

ASSISTED SUICIDE, EUTHANASIA, AND THE LAW

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[Editor's Note: As a contribution to analyzing an increasingly prevalent social phenomenon, this Note on Moral Theology discusses recent developments related to physician-assisted suicide, euthanasia, and the law; in particular Compassion in Dying v. Washington and Quill v. Vacco, the decisions of the Ninth and Second Circuit Courts of Appeals that found a constitutional "right to die" on behalf of competent, terminally ill patients.]

IS IT EVER morally right intentionally to kill innocent human beings in order to spare them the suffering that continued life would bring? If so, under what circumstances? If not, why not? Furthermore, which courses of action count as intentional killing in the context of medical decision making? When is it morally acceptable to forgo certain medical care, although it will likely prolong a patient's life? When is it permissible to seek certain treatment, despite the fact that it will probably hasten a patient's death?¹

These are the first-order moral questions raised by the closely related matters of assisted suicide and euthanasia. They are not unfamiliar to the readers of this journal. In recent years both Lisa Sowle Cahill and John Paris have discussed here bioethical issues relating to the end of life. Cahill devoted the majority of her attention to the controversial issue of whether or not artificial nutrition and hydration may be withheld or withdrawn from patients in a persistent vegetative state; she also probed contemporary discussions of whether taking active steps to end a patient's life might be justified in exceptional

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¹ I use the terms "physician-assisted suicide" or "assisted suicide" to refer to situations in which a physician prescribes a lethal dose of medication that is self-administered by the patient. The term "euthanasia" in general refers to a situation in which one party adopts a course of action with the intention of causing the death of a second party in order to alleviate suffering. "Voluntary" euthanasia is performed at the request of the patient; "nonvoluntary" euthanasia is performed on patients who have expressed and can express no view on the matter; and "involuntary" euthanasia is performed against the expressed will of the patient, or before consulting a competent patient who has as yet expressed no view.

cases. Paris delved more deeply into the latter question, offering a brief history of the euthanasia movement in Europe and the United States, as well as an unsettling critique of the practice of euthanasia in the Netherlands.²

In the years following Cahill's and Paris's discussions, the fervor of the national debate over assisted suicide and euthanasia has not abated. Instead, it has been recast in legal, individualistic terms, in a manner disturbingly reminiscent of our intractable social battles over abortion. No longer at the forefront of the discussion is the question when, if ever, it is *morally right* for dying or seriously ill individuals intentionally to take their own lives. Instead, the issue occupying center stage is whether they should have a *legal right* to do so, and if necessary to enlist the aid of a physician willing to prescribe the lethal dose.

Three events have hardened this shifting tenor of the national discussion of physician-assisted suicide and euthanasia. First, Dr. Jack Kevorkian's crusade to provide lethal assistance to persons seeking to end their own lives has gained momentum, as well as the appearance of impunity. Kevorkian has now facilitated the deaths of nearly 50 individuals, many of whom were not in the last stages of terminal illness, but plagued with chronic, degenerative afflictions such as Lou Gehrig's or Alzheimer's disease. In August 1996, Kevorkian's assistance at the death of Judith Curren, a 42-year-old woman suffering from obesity and chronic-fatigue syndrome, provoked sustained criticism by both opponents and supporters of legalizing assisted suicide. While opponents perceived this case to be emblematic of the dangers entailed by the practice, proponents contended that only legislation and regulation will curtail the abuses of mavericks like Kevorkian.³ Second, in 1995, Oregon became the first state to legalize physician-assisted suicide. In 1995–1996, bills were introduced in at least 15 other states to allow "aid-in-dying."⁴ Finally, in 1996, two federal courts of appeals proclaimed a new constitutional right protecting some types of physician-assisted suicide.

What should be the appropriate stance of the criminal and civil law toward various types of physician-assisted suicide and euthanasia? This question is extremely complex. At the heart of the matter, of course, are the moral questions alluded to in our opening paragraph.

² See Lisa Sowle Cahill, "Bioethical Decisions to End Life," *Theological Studies* 52 (1991), 107–127; John J. Paris, S.J., "Active Euthanasia," *TS* 53 (1992) 113–26. For a history, consult E. J. Emanuel, "The History of Euthanasia Debates in the United States and Britain," *Annals of Internal Medicine* 121 (1994) 793–802; Emanuel concludes that the arguments for and against euthanasia have not changed in the past 120 years.

³ Julia Pugliese, "Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide," *Hastings Law Journal* 44 (1993) 1291–1330.

⁴ See Charles H. Baron et al., "A Model State Act to Authorize and Regulate Physician-Assisted Suicide," *Harvard Journal on Legislation* 33 (1996) 1–34.

However, the resolution of the moral issue in and of itself does not dictate sound law. In some cases, a society might rightly choose not to punish acts it believes to be seriously immoral. Conversely, a society might decide to enact a blanket prohibition against certain types of behavior, despite the fact that they might be morally permissible in certain cases. Key factors in the decision about criminalization include whether the behavior in question directly harms only the individual performing it or others as well, how widely supported the moral judgment about that behavior is, whether the prohibition will be an effective deterrent, the level of resources required to enforce it, and the probability that it can be enforced equitably. Another crucial consideration is the undeniable pedagogical function of the law: how will enacting or repealing the relevant criminal prohibition, when combined with other aspects of our legal system, shape our understanding of a virtuous life and a good community?⁵ These are not questions that can be answered in the abstract, but only with reference to the dynamics of life within a particular society at a particular point in its history. The fundamental question is what legal framework will enhance the common good, and how the particular prohibition at stake coheres with that framework. In the U.S. this question at times becomes entangled in matters of American constitutional law.⁶ When the courts articulate a new constitutional right, they effectively prevent the elected representatives of the people from implementing any legal framework the courts judge to be inconsistent with that right.

In this note I shall first critically examine *Compassion in Dying v. State of Washington* and *Quill v. Vacco*,⁷ the assisted suicide decisions

⁵ For an examination of the pedagogical function of the law in the case of abortion, see M. Cathleen Kaveny, "Toward a Thomistic Perspective on Abortion and the Law in Contemporary America," *The Thomist* 55 (1991) 343–96.

⁶ The literature on assisted suicide and the law is burgeoning. See, e.g., a symposium on assisted suicide and religious liberty in *Issues in Law & Medicine* 10:2 (1994); a symposium in *Ohio Northern University Law Review* 20 (1993); George J. Annas, "The 'Right to Die' in America: Sloganeering from Quinlan and Cruzan to Quill and Kevoorkian," *Duquesne Law Review* 34 (1996) 875–97; Gerard V. Bradley, "Life's Dominion: A Review Essay," *Notre Dame Law Review* 69 (1993) 329–91; Mark E. Chopko and Michael F. Moses, "Assisted Suicide: Still a Wonderful Life?" *Notre Dame Law Review* 70 (1995) 519–80; Yale Kamisar, "Against Assisted Suicide—Even A Very Limited Form," *University of Detroit Mercy Law Review* 72 (1995) 735–69; Sylvia A. Law, "Physician-Assisted Death: An Essay on Constitutional Rights and Remedies," *Maryland Law Review* 55 (1996) 292–342; Richard S. Myers, "An Analysis of the Constitutionality of Laws Banning Assisted Suicide from the Perspective of Catholic Moral Teaching," *University of Detroit Mercy Law Review* 72 (1995) 771–86; Matthew P. Previn, "Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life," *Georgetown Law Journal* 84 (1996) 589–616; and T. Howard Stone and William J. Winslade, "Physician-Assisted Suicide and Euthanasia in the United States," *The Journal of Legal Medicine* 16 (1995) 481–507. See also the wide-ranging testimony found in Congress, House, Committee on the Judiciary, *Assisted Suicide in the United States: Hearing before the Subcommittee on the Constitution*, 104th Cong., 2nd sess., 29 April 1996, Serial 78.

