

ESSAY

DOES PRO-CHOICE MEAN PRO-KEVORKIAN? AN ESSAY ON *ROE*, *CASEY*, AND THE RIGHT TO DIE

SETH F. KREIMER*

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* Professor of Law, University of Pennsylvania Law School. This essay has benefitted from the comments of Art Caplan, Nancy Fuchs-Kreimer, Leo Katz, and Howard Lesnick. They have my deep gratitude, though not always my full agreement and responsibility for the views expressed remains my own. Thanks are due as well for the valuable assistance of Ron Day, Head of Reference Services of the Biddle Law Library.

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INTRODUCTION

1992 was the year of the right to choose. In *Planned Parenthood v. Casey*,¹ the Supreme Court by a five-to-four vote turned back the effort to eliminate federal constitutional protection for abortion rights.² Substantive due process rights to liberty, which had seemed to be destined for gradual elimination, reemerged as a stable part of the constitutional landscape as the *Casey* plurality articulated a vision of the role of unenumerated rights in the constitutional order. The election of Bill Clinton entrenched that decision, all but guaranteeing that the turnover of Justices for the next four years would leave protection for reproductive freedom untouched.³

During the past year and a half, the right to die has moved to center stage. In Canada, four of nine justices of the Supreme Court advanced the proposition that, under the Canadian Charter of Rights, a woman suffering from Lou Gehrig's disease had a right to the aid of a physician in committing suicide.⁴ In the State of Washington, a federal judge acting at the instance of a terminal cancer patient, a terminal AIDS patient, and a sufferer of emphysema, held the State's prohibition of assisted suicide unconstitutional as a violation of due

1. 112 S. Ct. 2791 (1992).

2. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804 (1992) (reaffirming "*Roe's* essential holding" by recognizing women's right to choose abortion "without undue interference from the State").

3. The substitution of Justice Ginsburg, who is generally regarded as pro-choice, for Justice White, who dissented from *Roe v. Wade*, 410 U.S. 113 (1973), solidifies the majority that preserved federal abortion rights in *Casey*. And although Justice Breyer is unlikely to be as enthusiastic a proponent of reproductive freedom as Justice Blackmun, *Roe's* author, it seems likely that he, too, will preserve the Court's role in maintaining the equilibrium reached in *Casey*.

4. See *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 349 (Can. 1993) (Lamer, C.J.C., dissenting); *id.* at 412 (Cory, J., dissenting); *id.* at 414 (McLachlin, J., dissenting, joined by L'Heureux-Dube, J.).

process.⁵ And in Michigan, home to Jack Kevorkian,⁶ three of six state judges in lower courts to address the subject, as well as two of the seven judges of Michigan's Supreme Court, would have held that the State's prohibition against assisted suicide violates the command of the federal Constitution.⁷

On November 8, 1994, Oregon became the first state to sanction assisted suicide when voters approved Ballot Measure 16, which permits physicians after a fifteen day waiting period to prescribe lethal medication to terminally ill adult patients who have expressed both written and oral wishes to die.⁸ Implementation of the initiative was preliminarily enjoined by a federal judge in response to a suit

5. Compassion in Dying v. Washington, 850 F. Supp. 1454, 1467 (W.D. Wash. 1994) (declaring Washington's statutory prohibition of suicide unconstitutional because it placed "undue burden" on exercise of protected Fourteenth Amendment liberty interest). In New York, a similar suit was filed by three physicians on behalf of three terminally ill patients weeks after the New York State Task Force on Life and the Law unanimously opposed lifting the ban on doctor-assisted suicide. See *Today's News: Update*, 212 N.Y. L.J. 1 (1994). The trial court granted summary judgment for the defendants. *Quill v. Koppel*, No. 94 Civ. 5321, 1994 U.S. Dist. LEXIS 17965 (S.D.N.Y. Dec. 15, 1994).

6. See Robert A. Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View From Without and Within*, 21 HASTINGS CONST. L.Q. 777, 777 (1994).

7. In *Hobbins v. Attorney General*, the Michigan Court of Appeals reviewed three consolidated cases involving Kevorkian. In the first case, the trial judge declared a newly enacted prohibition of assisted suicide unconstitutional based on objections under Michigan's state constitution to the procedure by which the statute was enacted. See *Hobbins v. Attorney Gen.*, 518 N.W.2d 487, 489 (Mich. Ct. App.), *aff'd in part and rev'd in part*, 1994 WL 700448 (Mich. Dec. 13, 1994). The trial judge in the second case found a federal constitutional right to commit suicide in some instances, and therefore dismissed the assisted suicide charge against Dr. Kevorkian. See *id.* The third judge dismissed the charge on the same basis as did the first judge, holding that the method of enacting the assisted-suicide-ban statute violated the Michigan Constitution. *Id.* In reviewing the consolidated cases, the Michigan Court of Appeals invalidated the statute criminalizing assisted suicide on state constitutional law grounds, but rejected the federal due process challenge, holding that there is no constitutional right to commit suicide. *Id.* at 489-94. Judge Shelton concurred that the statute violated the state constitution, but dissented on the federal constitutional claim, and would have held that a right to assisted suicide is a protected due process liberty interest. *Id.* at 494-99 (Shelton, J., concurring).

In a second case involving Kevorkian, *People v. Kevorkian*, the Michigan Court of Appeals reversed a state-law-based dismissal of a prosecution against Kevorkian. *People v. Kevorkian*, 517 N.W.2d 293 (Mich. Ct. App.), *vacated and remanded*, 1994 WL 700448 (Mich. Dec. 13, 1994). Judge Shelton's dissent would have upheld the dismissal on constitutional grounds. *Id.* at 298 (Shelton, J., dissenting). The other judges did not reach the constitutional issue.

In *People v. Kevorkian*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448 (Mich. Dec. 13, 1994), five justices of the Michigan Supreme Court rejected both the state constitutional objection and the federal due process attack on Michigan's assisted suicide statute. *Id.* at *8, *14 (opinion of Cavanagh, J.); *id.* at *20 (opinion of Boyle, J.). Another coalition of four justices remanded the murder prosecution against Kevorkian for further proceedings under a new state statutory standard. *Id.* at *20 (opinion of Cavanagh, J.). Justices Levin, *id.* at *27, and Mallett, *id.* at *32, each filed opinions that would have held that the prohibition on assisted suicide violates the federal protection against deprivations of liberty without due process.

8. Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. TIMES, Nov. 25, 1994, at A1; *The 1994 Elections: Ballot Issues; Voters in Oregon Allow Doctors to Help the Terminally Ill Die*, N.Y. TIMES, Nov. 11, 1994, at A28.

challenging the initiative as a violation of due process, equal protection, and the federal statutory protections of the handicapped.⁹

Each of the judges who has voted to permit assisted suicide has based his or her decision in part on an inference from the abortion cases: If a woman has a right to control her own body that allows her to avoid nine months of pregnancy and the trauma of childbirth, a patient suffering excruciating pain and indignity should have a similar right to end a condition that might continue years into the future, and should be able to exercise that right by invoking the aid of doctors to end her life.¹⁰ That inference is unwarranted. Neither *Roe v. Wade*¹¹ nor *Planned Parenthood v. Casey* made acquittal in *People v. Kevorkian*¹² a foregone conclusion as a matter of constitutional law.¹³ On the other hand, legitimate state concerns regarding bodily

9. *Lee v. Oregon*, Civ No. 94-6467-HO (D. Or. Dec. 27, 1994) (on file with *The American University Law Review*). The trial court based the preliminary injunction on the existence of what it regarded as serious constitutional questions about the Measure's legality in light of what it perceived as a great threat of irreparable injury.

10. A number of commentators have agreed. See RONALD DWORKIN, *LIFE'S DOMINION: AN ARGUMENT ABOUT ABORTION, EUTHANASIA, AND INDIVIDUAL FREEDOM* 26-28, 194-95, 216-17 (1993) (asserting connections between moral concerns debated in abortion and euthanasia issues); Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 888 (1992) ("A constitutional right of autonomy . . . extends to suicide and assisted suicide, although the extension could be resisted on plausible prudential grounds."); Tom Stacy, *Death, Privacy and the Free Exercise of Religion*, 77 CORNELL L. REV. 490, 496 (1992) (stating that "deep profound symmetry" underlies *Roe* and *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990)); Alan Sullivan, *A Constitutional Right to Suicide*, in SUICIDE: THE PHILOSOPHICAL ISSUES 229, 229 (M. Pabst Battin & David J. Mayo eds., 1980); Steven J. Wolhandler, Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 374-75 (1984) (arguing that *Roe's* protection of competent persons' rights to make their own decisions concerning personal and moral matters can be extended to protect competent persons' requests for voluntary, active euthanasia, as well as to individuals who assist patients in carrying out voluntary request to die).

Professor Sedler, counsel for the plaintiffs in *Hobbins*, 518 N.W.2d 487, takes the position that "[j]ust as the personal autonomy reflected in the constitutional right of reproductive freedom protects both the right of a woman to use contraception to prevent pregnancy from occurring and her right to have an abortion to terminate an unwanted pregnancy that has already occurred, the right of a terminally ill person to bodily integrity includes the right to hasten inevitable death." Sedler, *supra* note 6, at 788. But cf. *id.* at 794 (arguing that courts would sustain constitutionality of ban on suicide "as applied to persons who are not terminally ill or not so physically debilitated so that their life has become unendurable").

11. 410 U.S. 113 (1973).

12. 517 N.W.2d 293 (Mich. Ct. App.), *vacated*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448 (Mich. Dec. 13, 1994).

13. Abortion and the right to die are certainly linked for many abortion opponents; the proposition that the interest in preserving all fetal life is a compelling obligation of the State is consistent with the position that the State has an obligation to preserve the life of adults against suicide. See, e.g., *Nomination of Stephen Breyer to be an Associate Justice of the Supreme Court: Hearings Before the Senate Comm. on the Judiciary*, 103d Cong., 2d Sess. (July 15, 1994) (testimony of Paige Comstock Cunningham, president and attorney for Americans United for Life, opposing Justice Breyer's nomination because of his pro-choice position, and linking abortion rights to protection of assisted suicide), available through Federal Document Clearing House, in Westlaw, UStestimony database, 1994 WL 372056; cf. Carl E. Schneider, *Bioethics in the Language of the Law*, 24 HASTINGS CENTER REP., July-Aug. 1994, at 16, 18-19 (arguing that Supreme Court in *Cruzan* was reluctant

autonomy and personal choice would support a political choice to legalize assisted suicide.

Assisted suicide presents our society with a fearsome dilemma. Forbidding active assistance leaves some citizens with the prospect of being trapped in agony or indignity from which they could be delivered by a death they desire. But permitting such assistance risks the unwilling or manipulated death of the most vulnerable members of society, and the erosion of the normative structure that encourages them, their families, and their doctors to choose life. Unlike abortion, where the status of the fetus is a matter of intense moral debate, in the area of assisted suicide, the State must choose between preventing deliverance from suffering, and acquiescing in the risk of what all would concede is murder.

The current prohibitions against assisted suicide and euthanasia sacrifice the autonomy and dignity of some citizens for the safety and support of others. Its elimination would reverse the terms of the sacrifice but would not avert the tragic choice.¹⁴ In this circumstance, neither the claims of self-definition and procreational

to recognize "right to die" for fear of providing precedent supporting *Roe*). James Bopp, president of the National Legal Center for the Mentally Dependent and Disabled, a prominent opponent of assisted suicide, is currently counsel to plaintiffs challenging the constitutionality of Oregon's permission of assisted suicide. See First Amended Complaint, *Lee v. Oregon* (D. Or. 1994) (Civ. No. 94-6467-HO) [hereinafter *Lee Complaint*] (on file with *The American University Law Review*). In a prior incarnation, Mr. Bopp was General Counsel to the National Right to Life Committee. See James Bopp & Richard E. Coleson, *What Does Webster Mean?*, 138 U. PA. L. REV. 157, 157 n.† (1989); see also Memorandum by the Society for the Protection of Unborn Children (Nov. 2, 1993), in 2 SELECT COMM. ON MED. ETHICS, HOUSE OF LORDS, 1993-94 SESSION REPORT 231, 231 (1994) (opposing assisted suicide because of link to opposition to abortion).

The rejection of abortion rights, however, does not entail the rejection of the "right to die." In Germany, the federal constitution is read to require punishment of abortion. Donald P. Kommers, *The Constitutional Law of Abortion in Germany: Should Americans Pay Attention*, 10 J. CONTEMP. HEALTH L. & POL'Y 1 (1994). Since the 18th century, however, suicide and assistance have been legal under German law. See MARGARET PABST BATTIN, *THE LEAST WORST DEATH* 257-59 (1994); cf. Eric Rakowski, *The Sanctity of Human Life*, 103 YALE L.J. 2049, 2097-98 (1994) (reviewing DWORKIN, *supra* note 10, and concluding that right to die may be better rooted in moral theory than right to obtain abortion).

Although there has been no thorough analysis of the issue since *Casey*, I am not alone in concluding that the abortion cases do not determine the outcome of right to die issues. See Alexander M. Capron, *Easing the Passing*, 24 HASTINGS CENTER REP., July-Aug. 1994, at 25, 25 (stating that while "rhetoric" of *Casey* might support right to suicide, "reasoning" does not); Thomas W. Mayo, *Constitutionalizing the "Right to Die"*, 49 MD. L. REV. 103, 124 (1990) ("There is no inconsistency, or even irony, between the Court's extension of constitutional protections to a patient's choice of medical treatment to end the biological existence of a fetus, on the one hand, and the conclusion that the same privacy right does not extend necessarily to the decision to terminate an incompetent patient's life-sustaining medical treatment.").

