet call in a crescendoing reform effort. Even though the Cruzans lost, the Court apparently announced some kind of constitutional "right to die." The Court thus opened the door to the prospect of a series of cases limiting the ability of the states to regulate law at the end of life.

Further, like *Quinlan, Cruzan* has transformed public debate. Both cases received wide publicity. Both cases confronted the country with sympathetic parents arguing in the most earnest and appealing terms to be allowed to end their daughter's life. Of course, it is hard to measure the public's feelings about these questions. But some indication may be found in the fact that a book on how to commit suicide was for months a best-seller. More systematically, Justice Brennan quoted a poll purporting to find "that 80% of those surveyed favored withdrawal of life support systems from hopelessly ill or irreversibly comatose patients if they or their families requested it."[20] However, much depends on how pollsters phrase their questions. One regional poll found that 50 percent of those asked felt that "the Supreme Court should . . . approve removal of the feeding tube" in *Cruzan*. But when asked whether "the Supreme Court should . . . allow Ms. Cruzan to starve to death?" only 25 percent said yes.[21]

The evolving public mood has had practical manifestations. Publicity about *Cruzan* "helped assure passage by Congress of the Patient Self-Determination Act. . . ."[22] That law requires all health care institutions that receive federal aid to tell patients they have a right to refuse medical treatment and to employ advance medical directives like living wills and durable powers of attorney. But perhaps the most remarkable aftermath of *Cruzan* was the efflorescence of a movement to make it legal for doctors to help patients commit suicide. The remarkably rapid development in support for that movement is suggested by developments in the state of Washington. There, citizens can propose statutes and vote them directly into law. Initiative 119 would have been the first statute in the industrialized world directly authorizing doctors to kill patients who had less than six months to live and who had asked the doctor in writing to do so.

Initiative 119 would arguably have passed except for one man in Michigan. A week before the election, Dr. Jack Kevorkian met with two middle-aged women in a cabin in a park outside of Detroit. He provided one of them with a machine he called a "mercytron." This machine allowed her to inject herself with a fatal drug. Kevorkian furnished the other woman with a way to breathe carbon monoxide and thus suffocate. As Kevorkian watched, both women killed themselves.

Kevorkian publicized this event with great avidity. But many people found him and his crusade frightening. He acted alone, without formally established procedures for ensuring that the women had received adequate medical care, that they were competent, or that they truly and firmly wanted to die. Neither woman was fatally ill. One of them complained of incessant and unbearable pain, but at least one doctor later said that her disease was short-term, treatable, and should have caused only manageable pain. In short, Kevorkian was so much every patient's nightmare that he apparently shifted public opinion from its original 60 to 30 percent support of the proposal to a 54 to 46 percent rejection of it at the election.[23]

Nevertheless, the fact that so substantial a portion of the population was willing to vote for so substantial a change in the law was striking. And this was only the beginning. In 1992, precisely the same percentage of the voters in a California referendum expressed a similar willingness. In 1994, the voters of Oregon approved a referendum by a vote of 51 to 49 percent that authorized doctors to prescribe drugs that competent, terminally ill patients could use to commit suicide. And in 1997, after the Oregon legislature had exercised its power to revoke the statute the voters had passed, the voters of Oregon voted once again for the proposal, this time by a vote of 60 to 40 percent.

Particularly significant from our point of view is the number of courts that have announced some kind of constitutional defect in assisted-suicide statutes. In 1993, a Michigan trial court judge made such a ruling in a case involving Kevorkian,[24] although the Michigan Supreme Court reversed that ruling in 1994.[25] In that same year a federal trial court in Washington found the Washington assisted-suicide statute unconstitutional.[26] More significantly, that decision was upheld by the Ninth Circuit Court of Appeals in an en banc decision,[27] and the Second Circuit found the New York assisted-suicide statute unconstitutional.[28] The two circuit court opinions used importantly different reasoning. The Ninth Circuit found in the Due Process Clause of the Fourteenth Amendment a "liberty interest in determining the time and manner of one's own death"[29] and concluded none of the state's interests was sufficiently strong to overcome that liberty interest. The Second Circuit held that the New York statute violated the Equal Protection Clause of the Fourteenth Amendment. That clause requires that similarly situated people be treated similarly. The court reasoned that all terminally ill people are similarly situated but that, under New York law, they were treated differently: terminally ill people who were kept alive with medical help could die by refusing that help while terminally ill people who did not need such help could not die by refusing it.