⁷ The named plaintiff in this case is activist Timothy E. Quill, M.D., whose recent writings include *Death and Dignity: Making Choices and Taking Charge* (New York:

of the Ninth and Second Circuits.⁸ Then I shall discuss the dangers posed by legalization, evaluate the relationship between law and morality in recent relevant Supreme Court cases, and probe the relationship between the individual good and the common good. Finally, I shall touch upon some insights that the encyclical *Evangelium vitae* might bring to the convergences of law and morality at the end of life.

THE CIRCUIT COURT DECISIONS

Within a one-month period in the early spring of 1996, two federal courts of appeals handed down decisions with momentous implications not only for medical decision making at the end of life, but also in the context of severely painful or debilitating illness. Both courts held unconstitutional state prohibitions against aiding or abetting suicide, when those laws are applied to physicians prescribing lethal doses of medication for use by their competent, terminally ill patients. While agreeing upon the proper fate of the statutes in question, the two courts emphasized different aspects of the jurisprudential path taken to achieve it. The Supreme Court has granted certiorari to the two cases, and will likely render its decision late in the spring of 1997. No matter how the Court decides, the arguments raised by the Ninth and Second Circuits will shape the public discussion of assisted suicide and euthanasia for years to come.⁹

Compassion. In *Compassion in Dying v. State of Washington*, an eleven-member en banc panel of the Ninth Circuit Court of Appeals held that individuals have a constitutionally protected "liberty interest" in "choosing the time and manner of one's death."¹⁰ This liberty interest does not have a clear textual basis in the Constitution. Where, then, does it come from? Writing for the en banc majority,

W. W. Norton, 1993); "Physician-Assisted Death: Progress or Peril?" *Suicide and Life-Threatening Behavior* 24 (1994) 315-25; and with Christine K. Cassel and Diane E. Meier, "Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide," *New England Journal of Medicine* 327 (1992) 1380-84.

⁸ *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) and *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

⁹ For a helpful collection of articles largely from a liberal perspective, see *The Right to Die*, 2 vols., ed. Melvin I. Urofsky and Philip E. Urofsky (New York: Garland, 1996); see also Margaret Pabst Battin's influential work in *The Least Worst Death: Essays in Bioethics on the End of Life* (New York: Oxford University, 1994), and the articles in the Hastings Center issue "Dying Well? A Colloquy on Euthanasia and Assisted Suicide," *Hastings Center Report* 22:2 (1992).

¹⁰ The majority opinion anchors this liberty interest in the Due Process Clause of the Fourteenth Amendment, which provides in part that no state shall "deprive any person of life, liberty, or property, without due process of law." Although the Due Process Clause is seemingly limited to the design and implementation of fair governmental procedures, the Court has also interpreted it to protect certain substantive concerns that are "implicit in the concept of ordered liberty" (*Palko v. Connecticut*, 302 U.S. 319, 325-26 [1937]).

Judge Stephen Reinhardt attempts to anchor it in two cases recently decided by the Supreme Court: *Planned Parenthood v. Casey*, which reaffirmed a woman's constitutional right to abortion before fetal viability, and *Cruzan v. Director, Missouri Dept. of Health*, which assumed without deciding that competent adults have a constitutionally protected liberty interest in refusing medical treatment, including life-saving procedures and artificial hydration and nutrition.¹¹ A close examination of Reinhardt's reasoning reveals that neither case places his argument on solid ground.

Reinhardt relies upon what is colloquially referred to as *Casey's* "mystery passage," which spirals to the heights of rhetorical extravagance in describing the constitutional status of decisions about whether or not to conceive or bear a child: "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 Judging the decision of how and when to die to be at least as "intimate and personal" as the choice whether or not to obtain an abortion, Reinhardt concluded that "a competent, terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent."¹³

Reinhardt badly misconstrues both *Casey* and the role the mystery passage plays in that decision. *Casey* is not a ringing endorsement of an expansive jurisprudence of substantive due process. Although the *Casey* Court continues to protect a woman's choice between abortion and childbirth, it recharacterizes that choice more circumspectly as a "liberty interest" rather than as a "right," which it then situates within (and constrains by) the context of the longstanding constitutional protection given to "personal decisions related to marriage, procreation, contraception, family relationships, child rearing, and education." Furthermore, the Court does not rest its holding solely or even primarily on the importance of that liberty interest to women. Instead, in justifying its decision in *Casey*, the Court emphasizes the importance of the doctrine of *stare decisis*, which directs courts to give great although not conclusive deference to their own prior decisions. Finally, the Court articulates its fears that overruling *Roe* would "seriously weaken the Court's capacity to exercise the judicial power" by creating the appearance that it had capitulated to political pressure.¹⁴

¹¹ *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

¹² *Casey*, 505 U.S. at 851.

¹³ *Compassion*, 79 F.3d at 814.

¹⁴ *Casey*, 505 U.S. at 865.

Taken in context, then, the mystery passage is designed to provide rhetorical support for the Court's decision not to overrule *Roe*, despite its sober and explicit recognition of the serious criticisms that can be leveled against that decision, and its acknowledgment that, but for *stare decisis* and concerns about respect for the Court, some or all of the authors of the mystery passage itself might have denied or severely limited the constitutional right to abortion. This mystery passage cannot be the touchstone for an expansive and aggressive jurisprudence of individual rights. As Judge Diarmuid F. O'Scannlain, dissenting from an order denying rehearing by the full court, trenchantly queried, "if physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and indeed, the use of illicit drugs?"¹⁵

Reinhardt's attempts to draw support for the "right to die" from the Supreme Court's opinion in *Cruzan* are equally misbegotten. He correctly notes that the *Cruzan* majority assumed without deciding that a competent adult has a constitutionally protected liberty interest in refusing unwanted medical treatment, including artificial nutrition and hydration.¹⁶ He also rightly observes that in some cases, including that of Nancy Cruzan herself, refusal of medical treatment will lead inexorably to the patient's demise. From these two points, he leaps to the conclusion that "*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a *liberty interest in hastening one's own death*" (emphasis added). This leap is unwarranted, both in logic and in law.

First, a fair reading of *Cruzan* demonstrates that the right to refuse treatment is firmly grounded in the longstanding common-law prohibition against battery, which is generally if somewhat loosely defined as "unconsented touching."¹⁷ The liberty interest assumed by *Cruzan* is designed to protect each individual's bodily integrity against unwanted invasion in the name of medical science. To put the matter bluntly, it ensures that a competent individual will *not* be strapped to a gurney, intubated, sedated, and medicated without her consent, no matter how strongly her physicians believe such treatment to be necessary for her own well-being. The fundamental concern of the liberty interest assumed by *Cruzan* is not the "right to die," but the right to *live* unencumbered by unwelcome medical treatment. In some but

¹⁵ *Compassion in Dying v. State of Washington*, order denying request for rehearing by the full court, 85 F.3d 1440, 1444 (O'Scannlain, J., dissenting).

¹⁶ *Compassion*, 79 F.3d at 814–815, citing *Cruzan*, 497 U.S. at 278.

¹⁷ Building upon common expectations, the law generally *presumes* that incompetent persons would consent to life-saving medical treatment if they were able to do so, e.g., in the case of accident victims found lying unconscious by the side of the road. The narrow legal issue decided by *Cruzan* is that it is not unconstitutional for a state to require clear and convincing evidence rebutting that presumption before permitting life-saving treatment to be withheld or withdrawn from incompetent patients.

by no means all cases, a competent individual's decision to refuse such treatment may result in the "hastening of her death," sometimes intentionally so. In still fewer instances the refusal of treatment will allow the patient actually "to determine the time and manner" in which she dies. When Reinhardt recharacterizes the *Cruzan* liberty interest in these terms, he illegitimately replaces the fundamental purposes that the interest does further, and the purposes intended to be promoted by acknowledging the interest, with certain effects that may obtain when it is exercised in particular instances.

There are three possible dangers involved in this type of recharacterization.¹⁸ First, the effect in question might be antithetical to the very purpose of the right at stake. In this case, such a redescription will conflate the use of a right with its abuse. For example, it is not acceptable to redescribe the "free speech rights of the media" as the "right negligently to print false statements about public figures," although the Supreme Court has interpreted the First Amendment as forbidding successful libel suits in such situations.¹⁹

Second, although the effect in question might not directly conflict with the purpose of the liberty interest, it might be socially undesirable on other grounds. For example, it is inappropriate to redescribe the right to diplomatic immunity as the "right to flout the law," although one result of such a right will be that foreign diplomats will do precisely that.