14. Dean, now Judge, Guido Calabresi coined the term "tragic choice" to describe situations in which a legal system must allocate burdens or benefits involving great suffering or death as to which "basic ideals are in irreconcilable conflict." Guido Calabresi, *Bakke as Pseudo-Tragedy*, 28 CATH. U. L. REV. 427, 428 (1979); see also GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* 16-17 (1978). He identified societal treatment of euthanasia as one such tragic choice. *Id.* at 57.

autonomy, the mandates of bodily integrity, nor the theories of equality that undergird the governing opinion in *Casey* demand that society choose one result or the other.

I. THE RATIONALES OF *ROE* AND *CASEY*

Roe v. Wade is notorious as a case whose reasoning does not justify its conclusion. The opinion invokes a mixture of history and precedent in support of a right to reproductive privacy¹⁵ that leaves even supporters unsatisfied. Indeed, a small cottage industry among the last generation of legal scholars has revolved around the production of viable alternative rationales for the right to choose an abortion.¹⁶

15. *Roe v. Wade*, 410 U.S. 113, 129-66 (1973) (discussing history of abortion from Hippocratic Oath through English statutory law and early American law, and holding that right to abortion is based on right to personal privacy derived primarily from Fourteenth Amendment's concept of personal liberty).

16. See, e.g., ROBERT D. GOLDSTEIN, *MOTHER-LOVE AND ABORTION* 24-31 (1988) (discussing criticisms of *Roe* by Supreme Court); CASS R. SUNSTEIN, *THE PARTIAL CONSTITUTION* 270-85 (1993) [hereinafter SUNSTEIN, *PARTIAL CONSTITUTION*] (stating that equal-protection approach to abortion rights does not disparage view that fetuses deserve concern); LAURENCE TRIBE, *ABORTION, THE CLASH OF ABSOLUTES* 77-112 (1992) [hereinafter TRIBE, *CLASH OF ABSOLUTES*] (examining derivation of abortion rights from Constitution); LAURENCE TRIBE, *CONSTITUTIONAL CHOICES* 243-45 (1985) (examining Court's decision that withholding of public funding for abortion was constitutional); Susan R. Estrich & Kathleen M. Sullivan, *Abortion Politics, Writing for an Audience of One*, 138 U. PA. L. REV. 119, 141-55 (1989) (analyzing *Roe*'s trimester framework, and focusing on Justice O'Connor's criticisms of it); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 377-86 (1985) (positing that Court in *Roe* should have ruled only on extreme statute that it struck down, and should also have specifically addressed sex equality considerations); Kenneth L. Karst, *Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 58-59 (1977) (discussing Supreme Court's assumption in *Roe* that fetus is not person protected by Fourteenth Amendment, and how this assumption influences abortion analysis); Andrew Koppelman, *Forced Labor: A Thirteenth Amendment Defense of Abortion*, 84 NW. U. L. REV. 480, 486-508 (1990) (comparing involuntary servitude and State-compelled continuation of pregnancy in Thirteenth Amendment context); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1013-28 (1984) (arguing that biological differences should be taken into account in modern constitutional sex-equality doctrine, and in reproductive laws); Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1308-24 (1991) (discussing conditions of sex inequality as factor in abortion decision, both personally for women and legally in courts); Donald H. Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569, 1579-1645 (1979) (arguing that abortion rights could be secured under self-defense and samaritan principles, or under equal protection framework); Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 788-90 (1989) (arguing that prohibition of abortion is impermissible because it imposes profound, pervasive, and persistent effects that take over totality of a woman's life); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 262-67 (1992) (analyzing problems and benefits of framing abortion rights in equal protection context and situating abortion restrictions in historical context); David A. Strauss, *Abortion, Toleration and Moral Uncertainty*, 1992 SUP. CT. REV. 1, 18-22 (noting that abortion rights are important to minimize women's bodily subordination); Cass R. Sunstein, *Neutrality in Constitutional Law (With Special Reference to Pornography, Abortion and Surrogacy)*, 92 COLUM. L. REV. 1, 29-44 (1992) [hereinafter Sunstein, *Neutrality*] (arguing that laws restricting abortion violate Equal Protection Clause); Laurence Tribe, *Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 15-50 (1973) (discussing generally *Roe*, with specific attention

In *Planned Parenthood v. Casey*, a new generation of justices tried their hand at defending the abortion right. The governing plurality opinion, jointly authored by Justices O'Connor, Kennedy, and Souter, none of whom had sat in *Roe*, articulated three overlapping bases of support for the right to choose to terminate pregnancy.¹⁷ The plurality viewed the abortion right as standing "at the intersection of two lines of decisions":¹⁸ first, cases that have accorded protection to "liberty relating to intimate relationships, the family, and decisions about whether or not to beget or bear a child";¹⁹ and second, those that acknowledge rights of "personal autonomy and bodily integrity," by "recognizing limits on governmental power to mandate medical treatment or bar its rejection."²⁰ These precedents were bolstered by a third concern that interference with reproductive freedom undercuts "the ability of women to participate equally in the economic and social life of the nation,"²¹ and imposes a dominant vision of the roles of women in society.²²

This array of rationales helps structure inquiry regarding a constitutional right to physician-assisted suicide or voluntary euthanasia. I argue that none of these rationales supports such a right. The value of self-determination in situations of intimate and personal moral conflict is engaged by claims for assisted suicide in ways that

to liberty, historical religious entanglement in abortion issue, maternal health, and group and individual rights concerning private choice in abortion); see also Judith Jarvis Thomson, *A Defense of Abortion*, 1 PHIL. & PUB. AFF. 47, 55-63 (1971) (arguing, before *Roe*, that prohibition of abortion imposed obligation to sacrifice control of woman's body for benefit of fetus that was both morally unjustified and legally anomalous in regime that does not equate Good Samaritanism).

17. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804 (1992) (stating basic holdings in *Casey* as right to choose abortion, right of State to "restrict abortions after fetal viability," and interest of State in preserving health of mother and life of fetus from onset of pregnancy).

18. *Id.* at 2810.

19. *Id.*

20. *Id.* at 2798.

21. *Id.* at 2797.

22. *Id.* at 2807. Both suicide and assisted suicide have been historically punished both at common law and in American jurisdictions. See, e.g., *People v. Kevorkian*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448, at *11-12 (Mich. Dec. 13, 1994) (opinion of Cavanagh, J.) (setting forth history of suicide and assisted suicide as criminal offenses); *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 396-97 (Can. 1993) (opinion of Sopinka, J.) (same); *Quill v. Koppel*, No. 1994 U.S. Dist. LEXIS 17965, at *18-20 (S.D.N.Y. 1994). Contrary to the conclusion of the Michigan Supreme Court and the trial court in *Quill*, however, this condemnation does not in itself preclude the recognition of a protected constitutional interest under the *Casey* plurality's reasoning. Compare *Casey*, 112 S. Ct. at 2805-06 (opinion of O'Connor, Kennedy, and Souter, JJ.) (rejecting claim that due process protects only those practices legal or protected against government interference when Fourteenth Amendment was ratified; citing modern protection of right to interracial marriage, marriage of prisoners, and access to contraceptives) with *id.* at 2859-60 (Rehnquist, J., dissenting) (arguing that illegality of abortion at time of framing of Fourteenth Amendment and widespread prohibitions at time of *Roe* preclude constitutional protection).

differ significantly from the abortion cases. Assisted suicide and voluntary active euthanasia, unlike abortion, involve the extinction of what all involved agree is a human life. The societal values attached to avoiding the killing of those who do not desire to die, whether because of medical error, the effects of a blurring of norms, or the pervasive connection between treatable clinical depression and suicide are absent in the case of abortion.

Legalization of euthanasia and assisted suicide, unlike abortion, raises the specter of an increasingly cost-conscious medical system advertently or unconsciously tracking vulnerable populations away from expensive and personally demanding medical treatment or palliative care toward less expensive and easier medical suicide. Desperately ill citizens may feel themselves forced to justify their decision to remain alive. And unlike legalized abortion, the prospect of medical suicide threatens to taint pervasively the relations between doctor and patient.

The principles of bodily autonomy that undergird *Casey* guard against the "plenary override" of a citizen's considered choices regarding her own body. Yet both the moral force of the prohibitions against killing conceded human beings and the practical dangers of legalizing assisted suicide provide justifications for interference, which are absent in the case of abortion.

Finally, the concerns of women's equality that are implicated by abortion are absent from the arguments for assisted suicide or euthanasia. Indeed, while the prohibition of assistance denies to some handicapped individuals the practical option of suicide available to the nonhandicapped, it also arguably shields other handicapped individuals against lethal abuses to which they are disproportionately vulnerable.

II. PROCREATION, SELF-DEFINITION, AND THE MYSTERIES OF LIFE

Where Justice Blackmun in *Roe* contented himself with the doctrinal proposition that the "right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy,"²³ the *Casey* plurality articulated at greater length its reasons for holding that reproductive choices including abortion could claim constitutional protection:

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 Four-

23. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

teenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of the 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. . . . The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.²⁴

As Justice Scalia tartly noted in his dissent, this passage is long on evocative phrases and short on analysis that delineates the boundaries of the rights it defends.²⁵ Working from the concerns of the *Casey* plurality, however, parallels between abortion and suicide emerge.

Abortion and suicide both involve human control over the existence of life. Both are decisions that can have defining effects on the future life plans of the agents who make the choices. It is no stretch to characterize both as "choices central to personal dignity and autonomy."²⁶ Both are deeply contested moral decisions.

The structures of the moral contests appear similar. The controversy over abortion breaks into two levels. The first level concerns disagreement over the *prima facie* morality of abortion. It raises both issues regarding the status of the fetus²⁷ and (assuming the fetus has some moral status) debate over the moral obligation of the woman to refrain from terminating her pregnancy. The second level contests the right of the State to impose a moral vision upon women at the cost of substantial concrete harms.

The suicide debate has a parallel structure. Partisans first dispute whether taking a human life at the request of the subject is legitimately subject to prohibition and whether a particular level of suffering or indignity is adequate to outweigh the moral force of the prohibition.

24. *Casey*, 112 S. Ct. at 2807. The plurality went on to say that the "abortion decision may originate within the zone of conscience and belief," and to proclaim, that like contraception, abortion decisions constitute "personal decisions concerning not only the meaning of procreation but also human responsibility and respect for it." *Id.*

25. *Id.* at 2876 (Scalia, J., dissenting) ("It is obvious to anyone applying 'reasoned judgment' that the same adjectives can be applied to many forms of conduct that this Court . . . has held are not entitled to constitutional protection Those adjectives might be applied, for example, to homosexual sodomy, polygamy, adult incest, and suicide.").

26. *Id.* at 2807.

27. Ronald Dworkin distinguishes between the claim that a fetus is entitled to protection by virtue of its own interests and rights, and the claim that a fetus should be protected by virtue of the "sacred" character of human life. DWORKIN, *supra* note 10, at 24-26. Both claims go to the initial question of whether destruction of the fetus is a *prima facie* moral wrong. *Id.*

Professor Dworkin acknowledges that if the abortion debate turned on the fetus' status as a being with rights and interests, the resolution of the abortion controversy would be "logically disconnected" from the issues of euthanasia or assisted suicide. *Id.* at 27. He argues, however, that because the issue is the "sacred" character of human life, and the basis and means of showing respect for that sacral quality, conclusions about abortion imply conclusions about euthanasia. *Id.* at 27-28. At least as a constitutional matter, I disagree.

They then disagree over whether the State can impose a substantial concrete disadvantage on the basis of its adoption of a particular moral stance.

These apparent parallels are deceiving. On examination, the Court's resolution of the moral contests of the abortion cases provides insufficient constitutional sanction for a right to assisted suicide or active voluntary euthanasia.²⁸

Roe and *Casey* offer scant support for the proposition that the State's interests in prohibiting euthanasia or assisted suicide are so contestable as to be illegitimate as a matter of constitutional law. The State may grant that the prohibition imposes real and substantial costs on both patients who seek to end their lives and on their families, but may at the same time decide that it must impose those costs in the effort to avoid the premature death of others and to facilitate medical care that will preserve lives. This policy need not rely on arguments about life's sanctity or ignore the moral anguish of its victims.

Professor Dworkin is wrong in asserting that this legislative choice "fails to recognize that forcing people to live who genuinely want to die causes serious damage to them."²⁹ A legislature may acknowledge the tragic sacrifice it imposes on some of its citizens, yet still decide that the sacrifice is warranted by the interests of others. Dworkin is right when he asserts that "[t]here are dangers both in legalizing and refusing to legalize; the rival dangers must be balanced, and neither should be ignored."³⁰ But whether one balance or

28. Professor Rakowski questions the parallel between abortion and euthanasia, but concludes that the argument for euthanasia is stronger than that for abortion: "Abortion presents a possible opposition between two creatures' interests; euthanasia does not . . . [T]here seems no counterweight to—no separate harm to balance against—whatever net personal benefit suicide or euthanasia would bring to someone contemplating death." Rakowski, *supra* note 13, at 2097. I think Professor Rakowski has it backwards, at least as a matter of constitutional law. Cf. *id.* at 2101 (acknowledging that secular interests in preventing mistaken and coerced killings weigh against finding right to euthanasia but not abortion).