The United States Supreme Court has now, in the two opinions that are the subject of the essays collected in this book, reversed the holdings of both the Ninth and the Second Circuits. Those opinions—*Washington v Glucksberg*[30] and *Vacco v Quill*[31]—are described in these essays,[32] so I will not review them here. These questions bring us up to the present and conclude our brief investigation of the historical and legal background to the Court's

decision in *Glucksberg*. There is, however, one more story to tell about Nancy Cruzan. After the Supreme Court ruled against her parents, they went back to the same judge in the same courtroom in Missouri. They said they had found "new evidence," the testimony of three of Nancy's friends who said she had told them she wouldn't want to "'live like a vegetable' on medical machines."[33] Once again, the judge authorized the Cruzans to have the hospital remove the feeding tube. This time, no one appealed the court order. In December of 1990, the hospital obeyed the Cruzans' instructions, and on December 26, Nancy Beth Cruzan died.

Glucksberg

It may be helpful to supplement this brief summary of the background of *Glucksberg* with a brief introduction to some of the principal issues that case raises. It has become truly hard to know what the law at the end of life ought to do in particular cases or where it ought to draw its lines in general. In some of these cases, the real question may be what constitutes death. In them, the issue is not whether to keep the patient alive, but whether the patient is already dead. In other cases, there are real and perplexing questions about the best medical course to follow even if the only goal is to prolong the patient's life. In yet other cases, there are strong reasons for deferring to the patient's preference even if that preference is for death. If a truly competent patient who is genuinely about to die and who is in unrelievable pain irrevocably wishes to refuse "heroic" medical care, who are we to say he is wrong? Cases in all these categories, then, make it hard to say that life-sustaining treatment should never be withdrawn. The Ninth Circuit's description of one of the plaintiffs in *Compassion in Dying* makes this point painfully clear:

> Jane Roe is a 69-year-old retired pediatrician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. Although she tried and benefitted temporarily from various treatments including chemotherapy and radiation, she is now in the terminal phase of her disease. In November 1993, her doctor referred her to hospice care. Only patients with a life expectancy of less than six months are eligible for such care.
>
> Jane Roe has been almost completely bedridden since June of 1993 and experiences constant pain, which becomes especially sharp and severe when she moves. The only medical treatment available to her at this time is medication, which cannot fully alleviate her pain. In addition, she suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.[34]

But here we meet the slippery-slope problem. "Slippery slope" is the phrase lawyers use to describe the following kind of argument: "There is

nothing wrong with doing A. A in itself is unobjectionable. But if you do A, you will soon wind up doing B, and B *is* objectionable. Therefore, you should not do A." The idea, of course, is that once you start off doing the desirable A, you find yourself helplessly sliding down a slope toward the undesirable B.

But as I must often tell my students, slippery-slope arguments are, logically, unconvincing. If the first step is right, it is right even though the second step is wrong. If the second step is wrong, then 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 slippery-slope argument assumes that the top of the slope is very different from the bottom.[35]

Logically, this refutation of the slippery-slope argument seems convincing. But as Justice Holmes memorably 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, I think, the hazards of the slippery slope. For several reasons, this should not be surprising. First, slippery slopes work even if they logically shouldn't, partly 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 was *almost* the same as its predecessor, the end of the series may wind up quite far from the beginning. You may start at the top of the slope and, without realizing it, inch your way down to the bottom.

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."[36] Yet a third reason we slide down slippery slopes is that there are people pushing us. Several organized groups ardently want to reform the law at the end of life. They are well aware that the public is afraid of the bottom of the slope; they have consciously calculated how to move us by small steps down the slope.

I have been suggesting that while slippery-slope arguments are not logically convincing, they are practically persuasive. A quick review of the American experience shows just how far along the slope we have moved.[37] Up through at least the 1950s, and perhaps through the 1960s, the reformers themselves framed the debate primarily in the very limited terms of (1) withholding or withdrawing (2) medical treatment from (3) competent adults who (4) suffered from a fatal illness, who (5) were in pain, and who (6) expressly refused treatment.