Third, in some instances, the terms used to delineate a right may on their face encompass behavior that implicates other complicated issues of social importance. To recharacterize this behavior as itself a right would be to settle those issues prematurely. For example, a woman who has conceived and given birth to a baby has the right to choose whether to relinquish or retain her parental rights. Terminologically, this right is defined sufficiently broadly to encompass a situation in which a woman plans from the beginning to give birth to a baby who will be given up for adoption. However, as the vigorous debates over "Baby M" demonstrate, we have balked at creating a new "right to be a surrogate mother" simply because the words used to define another right can on their face be extended to encompass this behavior. Rights language creates and legitimates social practices. Precisely because the social practice of surrogate motherhood raises troublesome issues about exploitation of poor women and commercialization of children, its existence or nonexistence cannot be set-

¹⁸ The recharacterization actually involves four distinct steps: (1) description of the source right (right to refuse medical treatment); (2) explicit acknowledgment that the behavior protected by the source right may on occasion result in certain effects (right to refuse life-saving medical treatment, thereby hastening death); (3) redescription of the source right to focus on the effects, thereby creating a new right (right to hasten death); and (4) expansion of the new right to cover new situations (right to hasten death with medication prescribed by a physician).

¹⁹ *New York Times v. Sullivan*, 376 U.S. 254 (1964).

tled on terminological grounds. At the very least, Reinhardt's recharacterization of the *Cruzan* liberty interest involves the third type of mistake; as described below, the social practice of "aid-in-dying" may have troublesome ramifications, particularly for the weak and vulnerable members of society.

The tenuous jurisprudential roots of *Compassion's* newly announced liberty interest in "determining the time and manner of one's death" are further burdened by the broad and uncertain extent of its branches. The actual holding of the case is quite limited: the Washington statute is held unconstitutional only as applied to "the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths."²⁰ Nonetheless, there is no reason in the logic of the liberty interest to so constrict its application. In fact, the trajectory of a rapidly expanding "right to die" is clearly marked in Reinhardt's opinion.

First, by what rationale may this liberty interest be limited to the terminally ill? Is not the interest equally if not more important to those afflicted with severely debilitating chronic diseases, since they face a longer period of suffering? *Compassion* suggests as much, noting that its conclusion is "strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults."²¹

Second, it is not clear why this liberty interest should be limited to patients who are actually able to ingest the deadly medication themselves. Should not those too debilitated to perform the final lethal act also be able "to determine the time and manner of their own deaths"? Indeed, Reinhardt all but directs the expansion of the liberty interest from physician-assisted suicide to encompass voluntary active euthanasia.²²

Third, and most remarkably, even the court's emphasis on the key role played by the *patient's voluntary decision* proves to be fleeting. Buried at the end of a long footnote is a sentence that redefines *voluntary* euthanasia to encompass *nonvoluntary euthanasia performed with proper authorization*: "Finally," says the court, "we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself."²³ On the view encapsulated in this footnote, if the guardian of an elderly, incompetent patient suffering from Alzheimer's disease requests that the ward be put to death in order to preserve her dignity, this counts as an instance of *voluntary* euthanasia.

²⁰ *Compassion*, 79 F.3d at 798.

²¹ *Compassion*, 79 F.3d at 816.

²² "We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between voluntary and involuntary termination of an individual's life. . . . We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end" (*Compassion*, 79 F.3d at 831-32).

²³ *Compassion*, 79 F.3d at 832, n. 120.

In short, the holding of *Compassion* is extraordinarily deceptive. A reader begins by taking at face value Reinhardt's statement that the liberty interest in determining the time and manner of one's death will be operative only in narrowly circumscribed circumstances. She ends by wondering what, if any, limitations remain on the right to aim at the death of oneself or a person in one's care, provided that one's motives are to eliminate suffering. The only type of behavior that cannot glean implicit or explicit authorization in this opinion is the euthanasia of a currently competent person against her will.

Quill. In both structure and rhetoric, Reinhardt's opinion in *Compassion* is eerily reminiscent of Justice Blackmun's opinion in *Roe v. Wade*,²⁴ which many scholars consider to be the high water mark of judicial activism in the articulation of constitutionally protected individual rights. However, in recent years, the Supreme Court has expressed extreme skepticism about the soundness of *Roe*'s approach to constitutional interpretation.²⁵ Consequently, Reinhardt's opinion might garner little support from the current justices. In contrast, the Second Circuit's opinion in *Quill v. Vacco* does not exhibit the same jurisprudential defects as does *Compassion*, at least on a superficial level. In fact, *Quill* flatly rejects the argument that the right to assisted suicide is embedded in the Due Process Clause.²⁶ Instead, it anchors its holding in the Equal Protection Clause of the Fourteenth Amendment. In general, the Equal Protection Clause requires a state to treat similarly situated individuals in a similar manner. Of necessity, states employ numerous ways of categorizing human persons and their actions when enacting and applying laws. In order to survive an Equal Protection challenge, a statutory scheme of categorization that does not impinge upon a fundamental right or employ a suspect category (e.g. race, gender, or illegitimacy) need only be "rationally related to a legitimate state interest." Normally, this is a very low threshold for a state law to meet.

Nonetheless, the Second Circuit held that a New York law prohibiting aiding and abetting suicide does not meet that threshold, because it "does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such

²⁴ In fact, *Compassion* reads as if it is scrupulously following *Roe*'s "formula" for identifying and promulgating new constitutional rights. *Roe* talks of "back alley" abortions, while *Compassion* writes also of "back alley" assisted suicides; *Roe* includes a sweeping discussion of the phenomenon of abortion from ancient times to the present, while *Compassion* proffers a similar survey about attitudes toward suicide; *Roe* speaks with eloquent optimism about the power of virtuous physicians to ensure that the new abortion right is not abused, while *Compassion* passionately proclaims the ability of physicians to identify and forestall inappropriate cases of assisted suicide.

²⁵ See, e.g., *Bowers v. Hardwick*, 478 U.S. 186, 190 (1986) (refusing to extend the right of privacy to consensual homosexual sodomy).

²⁶ *Quill*, 80 F.3d at 724.

systems; but those who are similarly situated except for the previous attachment of life sustaining equipment are not allowed to hasten death. . . .²⁷ According to *Quill*, the state has no reason for treating these two groups of patients in a different manner.

There are two interlocking problems with *Quill's* analysis. First, *Quill* makes the same mistake as *Compassion* with respect to the description of the right to refuse medical treatment. Both opinions move illegitimately from the fact that in some instances, the right to refuse medical treatment foreseeably results in a more rapid death (which in some cases will have been the intention of the right-holder) to a redescription of that right as "the right to hasten death."²⁸

Second, by incorporating this first mistake into its Equal Protection analysis, *Quill* proceeds as if the state deliberately adopted a statutory scheme that conferred upon one favored group of terminally ill patients the right to hasten their own deaths, while denying this right to others in equally dire straits. Perhaps this *would* be an irrational classification scheme; however, it is *not* one that New York has adopted. Rather, the legal framework at issue consisted of two distinct elements: (1) the statute prohibiting aiding and abetting suicide in general; and (2) the constitutional, common law, and statutory right of all competent adults to refuse medical treatment (whether terminally ill or not). Clearly, there is no irrational scheme used to classify individuals in either element. For this reason, the *Quill* court's invocation of Equal Protection jurisprudence is deeply deceptive. Under the guise of prohibiting New York from employing a method of categorizing persons chosen by its legislature, *Quill* is in fact directing the state to implement an entirely new classification scheme *chosen by the Court itself*—one that categorizes persons according to whether or not they are competent and terminally ill. Furthermore, it confers a new right upon those who qualify under this newly constructed category. In the end, then, *Quill* is a jurisprudential Trojan horse: under the guise of a circumspect analysis under the Equal Protection Clause's deferential "rational basis" test, the Second Circuit has in fact created an aggressive new liberty interest.²⁹

²⁷ *Quill*, 80 F.3d at 729.