29. DWORKIN, *supra* note 10, at 197. A similar assertion is made by Joel Feinberg. JOEL FEINBERG, *FREEDOM & FULFILLMENT* 282 (1992) ("The enemy of voluntary euthanasia errs in minimizing the evils of human suffering and overrating the value of merely biological life . . ."). Feinberg ultimately acknowledges that "one cannot say that one of the two kinds of mistake is in itself . . . always more serious," *id.* at 275, and suggests that "we had better do whatever we can to let suffering patients determine their own course," *id.* at 281. This, of course, is the autonomy argument to which I turn in the next section of this Essay.

30. DWORKIN, *supra* note 10, at 198. Professors Dworkin and Feinberg argue that a decision to force the body to live is as irrevocable as the decision to allow it to die. At one level, this is true, for we cannot erase the experience of pain any more than we can bring the dead back to life. At other levels, however, this conclusion is not so clear. On one hand, the memory of suffering like all other memories does fade with time, and offers at least the possibility of being transformed in its import by the context provided by future actions. Death by contrast ends the agency of the deceased. Indeed, though Professor Dworkin cites Leo Tolstoy in support of the claim that an undignified death can taint a life, DWORKIN, *supra* note 10, at 203 (citing LEO TOLSTOY, *THE DEATH OF IVAN ILVCH* (1960)), the moral that Tolstoy draws is that as long as life

another is chosen seems in the first instance to be a matter of empirical investigation rather than abstract constitutional inference.

A. *The Life at Stake and the Moral Duty to Preserve Life*³²

The debate as to the prima facie morality of the act proceeds on different planes in the two situations. In *Roe* and *Casey*, the first issue in contest is the definition of the nature and value of the entity that is being harmed: the fetus.³¹ In contrast, the definition of the entity being harmed in suicide is clear: a fully developed human life is at stake.³²

Both *Roe* and *Casey* recognize that the viable fetus may be regarded as a second life that can, "in reason and all fairness, be the object of State protection that now overrides the rights of the woman."³³ Although a number of commentators have suggested that there is no moral duty to refrain from aborting even if the fetus is regarded as a rights-bearing person,³⁴ neither the majority in *Roe* nor the plurality in *Casey* endorsed this analysis. In recognizing the ability of the State in "reason and fairness" to prohibit third-trimester abortions, the Court in both *Roe* and *Casey* accepted the proposition that under some circumstances the State may usurp control of the bodies of women to sustain a second human life.³⁵

remains, the possibility of redemption is only a word or gesture away. To end life is to eliminate the possibility of future action.

Moreover, in weighing the balance between prohibition and permission, the issue is not merely the magnitude of the harms on each side, but their probability. If there is reason to believe that doctors will often err on the side of death, see *infra* note 50, and/or that most people will at some time want to live, then either a heavy burden of proof or prohibition may maximize the probability of serving the interests of any given individual.

31. See *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804-05, 2821-25 (1992) (recognizing State's interest in fetus, and permitting restrictions on abortion after viability); *Roe v. Wade*, 410 U.S. 113, 150-51, 159-66 (1973) (recognizing State's interest in fetal life).

32. One might argue in a *Quinlan*-type situation, where the patient is in a persistent vegetative state, that it is debatable whether the person is "alive." See Stacy, *supra* note 10, at 518-28 (arguing that patients in persistent vegetative states are not "alive"). *Quinlan* rejects that argument. See *In re Quinlan*, 355 A.2d 647, 662-68 (N.J. 1976). The problem of assisted suicide and voluntary euthanasia arises in the case of competent patients, so that there is no need to address the issue here.

33. See *Casey*, 112 S. Ct. at 2817; *Roe*, 410 U.S. at 150-51, 159-66.

34. The argument finds its roots in Judith Jarvis Thomson's 1971 Article. See Thomson, *supra* note 16, at 61-66 (arguing that even if fetus is "person," this does not mean that fetus has "right" to life, based on argument that pregnant woman should not be forced to bear child if it would require large sacrifice on part of woman); see, e.g., FRANCES M. KAMM, CREATION AND ABORTION: A STUDY IN MORAL AND LEGAL PHILOSOPHY 78-123 (1992) (exploring permissibility of abortion despite possibility that fetus may have rights); Regan, *supra* note 16, at 1571-93 (arguing that if women are compelled to carry pregnancies to term, State is forcing them to be "good samaritans," by legal definition, through physical discomfort and disfavored status of pregnancy).

35. See *Casey*, 112 S. Ct. at 2817 (discussing viability as factor determining when State may protect fetus); *Roe*, 410 U.S. at 154 ("[A] State may properly assert important interests in . . .

The State's overriding interest in preventing third-term abortions is not impeached by the fact that not everyone agrees the viable fetus is "a person" or that the moral basis for the "viability" line is at best obscure.³⁶ By parity of reasoning, "in reason and fairness," the State can claim interests of sufficient moment to override the conscience of a potential suicide in order to preserve what is, by consensus, human life.

We routinely allow citizens to put their lives at risk in the service of personal values or in hope of economic gain. But waiver on the part of the citizen does not totally divest the State of interest in preserving the citizen's life or health. Efforts to prohibit the use of tobacco or laetrile or the ban on duelling do not risk constitutional invalidation simply because the prohibitions interfere with the freely chosen, self-

protecting potential life The privacy right involved, therefore, cannot be said to be absolute." The *Casey* plurality suggested also that "[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child." *Casey*, 112 S. Ct. at 2817.

This "consent" claim is at least logically consistent with the proposition that the State has no right to expropriate a body to sustain another life. The difficulty is that it is a fairly weak moral "right" that in a "broad sense" can be "waived" very easily. As Professor Rakowski notes, "[I]f the difficulty of avoiding the burdens of pregnancy . . . should be weighed against the . . . [values] that abortion insults, why may the state not outlaw abortion when pregnancy results from a failure to use contraceptives?" See Rakowski, *supra* note 13, at 2086-87 (reviewing position taken by Ronald Dworkin in *Life's Dominion*).

36. Professor Dworkin points out the following three general reasons why protection of a viable fetus is defensible: (1) viability is the earliest time at which a fetus might be thought "to have interests of its own," in that "about the time of fetal vitality . . . the brain may have developed sufficiently so that a primitive form of fetal sentience is possible"; (2) "it is also the point at which [the fetus'] natural development is so far along that deliberately waiting until after that point seems contemptuous of the inherent value of human life"; and (3) it is "plainly late enough to give women a fair chance to exercise their right." DWORKIN, *supra* note 10, at 169-70.

On the first two points, it is hard to distinguish the adult who seeks to take her own life. First, she has "interests of her own,"—even if she seeks to disavow them—and more than a "primitive form of sentience." Second, although Professor Dworkin may not share the opinion, there are certainly those who view suicide as "contemptuous of the inherent value of human life"; the view is at least as plausible as a claim that all women seeking late term abortions for nonmedical reasons are "contemptuous." And if a forfeitable claim to individual autonomy is at issue, as the third point suggests, the suicide who doesn't take the opportunity to use a gun or plastic bag at an early stage in the illness can, with equal plausibility, be said to have "waived" her rights.

Elsewhere, Professor Dworkin has taken the position that fear of "the impact of widespread abortion on its citizens' instinctive respect for the value of human life and instinctive horror at human destruction or suffering which are values essential for the maintenance of a just and decently civil society" are strong grounds for prohibiting post-viability abortions. Ronald Dworkin, *The Great Abortion Case*, N.Y. REV. BOOKS, June 29, 1989, at 49, 52; cf. FEINBERG, *supra* note 29, at 53, 55-56 (arguing that killing of "well-developed fetuses . . . whose similarity to real persons is close enough to render them sacred symbols of the real thing" can be prohibited on utilitarian grounds).

This reasoning would count heavily against euthanasia. It is absent from his book *Life's Dominion*, possibly because Dworkin concludes that there is an insufficient basis for declaring fetuses to be persons under the U.S. Constitution. See DWORKIN, *supra* note 10, at 113-16.

regarding actions of competent adults. Indeed, the proposition that a contract to endanger the health of citizens *sui juris* is not immune from regulation was a part of the rejection of *Lochner v. New York*³⁷ in the New Deal cases.³⁸ On its face, therefore, the interest in preserving conceded human life distinguishes suicide from abortion.

The *Casey* plurality, however, rested its argument not only on the contested moral status of the fetus and of the woman's obligation, but on the particularly personal status of the decisions at issue. "Beliefs about these matters," according to the plurality, "could not define the attributes of personhood were they formed under compulsion of the State."³⁹ A similar observation supports protecting the decision whether to remain alive in the face of suffering or indignity.

A decision to choose life in such a situation, if freely embraced, could be a defining act of generosity or courage. The prohibition of assisted suicide places that final virtue outside of the grasp of some persons in pain. To remain alive in such circumstances becomes, when performed under compulsion, no longer a gift or sacrifice, but the mere payment of a tax. Despite its lack of historical roots, it is hard to deny the force of Justice Stevens' position that "[c]hoices about death touch the core of liberty. Our duty, and concomitant freedom, to come to terms with the conditions of our own mortality . . . [are] essential incidents of the unalienable rights to life and liberty endowed us by our Creator."⁴⁰

37. 198 U.S. 45, 47-64 (1905) (embodying economic substantive due process analysis based on Fourteenth Amendment, and declaring unconstitutional New York law setting maximum number of hours bakers could work because of law's interference with individuals' liberty of contract).

38. See, e.g., *West Coast Hotel v. Parrish*, 300 U.S. 379, 389-400 (1937) (upholding state minimum wage law for women, and stating that "[t]he Constitution does not speak of freedom to contract"); *Nebbia v. New York*, 291 U.S. 502, 520-58 (1934) (holding that Constitution does not prohibit price fixing of milk, and that state legislatures are free to adopt economic policies that promote public welfare).

39. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992).

40. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 343 (1990) (Stevens, J., dissenting).

Justice Cavanagh's prevailing opinion in *People v. Kevorkian*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448, at *12-14 (Mich. Dec. 13, 1994), reasons from the accurate proposition that suicide has been historically proscribed to the unwarranted conclusion that there is no liberty interest implicated by the prohibition. See *Quill v. Koppel*, No. 94 Civ. 5321, 1994 U.S. Dist. LEXIS 17965, at *18-20 (S.D.N.Y. Dec. 15, 1994) (rejecting claim of fundamental liberty interest in committing suicide on historical grounds). This reasoning is at best incomplete. If the personal importance of the choice of whether or not to bear a child is sufficient to import a liberty interest even in the face of a substantial history of prohibition of abortion, the deeply personal choices regarding the end of life cannot be entirely outside the protection of the Due Process Clause. Justice Cavanagh's rejection of this proposition may have been influenced by the curious reliance of his analysis not on the prevailing opinion in *Casey* but on Justice Rehnquist's opinion in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), and the commentary on *Webster* by James Bopp, Jr. & Richard E. Coleson, *Webster and*

Here, again, there are countervailing concerns, for to make one kind of personhood available is to deny others. Faced with the possibility of "giving" the gift of release to loved ones who suffer with her, a dying person may feel that she has no choice but to give. To make assisted suicide legal is to require each individual to justify (at least to herself) the decision to remain alive. We as a society may wish to preempt that burden with the social assertion that none of us need justify her life.⁴¹ This proposition that each citizen is equally and inalienably entitled to life has deeper roots than the view that the fetus should be regarded as having moral rights. By making assisted suicide illegal we turn the decision to choose life from an act for which the citizen can be accused of selfishness into an instance of rule abiding.

B. Sacrifice for Contested Ends

The second dimension of controversy that appears parallel for abortion and assisted suicide concerns the claim that a contested moral issue should not be the basis for imposing an abhorrent destiny upon objecting individuals. If it were possible to compare the threat of compulsory motherhood with the specter of a life of two, four, ten, or twenty years of painful, paralyzed dependency, one would have to judge the impact of the prohibition of suicide to be at least as great, and in many cases far greater, than the imposition on the life of a woman for whom abortion is prohibited. The moral stakes can be fully as momentous in the suicide case: whether to endure suffering and indignity in the interests of an ideal of human life or a hope of redemption (secular or religious) is a choice that can "define one's own concept of existence" and shape the "destiny" of a woman as fully as the decision whether or not to bear a pregnancy to term.

To impose such a resolution in the interests of a contestable and contested moral vision seems equally problematic in both cases. As Professor Dworkin argues:

The appeal to the sanctity of life here raises the same crucial political and constitutional issue that it raises in abortion. Once again the critical question is whether a decent society will choose coercion or responsibility, whether it will seek to impose a collective judgment on matters of the most profound spiritual character on

the Future of Substantive Due Process, 28 DUQ. L. REV. 271 (1990) (stating that *Webster* signalled disagreement on Court concerning reconsideration standard of *Roe* as well as recognizing that *Roe* was unconstitutional). *Kevoonian*, 1994 WL 700448, at *39 n.47.