Observe how far we have come. Neither Karen Ann Quinlan nor Nancy Beth Cruzan was, so far as anyone can know, in pain. Quinlan might have appeared to suffer from a fatal illness.[38] Cruzan not only did not, but her life expectancy of thirty years was one of the arguments for causing her death. The issue in *Quinlan* was whether to withdraw medical care—a machine that helped her breathe. When Quinlan's father was asked about withdrawing food and water, he was shocked, as doctors and laymen alike would have

been. But the Court in *Cruzan* barely noticed that the family wanted to withdraw food and water, not medical care as it is usually understood. Most significantly, neither Cruzan nor Quinlan refused treatment, and neither was competent to do so. Now voters in Oregon have twice adopted a referendum permitting physician-assisted suicide. And this describes only the movement of the law on the books. The law in action has also gone impressively far. It is hard to find out what goes on in the privacy of medical practice, but an impressive hint is given by the American Hospital Association. It believes "that 70 percent of the estimated 6,000 deaths that occur daily in the United States are somehow timed or negotiated with patients, family and doctors quietly agreeing on not using death-delaying technology."[39] And doctors like Timothy Quill acknowledge that some physician-assisted suicide is already occurring.[40]

Of course, a slippery slope is not a problem unless the bottom of the slope is bad. What is it that opponents of assisted suicide fear? First, as *Quinlan* reminds us, doctors can make mistakes.[41] We cannot want patients to die who think they are mortally ill but who in fact would recover. Second, there is the danger that patients who would rather live will be led by social pressure—by the emotional and economic distress of their families, by the impatience of their doctors, by the social symbolism embodied in a "right to die"—to ask for death. Third is the risk that the slide down the slippery slope will continue to encompass the only two remaining steps—active voluntary euthanasia and involuntary euthanasia.

Finally, we risk the lives of people who on some higher principle ought to live. Many of these will be ordinary people. But particularly jeopardized in this category will be people who are less than normal but not less than human. The American experience provides its share of disquieting impulses to end lives that observers think not worth living, or not worth supporting. Consider the words of the now-much-admired social reformer Charlotte Perkins Gilman, who in 1935 advocated "mercy killing" for "'incurable invalids', 'hopeless idiots', 'helpless paretics', and certain grades of criminals.'" She "asserted that 'the dragging weight of the grossly unfit and dangerous could be lightened'" in this way "'with great advantage to the normal and progressive.'"[42]

How can we summarize the lessons of the American experience with law at the end of life? Ultimately, I believe, it teaches us that we are condemned to uncertainty and sorrow. However deeply we think, we cannot know how to resolve every case. The strength of reason is too weak. However hard we try, we cannot write rules that will cause all cases to be decided as we would wish. The power of language is too poor. We are trapped in our own ambivalence about what is good and our own inability to attain even what we know is right.

Medical progress and the temper of our times have made the old rules unworkable. And surely rules that sentence the dying and the destroyed to prolonged and helpless agony can make the top of the slippery slope seem as

cruel as the bottom. But the new rules to which we are moving seem fraught with peril. In part, I believe we must accept that the law need not and cannot by itself assume the whole social burden of these decisions. Some responsibility should and will be borne by patients themselves, by their doctors, and by their families. But I believe our best hope in this uncertainty lies in candid, open, and civil public discussion of an issue about which we will disagree entirely, passionately, and irreconcilably. How else can we make wise policy about law at the end of life in the democratic society to which we are committed?