²⁸ See, e.g., *Quill*, 80 F.3d at 728. The opinion describes New York's health care agent statute, which enables patients to delegate another individual to make medical decisions on their behalf when they are no longer able to do so themselves. After observing that these decisions encompass the withholding or withdrawal of life-sustaining treatment, the opinion redescribes the power created by the statute as the right to hasten one's own death. "Accordingly, a patient has the right to hasten death by empowering an agent to require a physician to withdraw life-support systems."

²⁹ The Supreme Court has stated that the requirements of equal protection are implicated by the Due Process Clause of the Fifth Amendment; see *Bolling v. Sharpe*, 347 U.S. 497 (1954) and *Adarand Constructors, Inc. v. Peña*, 115 S.Ct 2097 (1995).

COMMON PROBLEMS FOR THE COMMON GOOD

In addition to their jurisprudential boldness, the Second and Ninth Circuits share a surprisingly sanguine attitude toward the potential for abuse entailed by legalization of assisted suicide and euthanasia. Several critical problems associated with legalizing, and therefore legitimizing, assisted suicide and euthanasia are discussed below.

Doctors as Killers. Physician-assisted suicide and voluntary euthanasia are not "private choices." They are choices that require the involvement of some of the most powerful figures in American society: members of the medical profession. Doctors who agree to participate in one or more instances of voluntary euthanasia or assisted suicide will not stop practicing medicine after so doing. They will go on to care for other persons who need their help, with their professional sensibilities now shaped by this new experience.³⁰ How will giving physicians the power to kill alter the character and ethos of the medical profession?³¹ In *Compassion*, the Ninth Circuit expressed the confidence 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."³² The American Medical Association does not take the same sanguine view of the matter.³³ Nor does Leon Kass. A physician as well as a philosopher, Kass is well aware of just how

³⁰ On physicians, virtue, and euthanasia, see Grant R. Gillett, "Learning to Do No Harm," *Journal of Medicine and Philosophy* 18 (1993) 253–68.

³¹ Numerous studies have been conducted on the attitudes of physicians and the public regarding the role of the physician in assisted suicide and voluntary euthanasia. See, e.g., "Been There: Physicians Speak for Themselves," *Cambridge Quarterly of Healthcare Ethics* 2 (1993) 9–17; Jerald G. Bachman et al., "Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia," *New England Journal of Medicine* 334 (1996) 303–15; Anthony L. Back et al., "Physician-Assisted Suicide and Euthanasia in Washington State," *Journal of the American Medical Association* 275 (1996) 919–25; David P. Caddell and Rae R. Newton, "Euthanasia: American Attitudes Toward the Physician's Role," *Social Science Medicine* 40 (1995) 1671–81; Chris Ciesielski-Carlucci, "Physician Attitudes and Experiences with Assisted Suicide: Results of a Small Opinion Survey," *CQHE* 2 (1993) 39–44; Merrijoy J. Kelner, Ivy L. Bourgeault, and Judith A. Wahl, "Regulation and Legislation of the Dying Process: Views of Health Care Professionals," *Death Studies* 18 (1994) 167–81; and Mildred Z. Solomon et al., "Decisions Near the End of Life: Professional Views on Life-Sustaining Treatment," *American Journal of Public Health* 83 (1993) 14–25. On the criminal law and physician conduct, see Norman L. Cantor and George C. Thomas III, "Pain Relief, Acceleration of Death, and Criminal Law," *Kennedy Institute of Ethics Journal* 6 (1996) 107–27.

³² "We do 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" (*Compassion*, 79 F.3d at 827).

³³ For arguments that assisted suicide is compatible with the physician's integrity, see Franklin G. Miller and Howard Brody, "Professional Integrity and Physician-Assisted Death," *Hastings Center Report* 25:3 (1995) 8–17; Richard Momeyer, "Does Physician Assisted Suicide Violate the Integrity of Medicine?" *Journal of Medicine and Philosophy* 20:1 (1995) 13–24.

difficult it can be to treat patients who are rapidly losing ground; house officers refer to them as "gorks," "gomers," and "vegetables." He suggests that making assisted death an option will impede the ability of physicians to enter fully into the task of caring for their patients.³⁴

Furthermore, there is reason to question whether the availability of assisted death will give physicians, as well as members of the broader medical community, an excuse for not remedying profound inadequacies in the way the U.S. health-care system currently manages end-of-life issues. These inadequacies are severe. In 1989, researchers began a comprehensive investigation of death and dying in American hospitals: the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT).³⁵ Phase I of the study concluded that for too many patients, dying in a hospital was a horrible thing. For example, many of the terminally ill patients included in the study had advanced directives that were hastily adopted in the last days of their illness. Patients' desires regarding end-of-life treatment were frequently not understood or respected by their physicians. Moreover, at least half the patients who could communicate reported moderate to severe pain at least half the time in the last three days of their lives.³⁶ If anything, however, Phase II of the study is more disturbing. After designing and implementing procedures to ameliorate some of the worst aspects of dying in a hospital, the investigators concluded that they had failed to achieve their goals. A key element of the failure was the inability or unwillingness of physicians to change their practice patterns to improve communication with their patients on end-of-life issues.

A closely related question is how the legalization of assisted suicide will affect the relationship between the physician and the patient.³⁷ How will introducing lethal options into the mix change their conversation with patients? In a recent debate with Ronald Dworkin, John Finnis perceptively wondered whether the practice will create "a new zone of silence" between doctors and patients. "Can I safely speak to my physician about the full extent of my sufferings, about my fears, about my occasional or regular wish to be free from my burdens? Will my words be heard as a plea to be killed? As a tacit permission?"³⁸

³⁴ Leon R. Kass, "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest* 94 (Winter 1989) 25-46. For a helpful anthology with several articles touching upon the physician's role, see *Arguing Euthanasia*, ed. Jonathan D. Moreno (New York: Simon & Schuster, 1995).

³⁵ "Dying Well in the Hospital: The Lessons of SUPPORT," *Hastings Center Report* 25:6 (1995) (special supplement) S1-S36.

³⁶ The New York State Task Force highlighted the inadequate pain management many patients receive, despite the availability of effective approaches (The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* [1994] chap. 3).

³⁷ See the classic work by Jay Katz, *The Silent World of Doctor and Patient* (New York: Free Press, 1984).

³⁸ John Finnis, "Euthanasia, Morality, and Law," Harry B. Burns Lecture, Loyola Marymount Law School, Los Angeles, Calif., November 22, 1996, 13. Dworkin's com-

Managed Care. The problems associated with giving physicians the power to kill are even more acute when we take into account the "managed care" revolution currently underway in the American health-care financing and delivery system.³⁹ Both the Second and Ninth Circuits appear nearly oblivious to this fact. Two aspects of this revolution are particularly likely to exacerbate the dangers associated with legalizing assisted suicide.⁴⁰ First, under managed care, most providers have a financial incentive to *limit* the treatment provided to their patients. Studies have shown that most health-care costs can be traced to expenses incurred in the last months of life. Employers and insurance companies could achieve great financial savings by encouraging patients to choose assisted suicide at the "appropriate" time.

Second, managed care is rapidly altering the nature of the physician-patient relationship.⁴¹ Employers frequently change health plans in order to obtain the lowest price, and health plans frequently reconfigure their provider panels in order to achieve greater efficiencies. Consequently, fewer patients may be able to develop the sort of stable, long-term relationship with a doctor that is presupposed by the Ninth Circuit as the appropriate setting for decisions about assisted suicide. In addition, it may be highly imprudent for patients to place too much trust in the advice of their physicians on these matters. More and more physicians are employed by managed care organizations (MCOs), or heavily dependent upon contracts with such organizations for their livelihood. They may be required contractually to follow the treatment protocols of the MCO. Furthermore, their compensation may depend in part upon their ability to hold down the costs of health care. As medical ethicist Susan Wolf has observed, physicians may find themselves in a crucible of conflicting interests and responsibilities, with loyalty to the patient only one element in the mixture.⁴²

The Plight of the Vulnerable. The New York Task Force on Life and the Law, whose membership encompassed a wide range of views on

mentary on the decisions of the Second and Ninth Circuits can be found in his "Sex, Death, and the Courts," *New York Review of Books* 43 (August 8, 1996) 44–50; see also his *Life's Dominion* (New York: Alfred A. Knopf, 1993).