41. See J. David Velleman, *Against the Right to Die*, 17 J. MED. & PHIL. 665, 675 (1992) ("[T]o offer the option of dying may be to give people new reasons for dying.").

everyone or . . . allow and ask its citizens to make the most central, personality defining judgments about their lives for themselves. . . . The great moral issues of abortion and euthanasia . . . have a similar structure. Each involves not just decisions about the rights and interests of particular people, but about the intrinsic cosmic importance of human life itself [T]he values in question are at the center of everyone's lives and no one can treat them as trivial enough to accept other peoples' orders about what they mean. Making someone die in a way that others approve but he believes is a horrifying contradiction of his life is a devastating, odious form of tyranny.⁴²

42. DWORKIN, *supra* note 10, at 216-17. Professor Dworkin believes that the constitutional rights that, in his view, underpin both the right to obtain an abortion and his position on voluntary euthanasia could be based on either the First Amendment, *id.* at 166, or on the proposition that coercion is impermissible because the effect on particular persons is great, and the convictions about life and death matters are "fundamental to our overall moral personalities," *id.* at 154-55.

The first claim has the allegiance only of Justice Stevens, but the second is congruent with the reasoning of the *Casey* plurality. Dworkin argues that, despite the settled constitutional proposition that moral disapprobation of the intrinsic worth of an act may be sufficient basis to prohibit it, the substantial impact of suicide prohibition on the lives of its subjects moves it into a different category:

A state may not curtail liberty, in order to protect an intrinsic value, when the effect on one group of citizens would be special and grave, when the community is seriously divided about what respect for that value requires, and when people's opinions about the nature of that value reflect essentially religious convictions that are fundamental to moral personality.

Id. at 157.

As a potential draftee into the Vietnam War, I would have been comforted by this proposition in 1970, but in light of the Selective Draft Law Cases, 245 U.S. 366 (1918), and the history of American conscription, I doubt its constitutional validity. *Cf.* *United States v. Kozminski*, 487 U.S. 931, 943-44 (1988).

The fabric of American constitutional history does cast doubt on at least one of the classic arguments for legally discouraging suicide. Opponents of suicide from Plato (*Laws*) and Aristotle (*Ethics*) to Aquinas (*Summa Theologica*) to Rousseau (*The Social Contract* and *The Second Discourse*) have taken the position that suicide is a violation of the duty the citizen owes the community. See Thomas J. Martzen et al., *Suicide, A Constitutional Right*, 24 DUQ. L. REV. 1, 20-50 (1985) (tracing views of suicide from ancient Greco-Roman culture to 18th century political philosophers). The common law prohibition rested in part on the parallel claim that the king has an interest in the preservation of his subjects. *Id.* at 60-83; see also *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 397 (Can. 1993) (opinion of Sopinka, J.) (stating common law concept that suicide offended God's and King's interest in lives of citizens). This position is consistent with the common law conception of citizenship as ineradicable.

By contrast, founded as a nation of emigrants, the United States has always viewed the right to renounce citizenship by expatriation as an "inherent and fundamental right." See JAMES H. KETTNER, *THE DEVELOPMENT OF AMERICAN CITIZENSHIP 1608-1870*, at 267-70 (1978); PETER H. SCHUCK & ROGERS M. SMITH, *CITIZENSHIP WITHOUT CONSENT* 54-57 (1985) (explaining that even before Fourteenth Amendment, Supreme Court had reluctantly noted right to expatriation). The right of expatriation was powerfully affirmed as a "natural and inherent right" by Congress in 1868. See KETTNER, *supra*, at 344; SCHUCK & SMITH, *supra*, at 62. If the American conception of citizenship is at odds with the claim that the State has a right to prevent emigration because of the organic link between State and citizen, it equally undercuts the claim that the State has a right to prevent citizens from leaving the polity by suicide. This argument, however, would not undermine either the Kantian claim that suicide is an impermissible treatment of the self as a means or the Millian claim that freedom cannot be exercised to permanently eliminate

But the issue in *Kevoorkian* and similar cases is not simply self-willed death; it is assisted suicide and voluntary euthanasia. Suicide itself is not a crime in American jurisdictions,⁴³ and, at least as long as guns, plastic bags, and tall buildings are freely available, most people have the practical capacity to kill themselves.⁴⁴ The considerations that are invoked by assisted suicide and voluntary euthanasia extend beyond the unadorned sanctity of the subject's life, and include the threats to the lives of others that arise from the dangers of abuse that might attend legalization.⁴⁵

While opponents of assisted suicide have not forsaken the claim that the State has a moral interest in preserving the life even of one who seeks to abandon it,⁴⁶ more recent arguments against legalizing assisted suicide have tended to focus not on the bare interest in preserving the life of the prospective voluntary suicide, but on the interest in avoiding the specter of involuntary euthanasia (particularly directed against the most vulnerable), and the erosion of support for the lives of those at risk.⁴⁷ The concrete dangers that the prohibi-

freedom.

43. See, e.g., *Quill v. Koppel*, No. 94 Civ. 5321, 1994 U.S. Dist. LEXIS 17965, at *19 (S.D.N.Y. Dec. 15, 1994); *Donaldson v. Lungren*, 4 Cal. Rptr. 2d 59, 64 (1992) (noting no state has criminal statute that includes suicide or its attempt); *People v. Kevoorkian*, 517 N.W.2d 293, 295 (Mich. Ct. App.), *vacated and remanded*, 1994 WL 700448 (Mich. Dec. 13, 1994) (noting that "Model Penal Code, which is widely regarded as the greatest criminal law reform project of this century, criminalizes aiding or soliciting another to commit suicide, but does not criminalize suicide or attempted suicide").

44. Indeed, for the determined and ill person, starvation and dehydration may be a relatively painless means of suicide. See James L. Bernat et al., *Patient Refusal of Hydration and Nutrition: An Alternative to Physician-Assisted Suicide or Voluntary Active Euthanasia*, 153 ARCHIVES INTERNAL MED. 2723, 2725 (1993) (stating that terminally ill patients dying of dehydration or lack of nutrition do not suffer if treated properly); Robert M. McCann et al., *Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration*, 272 JAMA 1263, 1265 (1994) (reporting that patients with terminal illnesses "can experience comfort despite minimal if any intake of food or fluids").

45. See *infra* notes 49-78 and accompanying text.

46. *Rodriguez*, 107 D.L.R.4th at 397 (opinion of Sopinka, J.) (stating that there is "deeply rooted belief in our society that human life is sacred or inviolable"); *Hobbs v. Attorney Gen.*, 518 N.W.2d 487, 492 (Mich. Ct. App.) (declaring that "State [has] an unqualified interest in the preservation of human life" (quoting *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 282 (1990))), *aff'd in part and rev'd in part*, 1994 WL 700448 (Mich. Dec. 13, 1994). Justice Cavanagh's prevailing opinion in *People v. Kevoorkian*, cited with approval the argument that "[r]ecognition of the dignity of human life demands resistance, rather than concession, to the real or imaginary death wishes of those who are afflicted with pain, depression, a sense of personal worthlessness, or a sense of burdensomeness to others," *People v. Kevoorkian*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448, at *39 n.45 (Mich. Dec. 13, 1994) (quoting *Guardianship of Jane Doe*, 411 Mass. 512, 531-32, *cert. denied*, 112 S. Ct. 1512 (1992) (O'Connor, J., dissenting), as well as the "state's paramount interest in protecting life," *id.* at *11).

Justice Boyle's concurring opinion similarly relied on the "fundamental value we have assigned to the preservation of human life as one of the last great faiths that unites us." *Id.* at *26 (Boyle, J., concurring in part and dissenting in part).

47. Thus, in the Canadian case, the parties agreed that "the legislation in question was aimed at the protection of persons who may be vulnerable to the influence of others in deciding

tion seeks to avoid fall into three categories. Each is debatable empirically, but all rest on essentially uncontested moral premises.⁴⁸

whether, when and how to terminate their lives." *Rodriguez*, 107 D.L.R.4th at 369 (Lamer, C.J.C., dissenting); see *id.* at 392 (opinion of Sopinka, J.) (stating that Government has "objectives of preserving life and protecting the vulnerable"); *id.* at 406 (stating that legislation was designed "to discourage those who consider that life is unbearable at a particular moment or who perceive themselves to be a burden upon others, from committing suicide"); *id.* ("Given the concerns about abuse . . . it cannot be said that the blanket prohibition . . . is arbitrary or unfair . . ."); *id.* at 415-23 (McLachlin, J., dissenting) (arguing that prevention of deaths not truly consented to is legitimate end, but can be adequately accomplished without blanket prohibition); see also, e.g., *R. v. United Kingdom*, 33 Eur. Comm'n H.R. Dec. & Rep. 270 (1983) (positing right of State to guard against inevitable criminal abuses that will occur in absence of legislation against aiding and abetting of suicide).

In rejecting proposals to weaken the ban on euthanasia and assisted suicide, the House of Lords Select Committee on Medical Ethics relied not only on the proposition that "belief in the special worth of human life is at the heart of civilized society," 1 SELECT COMM. ON MED. ETHICS, *supra* note 13, at 13, but also on concerns that "to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation," and that "vulnerable people . . . would feel pressure, whether real or imagined, to request early death," *id.* at 49; see also *Donaldson v. Lundgren*, 4 Cal. Rptr. 2d 59, 63-64 (Ct. App. 1992) (upholding statute banning assisted suicide because of interest in "protecting society against abuses" in view of "difficulty, if not impossibility, of evaluating the motives of the assister or determining the presence of undue influence"); NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT 120 (1994) [hereinafter TASK FORCE ON LIFE AND THE LAW] (stating that "legalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable"); *id.* at 135 (indicating that while task force members "feel deep compassion for patients in those rare cases where pain cannot be alleviated . . . , legalizing assisted suicide or euthanasia to make the practices readily available to these patients would create widespread and unjustified risks for many others").

In Michigan, the State advanced a claim, accepted by two intermediate court judges, that the "State [has] an unqualified interest in the preservation of human life." *Hobbins*, 518 N.W.2d at 492 (quoting *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 282 (1990)). The State also presented an argument, rejected by the dissenting judge, that "anything less than a total prohibition of assisted suicide will eventually result in the uncontrolled and irresponsible taking of a multitude of lives in situations far less compelling than the individuals involved in these cases." *Id.* at 499 (Shelton, J., concurring in part and dissenting in part) (rejecting above argument, and stating that if only means by which State can regulate personal choice is by prohibiting it "[t]here would be no meaningful choice in the first instance"). Justice Cavanagh's prevailing opinion on appeal in *People v. Kevorkian*, did not recognize a liberty interest sufficient to require state justification, *Kevorkian*, 1994 WL 700448, at *6-10, but Justice Boyle's concurrence buttressed its reliance on the "intrinsic value of life" with concerns both about "abuse of the vulnerable" and "the danger of increasing the risk of death for those who would have had a reason to live had society and the participant in their demise valued their continued existence." *Id.* at *22 (Boyle, J., concurring).

In Washington, the defendants argued that the State was attempting to protect two primary interests: "preventing suicide and protecting those at risk of suicide from undue influence from others." *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1464 (W.D. Wash. 1994). In neighboring Oregon, the preliminary injunction against implementation of Measure 16 rested on similar concerns about undue influence and mistake. *Lee v. Oregon*, Civ. No. 94-6467-HO (D. Or. Dec. 27, 1994) (on file with *The American University Law Review*).

The progenitor of this consequentialist argument against euthanasia and assisted suicide was Professor Yale Kamisar's article, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 1005-42 (1958) (objecting to "mercy-killing" on grounds that "mistakes are always possible" and that mercy killing may be used against people who are viewed as "nuisance to other people").

48. Each of these justifications involves the sacrifice of the particular innocent patient's autonomy for the benefit of others, despite the possibility that the exercise of autonomy is itself

1. *The killing of individuals who do not desire to die*

The argument for constitutionally protecting a right of assisted suicide stems from the concept of autonomy, from an obligation of the State to recognize and acquiesce in the considered desires of its citizens in important areas of their lives. While it might still be argued that painless nonvoluntary euthanasia is more fully in the interests of the patient than a painful life, *Roe* and *Casey* do not protect a right to have the State act in the citizen's best interests. The constitutional claim rests on an argument from the patient's right to autonomous choice and self-definition. If the prohibitions are necessary to avoid the death of those who actually have not chosen to die, there is no conflict of principle between the State's justification for the prohibitions and its obligation to respect its citizens' choices. It preserves the life, and hence the possibility of future choice for some at the expense of the choices of others, but need not deny the legitimacy of choice. The dangers of nonvoluntary euthanasia arise from three sources: the possibility of erroneous action, the spill-over effects of removing the prohibition, and the difficulties of avoiding requests rooted in treatable depression.⁴⁹

a. *Observational error*

Medical literature suggests that doctors often estimate the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-prolonging treatment."⁵⁰ In the case of intermittent, tentative, or ambiguous

morally unobjectionable. The constitutional limitations on the right of the state to demand such a sacrifice are discussed *infra* text accompanying notes 138-64.

49. Although opponents have expressed skepticism regarding the voluntariness of abortions, there is no data comparable to that in the assisted suicide realm suggesting that doctors substantially overrate the desire to obtain an abortion, that abortions are pervasively nonvoluntary, or that they are linked to treatable clinical depression. Indeed, the fact that before *Roe*, large numbers of women subjected themselves to substantial risk, pain, trouble, and expense to obtain illegal abortions suggests that women's choices are the result of settled and voluntary desires. Moreover, the moral weight to be given to a less than fully considered abortion is a matter of substantial debate, while the immorality of involuntary euthanasia is manifest.

50. Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786, 1786 (1994); see also Lawrence J. Schneiderman et al., *Do Physicians' Own Preferences for Life-Sustaining Treatment Influence Their Perceptions of Patients' Preferences?*, 4 J. CLINICAL ETHICS 28, 31 (1993) (suggesting that not only do physicians "often underestimate their patients' perceived quality of life," but also that they may be influenced by their own personal preferences); Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY MED. 115, 119 (1988) (stating that primary care physicians and spouses often misunderstand resuscitation preferences of elderly patients); Richard F. Uhlmann & Robert A. Pearlman,

requests for euthanasia or assisted suicide, the physician must judge the patient's "real" desires; the possibility of a lethal mistake weighs against removing the prohibition.⁵¹ Although procedural mechanisms could limit this possibility,⁵² the blanket prohibition is a more straightforward means of avoiding the errors.⁵³

b. Implicit permission for nonvoluntary euthanasia

If euthanasia becomes a legitimate option for consenting patients in pain, it is hard to believe that some doctors will not be attracted to

Perceived Quality of Life and Preferences for Life Sustaining Treatment in Older Adults, 151 ARCHIVES INTERNAL MED. 495, 496-97 (1991) (citing study showing that doctors rated their patients' quality of life significantly lower than patients themselves did, and showing that there was little correlation between doctors' perception of patients' quality of life and patients' treatment preferences); cf. Allison B. Seckler et al., *Substituted Judgment: How Accurate are Proxy Predictions?*, 115 ANNALS INTERNAL MED. 92, 94 (1991) (finding that physicians would not resuscitate patient in 14 of 69 cases where patient would have desired to live in current state of health); Jeremiah Suhl et al., *Myth of Substituted Judgment: Surrogate Decision Making Regarding Life Support Is Unreliable*, 154 ARCHIVES INTERNAL MED. 90, 94-95 (1994) (stating that surrogates would have withdrawn or withheld life support in 14.3% of cases against actual wishes of patients, and that surrogates would have favored life support in 26.1% of cases against actual wishes of patients).

51. The problem is most pressing in the case of euthanasia, where the doctor responds lethally to the patient's request. Where assisted suicide is sought, a patient's action in taking the pills or pulling the lever will often be less ambiguous. Even here, however, there is the danger that the patient may not fully comprehend the nature of the medication, or may change her mind in midstream. Cf. MICHAEL BETZOLD, *APPOINTMENT WITH DOCTOR DEATH* 212 (1993) (providing account of Kevorkian patient who may have sought unsuccessfully to end suicide).

52. For example, Oregon's newly enacted Measure 16 (on file with *The American University Law Review*), allows an attending physician to write a prescription for lethal medication to terminally ill adult patients who request such treatment and are likely to die within six months. It requires a 15 day waiting period, *id.* § 3.06, informed consent by the patient at several stages, *id.* § 3.04, two oral requests and one written request, *id.* § 3.06, two witnesses who attest to the voluntary and competent nature of the written request, *id.* § 2.02, confirmation of the medical diagnosis and the voluntariness and competence of the request by a second doctor, *id.* § 3.02, and documentation in medical records of all determinations and requests, *id.* § 3.09. If the attending physician believes the patient may suffer from a "psychological disorder," the prescription cannot be entered until a counselor determines that no such disorder is present. *Id.* § 3.03.

Justice Levin's dissent in *People v. Kevorkian* would have required that individuals seeking to invoke the right to terminate their lives apply for judicial authorization after a hearing to establish their competence and the circumstances of their request. *People v. Kevorkian*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448, at *28 (Mich. Dec. 13, 1994) (Levin, J., dissenting).

53. Cf. Jerri R. Fried et al., *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 153 ARCHIVES INTERNAL MED. 722, 722 (1993) (indicating that 1% of doctors surveyed stated they would give lethal injection if requested by competent, terminal patient; 12% stated they had been asked to give lethal injection; 1% stated that they had given lethal injections; 28% stated they would comply with requests for lethal injections if they were legal; and 35% believed that such actions should be legal); Robyn S. Shapiro et al., *Willingness to Perform Euthanasia: A Survey of Physician Attitudes*, 154 ARCHIVES INTERNAL MED. 575, 581 (1994) (finding that 35.2% of physicians surveyed had been asked to perform euthanasia, 2.2% had performed euthanasia, and 27.8% stated they would be willing to perform euthanasia if it were legalized). But cf. Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients, A Second Look*, 320 NEW ENG. J. MED. 844, 848 (1989) (stating that frequency of physician-assisted suicides is not known, but that they are "certainly not rare").

the reasoning of the court in *Quinlan*: Why should release from suffering be denied to a patient simply because she is unable to consent?⁵⁴ While the current legal system does not insure that abuses of this sort will never occur,⁵⁵ it is surely plausible to believe that the legal norm has some persuasive force in shaping behavior.⁵⁶ The argument is not only that bad actors are deterred by the threat of punishment, but that weak actors will be buttressed in difficult situations by the law's normative power. The doctor who is able to resist financial and psychological pressures to end life by invoking an absolute legal prohibition may be unable to refrain from euthanasia where the barrier of absolute prohibition is broken.

The leading laboratory for modern euthanasia is the Netherlands, where between 1973 and 1986, the law evolved a defense to charges of homicide on the part of doctors who, at the request of their patients, either end their patients lives or provided the means to commit suicide as a way of avoiding "unbearable suffering."⁵⁷ While still formally a violation of law, euthanasia and assisted suicide in the Netherlands do not subject doctors to legal sanction where the patient's request is persistent, conscious, and voluntarily made, where the patient's condition is beyond recovery or amelioration, and where the doctor has consulted with a colleague to assure the appropriateness of the request for euthanasia.⁵⁸ In the Netherlands, there are allegations that the legal permission to perform voluntary euthanasia

54. *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) (stating that if decision to terminate treatment is "valuable incident of her right of privacy . . . it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice"). The concerns about abuse may go further: in Canada, "[i]t was argued that if assisted suicide were permitted . . . there would be reason to fear that homicide of the terminally ill and persons with physical disabilities could be readily disguised as assisted suicide." *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 375 (Can. 1993) (Lamer, C.J.C., dissenting). My own suspicion is that institutional indifference and the impact of financial pressures are more likely sources of problematic consent than overt coercion, but that the lure of the ability to end pain by ending life will be the source of unconsented killing.

55. *Cf. It's Over Debbie*, 259 JAMA 272, 272 (1988) (setting forth resident's account of delivering fatal amount of morphine to terminal ovarian cancer patient in response to request "Let's get this over with").

56. See *supra* note 53 and accompanying text.

57. The fullest discussion of the evolution of Dutch law is CARLOS F. GOMEZ, *REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS* 25-48 (1991); see also BATTIN, *supra* note 13, at 130-44 (discussing practice of euthanasia in Netherlands, and attempting to provide greater understanding of laws governing euthanasia); David R. Schanker, Note, *Of Suicide Machines, Euthanasia Legislation and the Health Care Crisis*, 68 IND. L.J. 977, 992-97 (1993) (discussing evolution of Dutch laws governing euthanasia, and criticisms of Dutch system).

58. See Johannes J.M. van Delden et al., *The Rummelink Study Two Years Later*, HASTINGS CENTER REP., Nov.-Dec. 1993, at 24, 25 (outlining due caution standard that physician must meet to avoid prosecution for euthanasia or assisted suicide under Dutch law).

has been expanded by some doctors to implicitly license nonvoluntary or involuntary euthanasia.⁵⁹

The allegations have empirical support. The most recent estimates are that between 2% and 4% of the 129,000 annual deaths in the Netherlands result from either physician-assisted suicide or voluntary euthanasia of the sort that is legally sanctioned.⁶⁰ These same studies conclude that between 0.8% and 1.6% of Dutch deaths involved illegal active interventions by physicians to end their patients' lives without an express request by the patient.⁶¹ Furthermore, in

59. See GOMEZ, *supra* note 57, at 128-39 (arguing that evolution of Dutch law on euthanasia has resulted in narrowing of "instances in which [euthanasia] practice will be prosecuted," and calling for implementation of greater control and review of euthanasia practice); Richard Fenigsen, *A Case Against Dutch Euthanasia*, HASTINGS CENTER REP., Jan.-Feb. 1989, Supp. at 22, 24-26 (asserting that voluntariness of "voluntary euthanasia" is "often counterfeit and always questionable"); cf. Rodriguez v. British Columbia, 107 D.L.R.4th 342, 421 (Can. 1993) (McClachlin, J., dissenting) (acknowledging "evidence from foreign jurisdictions indicating that legal codes which permit assisted suicide may be linked to cases of involuntary deaths of aging and disabled," although maintaining support for legalization of euthanasia). But see Henk Rigtter, *Euthanasia in the Netherlands: Distinguishing Facts from Fiction*, HASTINGS CENTER REP., Jan.-Feb. 1989, Supp. at 31, 31-32 (repudiating existence of "involuntary" euthanasia).

60. See John Habgood, *The End of Life in Medical Practice, A Review of a Report by the Netherlands Central Bureau of Statistics, 1992*, 27 J. ROYAL C. PHYSICIANS LONDON 133, 133 (1993) (setting forth results of anonymous survey of doctors involved in deaths from July 1 to November 30, 1990, indicating that 2.7% of deaths involved prescription of drug to hasten death and 12.5% involved prescription of increased pain relief with aim of hastening death); Paul J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 LANCET 669, 669-70 (1991) (reporting findings of three-part study completed for Netherlands' Rummelink Commission). The study included interviews with a sample of 405 physicians from various disciplines, a sample of 7000 deaths that occurred from August 1 to December 1, 1990, and a prospective study in which the 405 physicians provided information about every death in their practice during the six months after the interview conducted for the first part of the study. Van der Maas' group reported that of the total deaths in the Netherlands (128,786 in 1990), 1.8% were the result of euthanasia, and 0.3% were the result of assisted suicide, according to the study's best estimate. *Id.* In the prospective sample, euthanasia accounted for 2.6% of deaths, and assisted suicide 0.4%. *Id.*; see also G. van der Wal et al., *Euthanasia and Assisted Suicide. I. How Often Is it Practised by Family Doctors in the Netherlands?*, 9 FAM. PRAC. 130, 132, 134 (1992) (estimating that, on basis of 67% response rate among sample of 1042 of all 6300 family physicians in Netherlands, for 1986-89, 2000 euthanasia or assisted suicides were performed annually by family doctors, and further estimating that rate of [Euthanasia/Assisted Suicide] for home deaths is 4%); Maurice A.M. de Wachter, *Euthanasia in the Netherlands*, HASTINGS CENTER REP., Mar.-Apr. 1992, at 23, 23-24 (quoting Dr. E. Borts-Eilers, Vice Chairman of Health Council of the Netherlands, as stating that, as of December 1990, 4000-6000 incidences of euthanasia occurred annually, equivalent to 3-4.5% of all deaths).

61. See Habgood, *supra* note 60, at 133 (stating that in 2.7% of deaths that involved prescribing drugs to hasten death, only 134 of 174 deaths involved "express requests"); van Delden et al., *supra* note 58, at 24 (finding that, out of 129,000 annual deaths in Netherlands, an estimated 1000 cases, or 0.8%, were result of life-terminating acts undertaken without patient's explicit request); Loes Pijnenborg et al., *Life Terminating Acts Without Explicit Request of Patient*, 341 LANCET 1196, 1197 (1993) (reporting Rummelink Study results that found 0.8% to 1.6% of examined deaths were result of life-terminating acts without explicit request of patient); *Translated Abstract of M.T. Muller et al., Levensbeëindigend handelen door huisartsen en verpleeghuisartsen zonder verzoek van de patient [Life-Terminating Actions by Family Practitioners and Nursing Home Physicians Without the Patient's Request]*, 138 NED TIJDSCHR. GENEESKD 395, 395 (1994), available in MEDLINE (stating that, in random sample of 521 Dutch general practitioners and 521 nursing home doctors responding to anonymous questionnaire, 65 general practitioners

the far larger proportions of Dutch deaths attributable to withholding or withdrawals of treatment (17.5% of deaths) or increased dosages of painkillers (17.5% of deaths), express consent of the patient was absent in the majority of cases.⁶²

c. The killing of individuals whose choice is not informed, free, and competently made

The core of the case for assisted suicide and voluntary euthanasia erodes when a request for assisted suicide is not voluntary, fully considered, and competently made. Professor Yale Kamisar's first classic foray against voluntary euthanasia expressed skepticism that the request could ever be sufficiently voluntary: "There is a good deal to be said . . . for Dr. Frohman's pithy comment that the voluntary plan is to be carried out 'only if the victim is both sane and crazed with pain.'"⁶³ This, surely, goes too far. While it is always possible to read the pain, vulnerability, fright, and asymmetric information of medical encounters as undercutting the possibility of "true" patient autonomy, we permit patients to both consent to life-threatening procedures and refuse life-sustaining treatments without falling into metaphysical paralysis over the tainted nature of the patient's will.

Nonetheless, Professor Kamisar's later sobering apprehension is that euthanasia or assisted suicide will often be invoked by persons affected by diagnosable and treatable psychiatric illnesses. He refers to literature suggesting that "suicide rarely occurs in the absence of a major psychiatric disorder" combined with "the inability of depressed persons to recognize the severity of their own symptoms and the failure of primary physicians to detect major depression in their patients."⁶⁴ Similarly, the New York State Task Force on Life

and 28 nursing home doctors stated that, between 1986 and 1989, they had deliberately terminated lives of 94 and 70 patients, respectively, without explicit request by patients).