I must close as I began, with a story. This is the true story of Carrie Coons, of Rensselaer, New York. This elderly lady fell into a persistent vegetative state. The doctors said her condition was hopeless and that she had no chance of recovery. Her eighty-eight-year-old sister asked a court to approve the removal of a feeding tube. The court agreed. Before the order could be carried out, however, her nurses asked her doctor to visit her. He found her awake and even alert. He described her legal problem to her. He asked what should be done. She replied, "These are difficult decisions." And she lapsed back into sleep.[43]

NOTES

1. 117 S Ct 2258 (1997).
2. Patients in this condition are unconscious and have lost higher cerebral functions. However, the brain stem, which controls "vegetative" functions, continues to work. See Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, Hastings Center Report 27 (Feb/Mar 1988).
3. In the Matter of Quinlan, 355 A2d 647, 667 (1976).
4. Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 Minnesota Law Review 969, 971 (1958).
5. 165 F2d 152 (1947).
6. Ibid. at 153.
7. Ibid. at 154–55.
8. In the Matter of Quinlan, 355 A2d 647 (1976). For a discussion of the historical importance of this case, see ch 9 of David J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making* (Basic Books, 1991).
9. 355 A2d at 664.
10. Ibid. at 664.
11. Ibid. at 663.
12. "[O]ne would have to think that the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient." Ibid. at 668.
13. *Cruzan v Director, Missouri Department of Health*, 497 U.S. 261, 290 n2 (1990) (O'Connor, J., concurring).
14. *Cruzan v Director, Missouri Department of Health*, 497 U.S. 261, 262 (1990).
15. Ibid. at 352.
16. Ibid. at 309.
17. Ibid. at 308.
18. Ibid. at 302.
19. Ibid. at 350.

20. Ibid. at 312 n11.
21. Gale P. Largey & Richard N. Feil, *Knowing the Public Mind,* 20 Hastings Center Report 3, 3 (July/Aug 1990).
22. Andrew H. Malcolm, "Judge Allows Feeding-Tube Removal," *New York Times,* Dec 15, 1990, § 1, at 10, col. 1.
23. Richard A. Knox, "Igniting a Deadly Debate," *Boston Globe,* Oct 27, 1991, 1.
24. *People v Kevorkian,* No. 93–11482 (Mich Cir Ct Wayne Cty Dec 13, 1993).
25. *People v Kevorkian,* 527 NW2d 714 (Mich 1994).
26. *Compassion in Dying v Washington,* 850 F Supp 1454 (WD Wash 1994).
27. *Compassion in Dying,* 79 F3d 790 (1996).
28. *Quill v Vacco,* 80 F3d 716 (1996).
29. 79 F3d at 793.
30. 117 S Ct 2302 (1997).
31. 117 S Ct 2293 (1997).
32. See particularly Sonia M. Suter, *Ambivalent Unanimity: An Analysis of the Supreme Court's Holding,* in this volume.
33. Andrew H. Malcolm, "Missouri Family Renews Battle Over Right to Die," *New York Times,* Nov 2, 1990, A14, col. 3.
34. 79 F3d at 794.
35. For a careful analysis of the slippery-slope argument, see Frederick Schauer, *Slippery Slopes,* 99 Harvard Law Review 361 (1985).
36. Carl E. Schneider, *Rights Discourse and Neonatal Euthanasia,* 76 California Law Review 151, 168 (1988).
37. For masterful treatments of the slippery-slope problem, see Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation,* 42 Minnesota Law Review 969 (1958), and Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There* No *Constitutional "Right to Live"?,* 25 Georgia Law Review 1203 (1991).
38. The *Quinlan* court seemed to believe that Quinlan was terminally ill, but that was in the face of the evidence available at the time, and, of course, it was wrong in fact.
39. Andrew H. Malcolm, "Right-to-Die Case Nearing Finale," *New York Times,* Dec 7, 1990, A24, col. 1.
40. See, e.g., Timothy E. Quill, *Death and Dignity: Making Choices and Taking Charge* (W. W. Norton, 1993).
41. As to error in diagnoses of the persistent vegetative state, Cranford notes that "even the generally accepted criteria, when properly applied, are not infallible. There have been a few unexpected, but unequivocal and well documented, recoveries of cognitive functions in situations where it was believed that the criteria were correctly applied by several neurologists experienced in the diagnosis of this condition." Cranford, *The Persistent Vegetative State* 29–30 (cited in note 2).
42. *The Right to Die,* 94 The Forum 297–300 (1935), quoted in Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation,* 42 Minnesota Law Review 969, 1019 (1958).
43. Sam Howe Verhovek, "Right-to-Die Order Revoked As Patient in Coma Wakes," *New York Times,* Apr 13, 1989, B3.