³⁹ The literature on managed care is voluminous. For a brief introduction to its ethical problems, see M. Cathleen Kaveny and James F. Keenan, S.J., "Ethical Issues in Health-Care Restructuring," *TS* 56 (1995) 136–50. On physician conflicts and managed care, see David Orentlicher, "Paying Physicians More to Do Less: Financial Incentives to Limit Care," *University of Richmond Law Review* 30 (1996) 155–197.

⁴⁰ See M. Cathleen Kaveny and John Langan, S.J., "The Physician's Call," *New York Times*, 15 July 1996, A-11.

⁴¹ See, e.g., David Mechanic, "Changing Medical Organization and the Erosion of Trust," *The Milbank Quarterly* 74 (1996) 171–89; Marcia Angell, "The Doctor as Double Agent," *Kennedy Institute of Ethics Journal* 3 (1993) 279–86.

⁴² Susan M. Wolf, "Health Care Reform and the Future of Physician Ethics," *Hastings Center Report* 24:2 (1994) 28–41.

the ethical issues, unanimously concluded that assisted suicide and euthanasia would be "profoundly dangerous" for "those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group."⁴³ Incredibly, *Quill* cites the Task Force report without responding to this conclusion.⁴⁴ The Ninth Circuit does no better in its treatment of dangers to vulnerable populations. *Compassion* contends the real problem is that the poor and the handicapped will be *denied* the right to kill themselves.⁴⁵

In addition to the poor, the elderly,⁴⁶ the mentally impaired,⁴⁷ and women⁴⁸ all face special risks in a regime of legalized aid-in-dying. Both practical and theoretical forces converge to magnify these risks. As a practical matter, American society is simply not committed to providing members of these groups with the social support and resources that they need. Our most recent attempt to provide universal health care was a dismal failure. Congress and the states are slashing Medicare and Medicaid in order to reduce the federal deficit and cut taxes. Furthermore, the theoretical justifications used for assisted suicide locate the true value of human life in autonomy and independence; in the capacities to choose and to do. When read closely, the Second and Ninth Circuit opinions manifest not only compassion for the severely incapacitated and those in the end stages of terminal illness; they also reveal an audible note of contempt and disgust.⁴⁹

The Netherlands. The Second and Ninth Circuits brushed aside the Dutch experience with euthanasia and assisted suicide as irrelevant to the way the issue is resolved in the U.S. To ignore the experience of the only Western country to officially sanction these activities is foolhardy.⁵⁰ Three points need to be made. First, the slope is very slippery indeed. Applicable guidelines for assisted suicide have been

⁴³ New York State Task Force, *When Death is Sought* vii-viii.

⁴⁴ *Quill*, 80 F.3d at 724.

⁴⁵ *Compassion*, 79 F.3d at 825.

⁴⁶ See Barbara J. Logue, *Last Rights: Death Control and the Elderly in America* (New York: Lexington Books, 1993), and Nancy J. Osgood, "Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide," *Issues in Law and Medicine* 10 (1995) 415–35.

⁴⁷ On end-of-life treatment decisions for demented patients, see Daniel Callahan, "Terminating Life-Sustaining Treatment of the Demented," *Hastings Center Report* 25:6 (1995) 25–31, and Rebecca Dresser, "Dworkin on Dementia: Elegant Theory, Questionable Policy," *Hastings Center Report* 25:6 (1995) 32–38.

⁴⁸ See Susan M. Wolf, "Gender, Feminism, and Death: Physician-Assisted Suicide and Euthanasia," in *Feminism & Bioethics*, ed. Susan M. Wolf (New York: Oxford University, 1996) 282–317.

⁴⁹ The bishops have emphasized the dangers that legalizing assisted suicide poses to the vulnerable; see, e.g., a statement that Bishop Anthony Pilla issued on behalf of the U.S. National Conference of Catholic Bishops, "True Compassion for the Seriously Ill," *Origins* 26 (December 5, 1996) 412–13.

⁵⁰ For a brief, helpful digest of the relevant information, see International Anti-Euthanasia Task Force, "Euthanasia in the Netherlands," <http://www.iaetf.org/fcthall.htm>.

interpreted by the Dutch courts and the Royal Dutch Medical Association in increasingly broad terms. For example, although the guidelines require that the patient be experiencing "unbearable pain," that requirement is now read to include "psychic suffering" or the "potential disfigurement of personality." In 1993, a landmark decision ruled that a psychiatrist was justified in helping his depressed but physically healthy patient commit suicide.

Second, careful examination of the statistics included in the Remelink Report, the official government study of the practice, reveals the prevalence of nonvoluntary (including involuntary) euthanasia in the Netherlands. The most frequently cited reasons for ending the lives of patients without their knowledge or consent were "low quality of life," "no prospect for improvement," and that "the family couldn't take it any more." In July 1992, the Dutch Pediatric Association announced that it was issuing guidelines on permissible killing of severely handicapped newborns.⁵¹

Third, the potential for abuse is exponentially greater in the American context. The Netherlands is a far more homogeneous nation than is ours. It also provides its citizens with universal health care and a more advanced network of social services. What will the practice of assisted suicide look like in our racially fragmented and economically stratified United States?

Constitutional Right or Statutory Right? All of the dangers described above would loom large if physician-assisted suicide or euthanasia were legalized by state legislatures, as Oregon has now done. However, their magnitude will increase exponentially if legalization is accomplished by the creation of a new constitutional liberty interest. As the long history of state and federal attempts to regulate the practice of abortion after *Roe* demonstrates, any law or governmental policy that impinges upon the exercise of an individual's constitutionally protected sphere of action will almost certainly elicit legal challenges requiring judicial resolution.

The judicial process is expensive and time-consuming. Disputed statutes or regulations are frequently subject to injunctions prohibiting their application while the courts decide whether their use-

⁵¹ The most painstaking analysis of the relevant statistics can be found in "Euthanasia in the Netherlands," in *Euthanasia Examined*, ed. John Keown (New York: Cambridge University, 1995) 261-96. For varying perspectives on euthanasia and the Dutch experience, see Margaret Battin, "Voluntary Euthanasia and the Risks of Abuse: Can We Learn Anything from the Netherlands?" *Law, Medicine, & Health Care* 20 (1992) 133-43; Richard Fenigsen, "The Report of the Dutch Governmental Committee on Euthanasia," *Issues in Law & Medicine* 7 (1991) 339-44; John Keown, "The Law and Practice of Euthanasia in the Netherlands," *The Law Quarterly Review* 108 (1992) 51-78; Paul J. van der Maas et al., "Euthanasia and Other Medical Decisions Concerning the End of Life," *The Lancet* 338 (1991) 669-74; Jos V. M. Welie, "The Medical Exception: Physicians, Euthanasia and the Dutch Criminal Law," *JMP* 17 (1992) 49-37, as well as articles by de Wachter, Capron, ten Have and Welie, and Battin in the colloquy in the *Hastings Center Report* 22:2 (1992).

fulness in curbing abuses justifies the burden they place on the exercise of the right in question. The cumbersome nature of formulating and implementing regulation touching constitutional rights has proved to be difficult and inconvenient in the case of abortion;⁵² it will likely prove disastrous with respect to assisted suicide. The health care delivery and financing system is evolving at such a rapid pace that regulations designed to curb a specified set of abuses are likely to be quickly outdated. In short, while legalization of physician-assisted suicide would be detrimental to the common good, its constitutionalization is likely to be far worse.⁵³

State Interests and the Common Good. What explains the general inability of the two circuit courts to take cognizance of the dangers posed by granting constitutional protection to the choice of assisted suicide? One possible answer to this question can be found in the way the opinions conceptualize the problem they believe themselves to be addressing. Over and against a competent, terminally ill individual's interest in ending her own life, the opinions set the interests asserted by the state. According to *Compassion*, the applicable state interests include preserving life, preventing suicide, avoiding undue pressure, avoiding traumatic effects on children, other family, and loved ones, preserving the integrity of the medical profession, and preventing adverse consequences (the "slippery slope" arguments discussed above).⁵⁴ None of these interests, asserts the court, is sufficiently served by a state policy that deliberately prohibits competent, terminally ill adults from putting an end to their pain and indignity by taking their own lives with the assistance of a physician.