This is not to suggest that all of these cases involved cavalier executions. The Rummelink Study concluded that 59% of participating doctors had some information about the patient's wishes, 83% had discussions with relatives, and 86% of those who died had their lives shortened by one week or less. See Pijnenborg et al., *supra*, at 1198 tbl. III (listing study results). For further discussion of Rummelink Study, see generally van der Maas et al., *supra* note 60.

62. See van der Maas et al., *supra* note 60, at 672. In 60% of the cases involving increased dosages, physicians did not consult patients before administering drugs. Of those cases, 73% of the patients were not competent to discuss treatment. *Id.* Similarly, in 63% of the cases involving withdrawal of treatment, the plan was not discussed with the patient. *Id.* In 88% of the withdrawal cases where the patient was not consulted, the patient was incompetent. *Id.*

63. Kamisar, *supra* note 47, at 985-86; see also *id.* at 985-93 (questioning ability of patients to voluntarily consent to euthanasia).

64. Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CENTER REP., May-June 1993, at 32, 38 & nn.37-39 (stating that 95% of suicide victims have diagnosable psychiatric illnesses, with majority suffering from depression (citing Herbert Hendin & Gerald

and the Law rested its opposition to legalization in part on the twin concerns that "a majority of individuals who kill themselves suffer from depression that is treatable" and that "most doctors are not adequately trained to diagnose depression especially in complex cases such as patients who are terminally ill."⁶⁵

Of course, the current suicide population in the United States excludes those who are deterred by the illegality of assisted suicide. It is entirely possible that those who are currently deterred are less characterized by psychiatric disorders. One recent study finds that in the Netherlands, less than a third of requests for euthanasia or assisted suicide are granted by the physician, and that fourteen percent of the refused requests come from patients who have been diagnosed as having a psychiatric illness.⁶⁶ This may be a testimony either to the difficulty of diagnosing psychiatric problems or to the existence of a large group of persons who choose euthanasia without psychiatric disturbance.⁶⁷ In American society, where 2.9% of the

Klerman, *Physician Assisted Suicide, The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143, 143 (1993)); see also James H. Brown et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208, 210 (1986) (reporting results of study that found that all terminally ill patients in study group who had desired death suffered from major depressive illness); Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 NEW ENG. J. MED. 1100, 1101 (1991) (finding that "90 to 100 percent of suicide victims die while they have diagnosable psychiatric illness," and noting that "primary care physicians often fail to recognize or treat depression").

For other recent discussion, see Eric D. Caine & Yeates C. Conwell, *Self-Determined Death, the Physician and Medical Priorities: Is There Time to Talk?*, 270 JAMA 875, 876 (1993) (reporting results of study that found that "more than 90% of persons" in the study who committed suicide had "major mental disorders," suggesting that primary care physicians who examined suicide victims shortly before death "missed or undervalued prominent psychiatric signs and psychological symptoms"); David C. Clark, *'Rational' Suicide and People with Terminal Conditions or Disabilities*, 8 ISSUES L. & MED. 47, 54, 56-58 (1992) (reviewing studies, and stating that there is "empirical justification for thinking that a suicide rarely, if ever, occurs in the absence of a major psychiatric disorder," and that there is, likewise, basis for concluding that physicians often fail to recognize depression); Yeates Conwell et al., *Suicide and Cancer in Late Life*, 41 HOSP. & COMMUNITY PSYCHIATRY 1334, 1337-38 (1990) (discussing study of eight cancer patients who attempted or committed suicide while under physicians' care, and emphasizing that attending physicians failed to treat depression in all eight cases); cf. Mary Jane Massie & Jimmie C. Holland, *Diagnosis and Treatment of Depression in the Cancer Patient*, J. CLINICAL PSYCHIATRY, Mar. 1984, § 2, at 25 (asserting that "depression in patients with cancer is underdiagnosed and undertreated"). But see Timothy E. Quill, *Doctor I Want to Die. Will You Help Me?*, 270 JAMA 870, 872 (1993) ("[T]here is growing clinical literature suggesting some of these suicides may be rational.").

65. TASK FORCE ON LIFE AND LAW, *supra* note 47, at 126-27.

66. See van der Maas et al., *supra* note 60, at 672 (setting forth findings based on approximately 9000 explicit requests for euthanasia or assisted suicide received each year in Netherlands).

67. Cf. *Dutch Court Expands Euthanasia Guidelines to Include Mentally Ill*, L.A. TIMES, June 23, 1994, at A18 (discussing Dutch Supreme Court's exemption from punishment of psychiatrist who assisted suicide of 50-year-old woman who was depressed after death of her sons and recent divorce).

adult population has made a suicide attempt and suicide accounts for 30,000 deaths per year,⁶⁸ these are no light concerns.

2. *Withdrawal of support for remaining alive*

The State need not rely on a contested argument about the absolute sanctity of human life to adopt the proposition that public policy should minimize the pressures that impel citizens to seek death, and maximize the forces that support them in choosing life.⁶⁹ Arguments for the prohibition of euthanasia and assisted suicide are rooted in part in the fear that legalization will unleash the opposite incentives.

In the worst version of this scenario, legalization would set loose the self-interested manipulation of doctors, hospital administrators, and avaricious (or cost-conscious) family members. Incentives for cost minimization in the emerging health care system have already fostered fears that illnesses, particularly chronic illnesses, will be undertreated.⁷⁰ If the need for costly treatment can be avoided by an early end to chronic suffering, the lure of efforts to hasten the "final exit" of patients or family members may be exacerbated.⁷¹ In a cost-conscious system that permits assisted suicide, temptations range from conscious manipulation of levels of care or pain relief for

68. Clark, *supra* note 64, at 149.

69. Cf. Rodriguez v. British Columbia, 107 D.L.R.4th 342, 396 (Can. 1993) (opinion of Sopinka, J.) (asserting that purpose of State's euthanasia law is to protect "vulnerable who might be induced in moments of weakness to commit suicide").

70. See Council on Ethical & Judicial Affairs, American Medical Ass'n, *Decisions Near the End of Life*, 267 JAMA 2229, 2232 (1992) [hereinafter *Decisions Near the End of Life*] (stating that "increasing pressure to reduce health care costs may serve as another motivation to favor euthanasia over longer-term comfort care").

71. The Dutch seek to avoid financial incentives by providing that doctors may obtain no remuneration for euthanasia. See Loes Pijnenborg et al., Letter to Editor, *Life Terminating Acts without Explicit Request of Patients*, 342 LANCET 308, 308 (1993) (noting that "Dutch law forbids a physician to profit directly or indirectly by the last will that a patient made during his illness" and that physician receives "no fee for practising euthanasia"); Pijnenborg et al., *supra* note 61, at 1199 ("99.4% of population is comprehensively insured for medical expenditures and 100% for the costs of long-standing illness. The ending of a patient's life never produces financial gain for the physician.").

Direct fees, however, are far from the only financial incentives at work in other health care systems. One unintentionally ominous premonition comes from the arguments in favor of physician-assisted suicide and euthanasia by the British Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death:

Nowadays much medical and surgical care is increasingly costly and doctors have to ensure a fair distribution of expensive investigations and treatment. . . . They may resent or even seek to dismiss this encroachment on their clinical freedom, but this is an increasing influence on decisions about prolonging life and refusing assistance of death, both of which may be costly in terms of medical resources.

Institute of Medical Ethics Working Party on the Ethics of Prolonging Life & Assisting Death, *Assisted Death*, 336 LANCET 610, 612 (1990).

costly patients to efforts to persuade patients that their duty is to leave their bed or estate to those who can use it better.

Less malignantly, but no less problematically, the incentive to expend resources seeking out state-of-the-art pain management may be undercut if a patient's pain can be ended by death.⁷² There is evidence that current medical practice radically undertreats pain, making suicide a more attractive option than is technologically necessary.⁷³ The poor and isolated who have the least leverage in seeking relief from the medical system will be particularly subject to this danger.⁷⁴

Motivations for encouraging suicide need be neither crass nor conscious to raise concerns. Caring for a terminal or suffering person exacts fearsome psychic tolls. One commentator observes: "There is ample evidence that physicians often have difficulty responding therapeutically to chronically ill or dying patients. They often underdiagnose and undertreat pain or depression These complex feelings can influence a physician to abandon a patient or affirm a person's suicidal intent, which in turn may precipitate

72. See Memorandum by the British Medical Ass'n, in 2 SELECT COMM. ON MED. ETHICS, *supra* note 13, at 26, 32 ("It is of particular concern to the BMA that less attention might be given to effective training in controlling pain and actively helping patients address their fears about death if euthanasia were seen to be an available or acceptable option."); Bernat et al., *supra* note 44, at 2723, 2727 (arguing that "legalizing [physician-assisted suicide] would make it unnecessary for physicians to strive to maximize comfort measures in terminally ill patients and unnecessary for society to support research to improve the science of palliation"); *Decisions Near the End of Life*, *supra* note 70, at 2232 (discussing possible creation of economic motivation if euthanasia were legalized).

One could argue that, for doctors who want their patients to remain alive, the incentive to minimize pain is sharpened by the threat that patients will kill themselves if pain is not adequately controlled. On the other hand, there is a documented tendency for the quality of services to deteriorate when the most quality conscious consumers have the ability to leave the system. See generally ALBERT O. HIRSCHMAN, EXIT, VOICE & LOYALTY (1970) (discussing consumer response to deterioration of performance through either "exit" or "voice" mechanism). "Final exit" may bleed off patients who would otherwise challenge the system.

73. See David A. Fishbain et al., *Completed Suicide in Chronic Pain*, 7 CLINICAL J. PAIN 29, 34 (1991) (suggesting that patients in chronic pain are at risk for suicide); Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14, 20 (1993) (concluding from study of health care professionals that "inappropriate management of pain is due partly to lack of knowledge of appropriate techniques for pain control and partly to misplaced fear of causing addiction"); Jamie H. Von Roenn et al., *Physician Attitudes and Practice in Cancer Pain Management: A Survey from the Eastern Cooperative Oncology Group*, 119 ANNALS INTERNAL MED. 121, 124 (1993) (noting that even oncologists are often poorly trained in pain management).

74. Cf. Charles S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENG. J. MED. 592, 594-95 (1994) (reporting findings that minorities, elderly, and women are more likely to receive poor pain treatment); Knox H. Todd et al., *Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia*, 269 JAMA 1537, 1538 (1993) (reporting results of study finding that Hispanic patients were twice as likely as non-Hispanic white patients to receive no emergency treatment pain medication). These same groups, however, are likely to suffer greatly from poor pain management if they remain alive.

suicides."⁷⁵ For family members, the costs are similar, and a plea from the patient's loved ones for "release" from the burdens of caregiving will often fall on receptive ears.⁷⁶ Eliminating the normative force of legal prohibition will decrease support for the difficult task of caring for the chronically ill.⁷⁷

Finally, legalization may generate desires to end life where none existed before, or dampen desires to live. The Canadian Supreme Court phrased the case negatively:

In upholding the respect for life [prohibition] may discourage those who consider that life is unbearable at a particular moment or those who perceive themselves to be a burden upon others from committing suicide. To permit a physician to lawfully participate in taking life would send a signal that there are circumstances in which the state approves of suicide.⁷⁸

But the point can be made positively: The refusal to make exceptions for those who are physically impaired sends the message that they are valued no less than their physically able fellows, and equally entitled to life.

75. Miles, *supra* note 50, at 1786; see also Grant Gillett, *Killing, Letting Die and Moral Perception*, 8 *BIOETHICS* 312, 323-25 (1994) (arguing that "easy, instant and decisive answer" provided by euthanasia appeals to technical enthusiasm and is likely to "do away with finely balanced . . . moral judgment").

76. While realizing the limits of survey data, it is striking that 47% of Americans who would consider ending their lives in the case of terminal illness state that they would do so "because of fears of burdening their families." See Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying?: The Public Perspective*, 267 *JAMA* 2658, 2660 (1992). By contrast, 20% would not want to live in pain, and 19% would not want to be dependent on machines. *Id.*

A retrospective study in the Netherlands, found that only 22% of patients mentioned "not wanting to be a burden" as a reason for requesting assisted suicide or euthanasia, with only 2% articulating this as the most important reason. See G. van der Wal et al., *Euthanasia and Assisted Suicide. II. Do Dutch Family Doctors Act Prudently?*, 9 *FAM. PRAC.* 135, 138 (1992) (reporting results of survey indicating reasons why patients sought information about euthanasia from family doctor).

77. See, e.g., *Decisions Near the End of Life*, *supra* note 70, at 2332 (discussing risks associated with allowing physician-performed euthanasia because it creates danger that "physicians and other health care providers may be more reluctant to invest their energy and time serving patients whom they believe would benefit from a quick and easy death").

78. *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 406 (Can. 1993) (opinion of Sopinka, J.); see also *id.* at 411 (maintaining that purpose of euthanasia legislation is "to discourage terminally ill from choosing death over life"); cf. Joan Teno & Joanne Lynn, *Voluntary Active Euthanasia: The Individual Case and Public Policy*, 39 *J. AM. GERIATRICS SOC'Y* 827, 828 (1991):

New patients to hospice often state they want to "get it over with . . ." These requests may be attempts by the patient to see if anyone really cares whether he or she lives. Meeting such a request with ready acceptance could be disastrous for the patient who interprets the response as confirmation of his or her worthlessness.