There are several basic problems with this way of conceptualizing the issue. The phrase "state interests" appears to pit the overweening activity of a nameless, faceless bureaucracy against the pain and suffering of specific individuals. Describing the relevant state policy in

⁵² For example, states have struggled over the years to implement requirements designed to ensure that a woman gives her informed consent to an abortion (e.g., requiring that she be offered information about comparative health risks of abortion and childbirth, gestational age and development of the fetus). Informed consent requirements are universally accepted in every other sphere of medical decision making. Nonetheless, before *Casey*, where they were finally upheld, the Supreme Court repeatedly struck down such regulations because they unjustifiably interfered with a woman's right to an abortion; see *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1990), and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986).

⁵³ "We do 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" (*Compassion*, 79 F.3d at 827). The American Medical Association begs to differ. In June 1996, the AMA House of Delegates reaffirmed its opposition to assisted suicide and euthanasia; see American Medical Association, "Physician Assisted Suicide, Report 59 of the Board of Trustees (A-96)." The report contains a helpful summary of recent legislative activities at the state level.

⁵⁴ *Compassion*, 79 F.3d at 816.

narrow, malevolent terms, the court at times suggests that the state's goal is deliberately to force each and every terminally ill person to continue living in pain and suffering.⁵⁶ Relatedly, the very term "state interests" occludes the fact that ultimately at stake is not an abstract political entity but a community composed of living human persons. It is more accurate to say that what the state is trying to protect is not its own interests, but the interests of members of the community who may be harmed by legalizing assisted suicide. If the goal of all lawmaking is to further the common good, then the state cannot fail to consider what legal scheme will work best for all of its citizens, not simply for the class of terminally ill citizens who wish to take their own lives.

CRUZAN: A WORKABLE RELATIONSHIP BETWEEN LAW AND MORALITY

Because New York has not chosen to pursue to the fullest possible extent its interest in prohibiting assisted suicide, *Quill* contends that the measures the state has chosen to take merit no respect at all. More specifically, *Quill* asserts that "the New York statutes prohibiting assisted suicide . . . do not serve any of the state interests . . . in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment."⁵⁶ Amazingly, *Quill* here charges the state of New York with irrationality for honoring a basic tenet of jurisprudence: the best can be the enemy of the good. A state legislature must make hard choices about how far to pursue certain goals, in the recognition that full implementation might require too many scarce social resources or impinge too heavily upon other important values. I suggest that it is possible to defend *Cruzan* (the most recent Supreme Court case on the matter) as drawing a sound and workable line with respect to treatment decisions with life-sustaining or death-dealing implications.

As both *Quill* and *Compassion* rightly observe, the distinction between "actively" taking steps likely to result in a patient's death and "passively" declining to provide treatment likely to forestall death cannot be decisive from a logical or an ethical perspective. Unfortunately, the opinions fail to recognize that the agent's intention in deciding what course of action to pursue can be defended as decisive. The line of intention cuts across the "active/passive" distinction.⁵⁷ Both Catholic moral theology and the American Medical Association

⁵⁶ For example, "But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? . . . And what business is it of the state to require the continuation of agony when the result is imminent and inevitable?" (*Quill*, 80 F.3d at 729-30). Similarly, *Compassion* suggests that under the relevant state laws, persons are "condemn[ed] . . . to unrelieved misery and torture" (79 F.3d at 814).

⁵⁶ *Quill*, 80 F.3d at 730.

⁵⁷ For a provocative philosophical exploration of these issues, see Jeff McMahan, "Killing, Letting Die, and Withdrawing Aid," *Ethics* 103 (1993) 250-79.

have recognized that, just as it is possible either to withhold a medical intervention or to provide a medical intervention *with the aim* of causing the patient's death, so it is possible either to refuse life-saving medical treatment or to furnish treatment that foreseeably shortens a patient's life (such as some types of painkillers) *without aiming* at death.⁵⁸

The line drawn by *Cruzan*, however, does not precisely track the logic of intention outlined in the previous paragraph. Instead, *Cruzan* assumes without actually holding that a competent adult patient has a liberty interest in refusing any medical treatment, including life-sustaining interventions. Consequently, from a moral perspective, the legal framework adopted by *Cruzan* might initially appear over-inclusive in the protections it confers. The *Cruzan* liberty interest encompasses decisions to withdraw medical treatment that aim at death, as well as those that are made to avoid treatment's burdens. Why not respond to the Second Circuit's challenge by cutting back the right to refuse care so as to protect only those decisions not made with the intent of causing death?

While it suffices for moralists to affirm the decisive nature of an agent's intention, lawmakers must also take into account the practical difficulties involved in discerning that intention. In the vast majority of cases involving competent, very ill individuals deciding to forgo medical treatment, it may be very difficult and time consuming for a person other than the patient to identify and assess the intentions prompting such a decision. Persons differ substantially in their capacities to bear the pain and uncertainty associated with medical treatment, as well as in their evaluations of the monetary and non-monetary costs associated with a continued battle against illness. For one person, a decision not to pursue a course of chemotherapy may truly be taken in order to pursue death; for another, it may simply be in order to avoid the pain and inconvenience of the treatment. In cases of doubt, it is appropriate for the law to allow the individuals most affected by a decision the freedom to make it themselves.

Moreover, it is important to recognize that there are in reality two moral questions raised by lawmaking in this area. The first is whether a patient may morally refuse life-sustaining treatment. As we saw above, the answer to this question depends in part upon the intention of the patient in making such a refusal. The second question is equally important. Assume that a competent, adult patient has decided to forgo treatment precisely in order to bring about death. How far can the state go to stop her from carrying through with her plan?

⁵⁸ If taken at its face, *Quill's* unqualified dismissal of the distinction between intention and foresight may be the most jurisprudentially radical aspect of the case. This distinction runs indispensably throughout the American legal system. It is a lynchpin of the criminal law. See Wayne R. LaFare and Austin W. Scott, Jr., *Criminal Law*, 2nd ed. (St. Paul: West, 1986) section 3.5.

The simple fact that one individual intends to follow an illicit course of action does not entitle other members of the community to do anything necessary to prevent her from so doing. As noted above, in order to prevent a competent, adult patient from deliberately killing herself by refusing necessary medical care, we would need to strap her down and force treatment upon her. By recognizing the liberty interest in refusing medical treatment, *Cruzan* can be read as saying that the end does not justify such means.

THE INDIVIDUAL GOOD AND THE COMMON GOOD

In conferring constitutional protection upon the choice of assisted suicide, both the Second Circuit opinion and the Ninth Circuit en banc opinion begin with vivid and heart-wrenching descriptions of the sufferings borne by the pseudonymous terminally ill plaintiffs in the case. *Quill* incorporates lengthy passages from the affidavits of a woman suffering from advanced cancer and two men dying of AIDS.⁵⁹ *Compassion* recounts the pain of a cancer patient, an AIDS victim, and an individual plagued with heart failure and emphysema.⁶⁰ In contrast, such accounts are not to be found in either the lower court opinion overruled by the Second Circuit, or in the three-judge panel opinion vacated by the Ninth Circuit sitting en banc. Both of these superseded opinions, which declined to find a "right to die" in the Constitution, alluded to the plight of the terminally ill plaintiffs only in the vaguest and most abstract terms.⁶¹

This difference in emphasis dividing the opinions favoring and those opposing constitutional protection for assisted suicide starkly reveals the fundamental moral question underlying this problem of special ethics: How do we reconcile the good of the individual and the common good? The opinions supporting the "right to die" seem to embody a straightforward liberal individualism. In general, they assume that an individual's dignity is enhanced by expanding the range of choices open to her. As their cavalier discussions of the social dangers posed by assisted suicide demonstrate, they simply presume that a legal scheme that expands individual freedom cannot in the end be harmful to the population at large.

The mirror image of these assumptions can be found in the opinions opposing the development of a new "right to die." Heavily impressed by the potential dangers of legalizing assisted suicide, they all but ignore the neuralgic pleas for help presented in the case studies of the plaintiffs. The most pressing challenge facing opponents of as-

⁵⁹ *Quill*, 80 F.3d at 718–22.

⁶⁰ *Compassion*, 79 F.3d at 794–796; see also p. 814 for an additional case history.

⁶¹ *Quill v. Koppell*, 870 F.Supp. 78 (S.D.N.Y. 1994), and *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995). The last reference is to the decision of the panel of three Ninth Circuit judges that originally heard the case; the opinion for the panel was authored by Judge John T. Noonan, Jr.

sisted suicide or voluntary euthanasia can be found in the faces of those who request such practices in order to put an end to their suffering. They are pointing to their own pain as a justification for carving out an exception to the general legal and moral rule against intentionally killing the innocent. What can those opposed to the recognition of such an exception say to them?⁶²

The responses that come immediately to mind are not entirely satisfactory. First, we could say that both the rule itself and permissible exceptions are determined entirely with reference to the well-being of society as a whole. Thus, we could contend that physician-assisted suicide and euthanasia are not permitted because they harm the common good, not because they harm the individuals who request the procedures. Moreover, we could go so far as to acknowledge that the prohibition in question does in fact harm some patients. On this view, asking a terminally ill person to obey the law on end-of-life decision making is analogous to asking a young man to obey his draft notice. In both cases, society is requiring an individual to suffer a real harm for the sake of other members of the community.

This approach is entirely sufficient to justify the *legal* prohibition against assisted suicide and euthanasia. Lawmakers are accustomed to making difficult trade-offs. One could argue that the "right to determine the time and manner of one's death" articulated by *Compassion* must encompass the choice to die a natural death as well as the choice to request aid-in-dying. If the legislature determines that legalizing assisted suicide will impinge upon the ability of persons to exercise the former choice more than it facilitates the ability of persons to exercise the latter choice, then a decision to maintain the prohibition is justified even in terms of Reinhardt's own analysis. From a purely pragmatic perspective, the choice is between the costs and benefits of two legal-cultural frameworks: on the one hand, legalizing assisted suicide and voluntary euthanasia; and, on the other, retaining the current legal prohibition, with the recognition that some physicians will continue to practice a bastardized form of "civil disobedience" in exceptional cases.⁶³ When the jurisprudential decision facing the U.S. is cast in these terms, it becomes perfectly clear that persons who believe there are exceptional circumstances in which assisted suicide or euthanasia can be *morally* justified (like some members of the New York Task Force) might consistently hold that the *legal* prohibition should remain intact.

⁶² See the haunting accounts in Lonny Shavelson, *A Chosen Death: The Dying Confront Assisted Suicide* (New York: Simon & Schuster, 1995), and Sherwin B. Nuland, *How We Die* (New York: Alfred A. Knopf, 1994).

⁶³ See Charles Krauthammer, "First and Last, Do No Harm," *Time* 147 (April 15, 1996) 83. "If it must be done at all—and in the most extreme and pitiable circumstances it will—let it be done with trembling, in shadow, in whispered acknowledgment that some fundamental norm is being violated, even if for the most compassionate of reasons."

From the perspective of a *morality* informed by Christian anthropology, which recognizes each human being as the image of the living God, it is far more difficult to accept an approach which acknowledges the need to sacrifice the well-being of some individuals to safeguard the well-being of the society as a whole.⁶⁴ The alternative is to find some way to reconcile the good of the community and the good of each individual. Unfortunately, the approaches that have been developed to date are far from entirely persuasive. For theological ethicists who desire to defend the moral prohibition against assisted suicide and euthanasia, the major challenge ahead is to work with renewed creativity on this problem.

One possibility is to invoke the Kantian concept of God as an "umpire" who will ensure that those who do not follow the rules will suffer, in the next world if not in this one. The moral course of action continues to be determined with reference to the broader good of society; however, it becomes easier to ask persons to sacrifice themselves for the moral course of action because of the assurance that accounts will be settled after death. This approach is unsatisfactory, not only because it is not likely to be plausible in a secular society but also because it is subject to criticism on Christian theological grounds. The God of Jesus Christ cannot be reduced to a *deus ex machina* whose sole concern with human well-being is expressed through the role of eternal enforcer.

The approach just described draws upon extrinsic harm and benefit to the individual to explain why it would not be wise for her to engage in a prohibited act. It is also possible to develop such an argument that hinges on a conception of intrinsic harm. To take this approach, we need to offer an account of why obeying the prohibition against assisted suicide will be better for a very ill person tempted to engage in it, not because of external rewards and punishments, but because of how the act will affect the person herself.

There have been various attempts to provide such an account. None, taken in and of itself, has been completely successful. One approach is to invoke the redemptive nature of suffering. But in many contexts, for many people, suffering is not redemptive or transformative; it impedes their ability to relate to one another and to God. Avoiding suffering is an entirely legitimate reason to engage in many acts. Why not this one?

A second approach is to say that by seeking assistance in bringing

⁶⁴ On the intersection between religion and public life, see *Choosing Death: Active Euthanasia, Religion, and the Public Debate*, ed. Ron Hamel (Philadelphia: Trinity International, 1991); *Mercy or Murder? Euthanasia, Morality and Public Policy*, ed. Kenneth R. Overberg, S.J. (Kansas City, Mo.: Sheed & Ward, 1993); Kenneth L. Vaux, *Death Ethics* (Philadelphia: Trinity International, 1992). A helpful collection of official statements can be found in *The Churches Speak on Euthanasia: Official Statements from Religious Bodies and Ecumenical Organizations*, ed. J. Gordon Melton (Detroit: Gale Research, 1991).

about their own deaths, persons are wrongly making judgments about their own "quality of life," and demeaning their own dignity by implying that their lives are "not worth living." Yet the use of such tendentious language may be misleading. Precisely the same sort of quality-of-life judgments are made in many decisions not to pursue treatment. Furthermore, the Roman Catholic tradition on death and dying has been known at times to describe death as a welcome friend, as the gateway to a new life with God in the communion of saints.⁶⁵ Do not these descriptions at least involve the judgment that one has completed the tasks assigned to this mortal life?⁶⁶

A third theological approach is to say that intentionally aiming at one's own death is inconsistent with one's nature as a creature of God, who has been granted stewardship but not ownership over one's earthly existence. By aiming at our own deaths, we usurp God's proper province in allotting the span of our lives; so doing warps our relationship with God. But as Margaret Farley has challenged, "Is it not conceivable that profound 'acceptance' of death, acknowledgment of an ending that is indeed God's will, can be expressed through action as well as passion, through doing as well as being done unto. . . . Can 'yielding' ever be expressed through an active ceding of life by one's own hand or another's?"⁶⁷ To respond to this challenge, it will be necessary to probe more deeply the contours of the real but nonetheless circumscribed responsibility entailed in the ideal of stewardship.⁶⁸

⁶⁵ In teaching us all how to die, Joseph Cardinal Bernardin described how he came to view death in this manner. A difficult challenge for Catholic moral theology—and its intention-based action theory—is to account for why it is permissible and (how it is possible) to wish, pray, and hope for death, but not to intend it. This problem seems particularly difficult in the context of decisions to withdraw life-saving treatment.

⁶⁶ For a thought-provoking meditation on the meaning of mortality, see Daniel Callahan, *The Troubled Dream of Life* (New York: Simon & Schuster, 1993).

⁶⁷ Margaret A. Farley, "Issues in Contemporary Christian Ethics: The Choice of Death in a Medical Context," Santa Clara University Public Lecture, 1 May 1995.