But cf. Paul Cotton, *Rational Suicide: No Longer 'Crazy'?*, 270 *JAMA* 797, 797 (1993) (noting argument that providing option of suicide may give patient sense of control, which makes suicide less likely).

3. *Legalization may taint the relation between patients and doctors*

The longstanding prohibition of the Hippocratic Oath that enjoins physicians not to "give deadly drug to anyone if asked for it, nor suggest any such counsel"⁷⁹ illustrates that the temptations of euthanasia are not new, and that the associated dangers for the medical role are not inconsiderable. Before fixing too quickly on this source, however, we should recall that the Oath's next maxim is "in like manner I will not give to a woman a pessary to produce an abortion."⁸⁰

The popular understanding of the medical role, nonetheless, rests on a conception of the physician as healer; the patient's acquiescence in invasive or dangerous treatment rests in part on the faith that the power the physician exercises is directed toward the patient's recovery. Many prohibitionists believe that trust would be undermined if physicians took part in affirmatively hastening their patients' deaths, even on request.⁸¹ Conversely, the prohibition may ease the emotionally difficult task for doctors of engaging with dying patients. As one proponent of prohibition puts the case:

It may foster a therapeutic intimacy by creating a "landmark" for a physician in an emotionally disorienting relationship with a dying patient. If I know I may not project my disquiet back on a patient by improperly leading him or her to choose suicide, perhaps I will then dare to create a more intimate clinical relationship in which I can face more of my discomfort with her suffering.⁸²

In a medical system in which personal encounters are less common than ever before,⁸³ abandoning a medical landmark that fosters personal trust is a move that carries substantial potential secular costs.

79. Hippocratic Oath, *reprinted in* THOMAS A. MAPPES & JANE S. ZEMBATY, *BIOMEDICAL ETHICS* 53 (3d ed. 1991).

80. Hippocratic Oath, *quoted in* *Roe v. Wade*, 410 U.S. 112, 131 (1973).

81. *E.g.*, *Decisions Near the End of Life*, *supra* note 70, at 2232 (arguing that offering death as legal medical treatment "might undermine public trust in medicine's dedication to preserving . . . life"); William Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139, 2139-40 (1988) (condemning actions of medical resident for administering fatal dose of painkiller, and calling for medical community to resist efforts to legalize active euthanasia); David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1844-45 (1989) (arguing that if physician seems willing to assist in suicide, patient may lose confidence in that physician's commitment to his or her care); *cf.* GOMEZ, *supra* note 57, at 119 (stating that some Dutch nursing homes advertise publicly that they do not perform euthanasia).

82. Miles, *supra* note 50, at 1787.

83. See generally Martin L. Cook, *The End of Life and the Goals of Medicine*, 153 ARCHIVES INTERNAL MED. 2718, 2719 (1993) (discussing risk of medicine becoming "mere service industry" as result of increase in managed care system and increasingly impersonal physician-patient relationships).

III. *ROE* AND BODILY INTEGRITY

The plurality in *Casey* reached beyond the procreational privacy that was staked out in *Roe*⁸⁴ to rest on a "rule (whether mistaken or not) of personal autonomy and bodily integrity";⁸⁵ "the mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear Her suffering is too intimate and personal for the State to insist without more on its own vision of the woman's role."⁸⁶ In many of the contexts where patients seek euthanasia or physician-assisted suicide, the "anxiety, physical constraints and pain" entailed by their physical condition are often equally incontestable and personal.

One plaintiff in the Washington case, "Jane Roe," with a life expectancy of six months, "suffered from cancer which [had] . . . metastasized throughout her skeleton."⁸⁷ She experienced constant pain "which [could] not be fully alleviated by medication."⁸⁸ She was "bedridden" and "suffer[ed] from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of the bowel and general weakness."⁸⁹ A second, "James Poe," "suffer[ed] from emphysema, which cause[d] him a constant sensation of suffocating."⁹⁰ In the Canadian case, the plaintiff, Sue Rodriguez, faced a life expectancy of between two and fourteen months, during which she would "lose the ability to swallow, speak, walk and move her

84. See *Roe*, 410 U.S. at 152-54 (affirming that right of privacy protects activities "relating to procreation," but holding that this right is not absolute).

85. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2810 (1992). The plurality goes on to observe that "our cases since *Roe* accord with *Roe's* view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." *Id.* (citing *Riggins v. Nevada*, 112 S. Ct. 1810, 1815 (1992); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990); *Washington v. Harper*, 494 U.S. 210 (1990); *Rochin v. California*, 342 U.S. 165 (1952); *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 (1905)). In each of the cited cases, the Court sanctioned interference with the rights of bodily autonomy.

86. *Id.* at 2807; see also *id.* at 2840 (Stevens, J., concurring in part and dissenting in part) ("One aspect of this liberty is a right to bodily integrity, a right to control one's person 'Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds' The same holds true for the power to control women's bodies." (quoting *Stanley v. Georgia*, 394 U.S. 557, 565 (1969))); *id.* at 2846 (Blackmun, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("Compelled continuation of a pregnancy infringes upon a woman's right to bodily integrity by imposing substantial physical intrusions and significant risks of physical harm [R]estrictive abortion laws force women to endure physical invasions far more substantial than those this Court has held to violate the constitutional principle of bodily integrity in other contexts.").

87. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1456 (W.D. Wash. 1994).

88. *Id.*

89. *Id.*

90. *Id.* at 1457.

body without assistance."⁹¹ Rodriguez would "be required to live until the deterioration from her disease is such that she w[ould] die as a result of choking, suffocation or pneumonia caused by aspiration of food or secretions."⁹²

Although current advances in pain management allow palliation of much physical suffering, an irreducible core of patients are trapped in physical agony (if they are awake).⁹³ Many more find their irreversibly helpless and medically hopeless conditions offensive to their sense of dignity and meaning.⁹⁴ A recent proponent of assisted suicide describes a sixty-seven-year-old retired grandfather suffering from inoperable, metastatic lung cancer, whose condition, despite treatment that had resulted in a "relatively good year," had advanced to the point that he "could no longer tolerate his grandchildren," who had been his main joy in life:

[H]is days felt empty and his nights were dominated by despair about the future [H]is severe bone pain required daily choices between pain and sedation. . . . Death was becoming less frightening than life. . . . His thigh had crumbled; he could no longer walk. . . . He saw his life savings from 45 years of work rapidly depleting He wanted to die.⁹⁵

The *Casey* plurality's articulation of an interest in bodily autonomy rested in part on the Court's discussion two years before in *Cruzan v.*

91. *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 349 (Can. 1993) (Lamer, C.J.C., dissenting).

92. *Id.* at 391 (opinion of Sopinka, J.).

93. Cf. Nancy Volkens, *Federal Agency Releases Guidelines for Pain Treatment*, 86 J. NAT'L CANCER INST. 490, 490 (1994) ("No matter the source [of the pain], 'pain . . . can be effectively controlled in up to 90% of all cancer patients.'" (quoting Phillip R. Lee, Assistant Secretary for Health, Dep't of Health & Human Services)). See generally Susan D. Bloch & Andrew Billings, *Patient Requests to Hasten Death*, 154 ARCHIVES INTERNAL MED. 2039 (1994) (discussing studies that found "uncontrolled pain" as major risk factor for suicide among cancer patients); Gregg A. Kasting, *The Nonnecessity of Euthanasia*, in PHYSICIAN-ASSISTED DEATH 25, 35 (James Hunter et al. eds., 1994) (surveying literature suggesting that up to 35% of terminal patients experience pain).

94. See van der Maas et al., *supra* note 60, at 672 (reporting results of Dutch survey of reasons given by those who sought euthanasia or assisted suicide). The survey reported that 57% of those surveyed cited "loss of dignity," 46% cited pain, 46% "unworthy dying," 33% were concerned about dependency on others, and 23% indicated that they were "tired of life." The survey emphasized that only 5% of those surveyed mentioned "pain" as the only reason for their decision to seek either euthanasia or suicide. *Id.*; see also de Wachter, *supra* note 60, at 24 (stating that primary reason for requesting aid in dying is unbearable suffering of both physical and psychological nature); cf. *Compassion in Dying*, 850 F. Supp. at 1456 (discussing John Doe, 44-year-old artist dying of AIDS, experiencing chronic severe skin and sinus infections, and "degenerative disease which will result in blindness and rob him of his ability to paint"); *People v. Kevorkian*, 517 N.W.2d 293, 294 (Mich. Ct. App.) (describing assisted suicide of Sherry Miller who, 16 years after diagnosis with multiple sclerosis, was confined to bed or wheelchair, did not have use of her legs and right arm, and had difficulty breathing), *vacated and remanded*, 1994 WL 700448 (Mich. Dec. 13, 1994).

95. Quill, *supra* note 64, at 871.

Director, Missouri Department of Health.⁹⁶ *Cruzan*, like *Quinlan* years earlier, was a "right to die" case regarding the State's standards of proof for permitting withdrawal of life-sustaining treatment from an incompetent person in a persistent vegetative state. It dealt in passing with the constitutional rights of a competent patient who seeks to refuse life-sustaining treatment.

The Court's majority in *Cruzan*, which included three of the four dissenters in *Casey*, "assumed that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."⁹⁷ Four *Cruzan* dissenters wrote strongly in support of that right,⁹⁸ and Justice O'Connor's pivotal concurring opinion observed that "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination,"⁹⁹ and advanced the proposition that "the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."¹⁰⁰ Only Justice Scalia unambiguously rejected constitutional protection of the right to refuse life-saving treatment.¹⁰¹

The *Cruzan* discussion was indicative, but less than an explicit affirmation of a constitutional right to refuse treatment. In *Casey*, however, the plurality characterized *Roe* as a case "recognizing limits

96. 497 U.S. 261 (1990).

97. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 279 (1990). The majority, Chief Justice Rehnquist, along with Justices O'Connor, Scalia, Kennedy, and White, also commented that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Id.* at 280.

98. Justice Brennan, writing for himself and Justices Blackmun and Marshall, characterized the right to be free of unwanted medical treatment "as fundamental, although not necessarily absolute." *Id.* at 312 (Brennan, J., dissenting). Justice Brennan's opinion, therefore, left open the possibility that the interests of a conscious individual, the interests of third parties, or the interests of society as a whole might be sufficient in some cases to override the individual's decision.

In a separate dissent, Justice Stevens stated:

Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly so rooted in the traditions and conscience of our people as to be ranked as fundamental, and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator.

Id. at 343 (Stevens, J., dissenting) (quotations and citations omitted). Justice Stevens' dissent, however, seemed to leave some room for anti-suicide laws or decisions addressing the quality of life of incompetent but conscious patients. *See id.* at 347 (Stevens, J., dissenting) (stating that such laws and decisions recognize individuals' interest in living).

99. *Id.* at 287 (O'Connor, J., concurring).

100. *Id.* at 289 (O'Connor, J., concurring).

101. *See id.* at 299-300 (Scalia, J., concurring) (emphasizing that Due Process Clause neither explicitly nor through tradition recognizes right to refuse life-saving treatment).

on governmental power to mandate medical treatment or bar its rejection" and cited *Cruzan* as in "accord with *Roe*'s view."¹⁰² The plurality illustrated the "soundness" of *Roe*'s implicit recognition of a right to bodily integrity with a citation to *Quinlan*'s reliance "on *Roe* in finding a right to terminate medical treatment."¹⁰³ After *Casey*, therefore, it seems that a majority of the Court would not view the government's interest in preserving the life of a person who seeks to end her existence as justifying imposition of life-sustaining medical treatment against a patient's will. The right to bodily integrity, which was arguably dicta in *Cruzan*, became a building block in the plurality's reasoning in *Casey*.

A number of commentators take this proposition to establish a constitutionally protected "right to die."¹⁰⁴ Indeed, Justice Scalia's argument against the right to refuse treatment in *Cruzan* made use of the supposed entailment of a right to suicide as a point against constitutionalizing the right to refuse.¹⁰⁵ Although *Casey* strengthens this position, ultimately the claim fails.¹⁰⁶

102. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2810 (1992). The plurality carefully went on to cite *Cruzan* as a case in "accord with *Roe*'s view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." *Id.* Exactly what "non-plenary" overrides are acceptable is left ambiguous.

103. *Id.* at 2811; see also *In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (holding that right to decline medical treatment is analogous to *Roe*'s constitutional right to terminate pregnancy).

104. See, e.g., John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139, 1177 (1991) (arguing that consensual active euthanasia should logically be constitutional right because prohibitions on suicide or assisted suicide, like forcing unwanted treatment on competent person, may impose undue bodily burdens); Sedler, *supra* note 6, at 777, 787-89 (suggesting that under *Casey*, absolute ban on physician-prescribed medication used to hasten death would impose undue burden on terminally ill patient's right to die); Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 HARV. L. REV. 2021, 2036 (1992) (arguing that competent, terminally ill patient has legal right to refuse or discontinue life-sustaining treatment); see also *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1461 (W.D. Wash. 1994) (questioning distinction between refusing life-sustaining medical treatment and physician-assisted suicide); *id.* at 1467 (stating that distinction between removal of life support and assisted suicide violates equal protection because "distinction between natural and artificial death" does not "justifiably" disparate treatment of [these two] similarly situated groups"); *Hobbs v. Attorney Gen.*, 518 N.W.2d 487, 496 (Mich. Ct. App.) (Shelton, J., concurring in part and dissenting in part) ("If a terminally ill person can lawfully end her life by disconnecting a life-sustaining machine (*Cruzan*) why cannot she end that same life by connecting a life-ending machine?"), *aff'd in part and rev'd in part*, 1994 WL 700448 (Mich. Dec. 13, 1994); cf. *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 413 (Can. 1993) (Cory, J., dissenting) (stating that right to die should be afforded constitutional protection because it is integral part of life); *id.* at 420 (McLachlin, J., dissenting) (commenting that right to die should be protected against arbitrary state action).