⁶⁸ Helpful recent theological writings include Anthony Fisher, "Theological Aspects of Euthanasia," in *Euthanasia Examined* 315–32; this volume contains some of the best recent essays on both sides of the issue. See also Paul Badham, "Should Christians Accept Active Voluntary Euthanasia," *Studies in Christian Ethics* 8:2 (1995) 1–12; John P. Burgess, "Can I Know That My Time Has Come? Euthanasia and Assisted Suicide," *Theology Today* 51 (1994) 204–18; Courtney S. Campbell, "Religious Ethics and Active Euthanasia in a Pluralistic Society," *Kennedy Institute of Ethics Journal* 2 (1992) 253–77, and "Sovereignty, Stewardship, and the Self: Religious Perspectives on Euthanasia," in *Euthanasia: The Good of the Patient, the Good of Society*, ed. Robert I. Misbin (Frederick, Md.: University Publishing Group, 1992) 165–82; James F. Bresnahan, "The Catholic Art of Dying," *America* 173 (November 4, 1995) 12–16; John F. Kilner, "Physician-Assisted Suicide; What's the Story?" *Christian Scholar's Review* 23 (1994) 349–59; Hans Küng and Walter Jens, *A Dignified Dying* (London: SCM, 1995); Gilbert Meilaender, "Human Equality and Assistance in Suicide," *Second Opinion* 19:4 (1994) 17–25, and "Love's Casuistry": Paul Ramsey on Caring for the Terminally Ill," *Journal of Religious Ethics* 19:2 (1991) 133–56; and Thomas A. Shannon, "Physician Assisted Suicide: Ten Questions," *Commonweal* 123 (June 1, 1996) 16–17. The U.S. Bishops issued a statement on abortion and euthanasia entitled "Faithful for Life," *Origins* 25

Finally, a fourth approach might attempt to show how a true understanding of an individual's own good must take into account one's essential connection with the wider human community. What concretely, do we mean by saying that human beings are essentially social other than that their good must somehow be bound up with the good of other members of the human community? Notwithstanding the serious objections that have been levied against it from the vantage of contemporary philosophy, the hoary and hallowed concept of a common human nature inhering in each and every human person provided a way to affirm that connection.

To make progress along these lines, theologians would need to offer a contemporary account of how acts such as euthanasia or assisted suicide are antithetical to our common human nature, and how such acts are also antithetical to the flourishing of the individual who might seek to engage in them, precisely because at the core of one's very self is the nature shared with all others who bear the human countenance. Making this case will not be easy at this time in Western culture. Heavily influenced by nominalism and individualism, we have become reluctant to apply general concepts such as human nature and human dignity without examining their applicability to individuals on a case-by-case basis.⁶⁹

EVANGELIUM VITAE, ASSISTED SUICIDE, AND THE LAW

As Charles Curran and others have pointed out, Pope John Paul II in his encyclical *Evangelium vitae*⁷⁰ understands humanity as facing a sharply dichotomous choice between "the culture of life" and "the culture of death."⁷¹ An important locus of the ongoing struggle is the positive law, which both shapes and reflects the ethos of a community. After arguing that assisted suicide and euthanasia, no less than abortion, are always impermissible, the pope contends that "laws which legitimize the direct killing of innocent human beings through abortion or euthanasia are in complete opposition to the inviolable right

(June 29, 1995) 116–20. See also the discussion of stewardship in Ohio Bishops, "Pastoral Reflections: Euthanasia, Assisted Suicide," *Origins* 23 (November 4, 1993) 373–78. The role of religion in attitudes toward euthanasia is discussed in Peter Baume, Emma O'Malley, and Adrian Bauman, "Professed Religious Affiliation and the Practice of Euthanasia," *Journal of Medical Ethics* 21 (1995) 49–54.

⁶⁹ For a description of some of the factors that a compelling contemporary account of human nature would need to take into account, see Charles Taylor, *Sources of the Self: the Making of the Modern Identity* (Cambridge, Mass.: Harvard University, 1989).

⁷⁰ Pope John Paul II, *Evangelium vitae* (Boston: Pauline Books & Media, 1995). Other essays on the encyclical include J. Bryan Hehir, "Get a (Culture of) Life," *Commonweal* 122 (May 19, 1995) 8–9, and those collected in *Choosing Life: A Dialogue on Evangelium Vitae*, ed. Kevin W. Wildes, S.J. and Allan Mitchell, S.J. (Washington: Georgetown University, forthcoming, 1997).

⁷¹ Charles E. Curran, "Two Traditions: Historical Consciousness Meets the Immutable," *Commonweal* 123 (October 11, 1996) 11–13.

to life proper to every individual; they thus deny the equality of every one before the law." On this basis, he concludes that "there is no obligation in conscience to obey such laws; instead there is a *grave and clear obligation to oppose them by conscientious objection*."⁷²

As Richard McCormick, S.J., has predicted,⁷³ these and other passages in the encyclical describing the proper relationship between the civil law and the moral law are likely to generate the most interest—and the most controversy—in the years to come. If the Supreme Court affirms *Quill* or *Compassion*, Catholic moral theologians and lawyers will need to work out precisely what differentiates an unacceptable law that "legitimizes" or "promotes" euthanasia or assisted suicide from a law that "leaves unpunished" these practices, which the pope acknowledges may be acceptable under some circumstances. How, for example, should we classify the legal framework of the Netherlands? The Dutch Penal Code has maintained its proscription against euthanasia. However, invoking the necessity defense, the highest Dutch court and the legislature have determined that doctors will not be punished for engaging in the practice, provided that they have followed certain procedures before doing so. Furthermore, according to John Keown, who has carefully analyzed the available statistics for the year 1990, almost one in twelve deaths was intentionally hastened by a physician.⁷⁴ Clearly, the distinction toward which the encyclical is pointing cannot be applied simply by perusing the penal codes of a society.

Evangelium vitae indisputably emphasizes the absolute nature of the prohibition against the intentional killing of the innocent. Nonetheless, it is important to recognize that the encyclical reaches beyond negative absolutes to insist upon the positive duties that we all have toward the weak and vulnerable members of society. It is precisely in the case of the most needy that the distinction between negative and positive obligations begins to break down. As the pope recognizes, the weak, almost by definition, need assistance from the stronger in order to survive. Consequently, the culture of life demands not only that "human life [must] not be taken, but it must be protected with loving concern."⁷⁵ Furthermore, the persons most tempted to kill the weak and the innocent are those upon whom the positive duties of continuing to care for them rest most heavily.⁷⁶ Thus the encyclical emphasizes the important place of families in promoting respect for life; yet it also acknowledges the role to be played by social-welfare agencies,

⁷² Pope John Paul II, *Evangelium vitae* nos. 72–73 (emphasis in original).

⁷³ Richard A. McCormick, S.J., "The Gospel of Life," *America* 172 (April 29, 1995) 10–17.

⁷⁴ Keown, "Euthanasia in the Netherlands: Sliding Down the Slippery Slope," in *Euthanasia Examined* 261–96.

⁷⁵ *Evangelium vitae* no. 81.

⁷⁶ M. Cathleen Kaveny, "The Limits of Ordinary Virtue: The Limits of the Criminal Law in Implementing *Evangelium Vitae*," forthcoming in *Choosing Life*.

government, and mediating institutions such as hospitals, clinics, and convalescent homes.⁷⁷ In striking fashion, the tradition's longstanding prohibition against euthanasia is firmly situated within the context of a broad social and personal responsibility to act with solidarity and charity toward all fellow human beings, particularly those most in need.⁷⁸ The enduring contribution of *Evangelium vitae* may well be the groundbreaking way in which it integrates Catholic social teaching with the doctrine on medical-moral questions. The synergy created by that integration could inspire the solidarity and hope that American Catholics might offer our fellow citizens as we grapple together with the issue of euthanasia and public policy.⁷⁹

⁷⁷ *Evangelium vitae* no. 88.

⁷⁸ *Ibid.* chap. 4.

⁷⁹ I would like to thank Tobias Winright for his assistance in gathering the materials used in this Note.



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