105. See *supra* note 101 (noting Justice Scalia's view that neither right to suicide nor right to refuse treatment finds support in constitutional traditions).

106. The *Cruzan* majority strongly suggested that its holding would not extend to assisted suicide. See *Cruzan*, 498 U.S. at 280 (emphasizing that State has strong interest in protecting and preserving human life, and may impose criminal penalties on those who assist others to commit suicide). Of course, three of the members of the *Cruzan* majority dissented from *Casey*.

A. *The "Right to Refuse" v. the "Right to Control":
Casey's Erosion of the Distinction*

Justice O'Connor's pivotal opinion in *Cruzan* phrases the constitutional right that she would recognize as a right against both "incursions into the body," and "restraint and intrusion."¹⁰⁷ The central image is the picture of a physician "passing a long flexible tube through the patient's nose, throat and esophagus and into the stomach. Because of the discomfort such a tube causes, [m]any patients need to be restrained forcibly and their hands put into large mittens."¹⁰⁸ This image, however, differs from the plight of Sue Rodriguez or Washington's Jane Roe. For them, the State's imposition is not a physical "intrusion" on their bodily integrity but a refusal to permit lethal intrusions at their own request.

Under the Due Process Clause, the Supreme Court has held involuntary stomach pumping in the search for evidence and gratuitous shackles in the effort to treat mental illness to be prohibited impositions that "shock the conscience of the court."¹⁰⁹ Yet to allow a citizen to resist physical intrusions by the State is not to conclude that the Constitution vests her with plenary control of her body. A right to refuse invasions by outside forces that bring about a certain state of affairs is not equivalent to a right to prevent that state of affairs; it may be only the particular kinds of invasions that are prohibited. The fact that one can refuse to submit to a stomach pump to determine the contents of his abdomen does not entail a right to refuse to submit to a less intrusive X-ray for the same purpose.¹¹⁰ It is fully consistent to recognize an interest in refusing the bodily invasion of life-sustaining treatment without recognizing the different interest in affirmatively acting to end life.¹¹¹ Indeed,

107. *Id.* at 287-88 (O'Connor, J., concurring).

108. *Id.* at 288-89 (citation and internal quotation marks omitted).

109. See *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (holding that Due Process Clause guarantees mentally retarded person right to reasonably nonrestrictive confinement); *Rochin v. California*, 342 U.S. 165, 172 (1952) (holding that mandatory stomach pumping violates Due Process Clause).

110. Cf. *Schmerber v. California*, 384 U.S. 757, 770-72 (1966) (holding that involuntary blood test did not violate Constitution because test was minor intrusion given circumstances).

111. Cf. Bernat et al., *supra* note 44, at 2723, 2724 (arguing that key legal and moral distinction should be between honoring patient refusals to allow or continue interventions and patient requests for active treatments by physician). If the studies cited by Bernat are correct that the refusal of nutrition and hydration are "associated with trivial suffering," and can be "managed in such a way that the patients remain comfortable," it may be that *Cruzan* has established a right to an effective suicide for competent patients, although not to a quick one. See *id.* at 2725-26 (citing statistical studies and observations that suggest suffering is minimal when patient dies from starvation and dehydration); cf. David M. Eddy, *A Conversation with My Mother*, 222 JAMA 179 (1994) (providing account of 85-year-old woman's successful suicide by

the common law right to refuse medically advised treatment, which supported a claim to historical pedigree of the right in *Cruzan*, recognizes no correlative right to demand treatment that is medically contraindicated.¹¹²

This distinction between a right to resist bodily invasion and a right to demand lethal medical attention establishes a comprehensible line between the right to refuse treatment and the right to assisted suicide that tracks the current center of gravity in the medical profession.¹¹³ The distinction, however, is weakened by *Casey*.

While the "invasion" paradigm governs Justice O'Connor's opinion in *Cruzan*, the right of "personal autonomy and bodily integrity" explicated in the plurality opinion that Justice O'Connor jointly authored in *Casey* is not so easily confined to a right to resist incursions by the State.¹¹⁴ In this respect, *Casey* strengthens the claim for the right to assisted suicide.

The right to "choose whether to carry a pregnancy to term" imports a woman's right to exercise affirmative control over her own body, not merely her right to resist external intrusions. Thus, the *Casey* plurality viewed the requirement that women notify their husbands before obtaining abortions as touching "upon the very bodily integrity of the

refusal of hydration).

112. Cf. Kamisar, *supra* note 64, at 35 (arguing that *Cruzan*'s recognition of right to terminate life-sustaining treatment is consistent with rationale of tradition allowing refusal of treatment but that no similar tradition supports suicide).

This is not to say that a principle protecting a right to control life and death could not also encompass a right to refuse treatment. But only Justice Stevens seemed to view *Cruzan* in these terms. See *Cruzan*, 487 U.S. at 343 (Stevens, J., dissenting) (stating that "right to be free from unwanted life-sustaining treatment [is not] reducible to a protection against batteries undertaken in the name of treatment . . . Choices about death touch the core of liberty . . . and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator.").

113. E.g., *Decisions Near the End of Life*, *supra* note 70, at 2233 (advocating physician's duty to honor patient's request to withhold treatment, but refusing to endorse physician-assisted suicide); Bernard Gert et al., *Distinguishing Between Patients' Refusals and Requests*, 24 HASTINGS CENTER REP., July-Aug. 1994, at 13, 14 (commenting that distinction between patient's refusal and request is "of critical importance in understanding distinction between killing and letting die").

114. Cf. Martha A. Field, *Pregnancy and AIDS*, 52 MD. L. REV. 402, 412 (1993) (stating that right to make one's own medical decisions involves constitutionally protected interest, "[w]hether we speak of the right to refuse medical treatment, as in *Cruzan*, or the right to obtain it, as in *Casey*").

In its recent legal discussion on the subject, the New York State Task Force on Life and the Law rested its conclusion that *Cruzan* does not countenance a right to assisted suicide on the proposition that "the imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity." TASK FORCE ON LIFE AND THE LAW, *supra* note 47, at 71. The Task Force failed, however, to acknowledge *Casey*. Additionally, the Task Force makes the curious assertion that "the Supreme Court has afforded constitutional protection only to those individual practices 'deeply rooted in this nation's history and tradition,'" and cited the plurality in *Michael H. v. Gerald D.*, 491 U.S. 110, 123 (1989), whose members dissented in *Casey*. TASK FORCE ON LIFE AND THE LAW, *supra* note 47, at 72.

pregnant woman,"¹¹⁵ although the requirement constituted no direct invasion of the woman's body by the State. The Constitution, according to the *Casey* plurality, forbids statutes that "place a substantial obstacle in the path of a woman's choice" before viability, not merely those that allow a direct invasion of her body.¹¹⁶

B. Countervailing Interests: Justifications for Limiting Active Euthanasia

After *Casey*, it is hard to maintain that it is only bodily "invasions" that draw constitutional scrutiny.¹¹⁷ The autonomy right of the patient who seeks assistance in ending her life is thus sufficiently analogous to the right of the patient who refuses life-sustaining treatment to support a claim that neither interest is subject to a "plenary override."

But even if this is true, neither right is absolute. State action that brings about conditions of "anxiety, physical constraint, and pain" is not inevitably unconstitutional. Just as the concerns of privacy can be outweighed by the interest in the survival of the viable fetus, the *Casey* plurality accepts the proposition that the State's interest in preserving fetal "life" after viability is a sufficient reason to interfere with a woman's bodily autonomy.¹¹⁸ The constitutional right to choose to terminate pregnancy with a doctor's assistance similarly does not entail a right to have the procedure performed by a nonphysician; the

115. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2830 (1992).

116. *Id.* at 2820; *see also id.* at 2821 (holding that measures aimed at promoting childbirth over abortion will be invalid if they impose undue burden on woman's choice).

117. The individual interest in refusing treatment may still be more weighty than the interest in obtaining an abortion because it encompasses both an "invasion" and a "loss of control." *See supra* notes 107-08 and accompanying text. Just as the preservation of a viable fetus' life may be sufficient to justify preventing an abortion, yet inadequate to justify a compulsory cesarean section, the preservation of an adult life may be sufficient to justify prohibiting euthanasia but inadequate to justify the imposition of life-sustaining treatment. *Cf. Doe v. Doe*, 632 N.E.2d 326, 334-35 (Ill. App. Ct.) (holding that State's interest in preserving potential life of fetus does not justify intrusion on woman's body), *cert. denied*, 114 S. Ct. 1198 (1994).

On the level of the balance of practical harms, moreover, the situation before the Court in *Roe* and *Casey* differed in another dimension. It was clear that the prohibitions struck down in *Roe* were widely evaded, but the cost of evasion was the maiming and unnecessary death of women who sought illegal abortions. Legalization of abortion saved the lives and health of women who would have violated the law. By contrast, it is hard to make a case that legalization of assisted suicide or voluntary euthanasia would save lives.

118. Indeed, *Roe* contemplated regulations of abortion in the interest of the "health of the mother." *Roe v. Wade*, 410 U.S. 113, 150 (1973); *cf. Casey*, 112 S. Ct. at 2821 ("As with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right."). The question left open by *Casey* is whether it is any health regulation that imposes a substantial obstacle, or only "unnecessary" health regulations, that violate the Constitution. If only "unnecessary" regulations are prohibited, logically there may be situations where the woman's right to choose may be infringed against her will in the interests of her own health.

woman's interest in unfettered choice is outweighed by other legitimate State concerns.¹¹⁹

A right to refuse life-sustaining treatment does not establish a right to assistance in ending life if the State's interests in avoiding voluntary suicide and euthanasia are more powerful than its interest in mandating unwanted medical interventions. Two sets of State interests serve to distinguish assisted suicide and voluntary euthanasia from the right to refuse treatment: moral interests and practical interests.

1. *Moral interests: killing and letting die*

Although the patient does not object, and indeed seeks death in both a refusal of treatment and a request for lethal assistance, the State may have a legitimate basis for morally distinguishing the act of the doctor who removes life support from that of the doctor who provides a lethal injection not because the rights of the patient differ, but because of distinctions in the doctor's culpability. The State may judge that the injection is more culpable, not because it violates the "rights" of the patient, but because the direct, active, and intentional killing of a human being is intrinsically more blameworthy morally. The argument is that although there is a protectable interest in affirmatively controlling one's body in both situations, the constitutional right of bodily autonomy is overcome in the case of "active" but not "passive" voluntary euthanasia by the greater moral culpability of the former.¹²⁰

A moral distinction between "active" and "passive" euthanasia is widely recognized among the medical profession.¹²¹ Doctors who

119. See *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) (per curiam) (holding that prosecuting nonphysicians who perform abortions does not infringe woman's privacy interests); *Roe v. Wade*, 410 U.S. 113, 165 (1973) (permitting States to proscribe abortions by nonphysicians because of interest in preserving health and life of mother). But see *Benten v. Kessler*, 112 S. Ct. 2929, 2930-31 (1992) (Stevens, J., dissenting from denial of application to vacate stay) (stating that right to choose to terminate pregnancy entails right to use nonapproved drug in order to induce nonsurgical abortion when no significant health risk exists).

120. The author of a Harvard Law Review Note concerning physician-assisted suicide ignores this possibility and maintains that, because the terminally ill and medically dependent patient has a right to die by refusing treatment, the State's interest is no greater in avoiding death by poison. Note, *supra* note 104, at 2036.

121. See, e.g., PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 61 (1983) (stating that distinction between "acting" and "omitting to act" is one factor to determine whether medical decision is morally and legally acceptable); ROBERT F. WEIR, ABATING TREATMENT WITH CRITICALLY ILL PATIENTS: ETHICAL AND LEGAL LIMITATIONS TO THE MEDICAL PROLONGATION OF LIFE 306-07 (1989) (agreeing that "reasonable line can be drawn both conceptually and morally between treatment abatement and euthanasia"); American Geriatrics Society, Public Policy Committee, *Voluntary Active Euthanasia*, 39 J. AM. GERIATRICS SOC'Y 826, 826 (1991) (stating that

would not think of lethally injecting their patients draw what they regard as a substantial moral distinction between that act and the removal of life support. Those who recognize the distinction between "active" and "passive" euthanasia view their opponents as obtuse to the point of moral myopia.¹²²

The distinction is not alien to the law. The distinction in culpability between directly and actively causing harm and merely allowing it to happen is embedded in criminal jurisprudence¹²³ and tort law.¹²⁴ Indeed the distinction between passively allowing a result to come about and actively promoting it is well-established in the Supreme Court's state action jurisprudence.¹²⁵ Justice Scalia's claim in *Cruzan* that there is no difference between suicide and refusal of life support rests uncomfortably with a series of cases in which he

physicians should not provide treatment that "actively, directly, and intentionally" causes patient's death); Dan W. Brock, *Voluntary Active Euthanasia*, 22 HASTINGS CENTER REP., Mar.-Apr. 1992, at 10, 10 (observing that debate between voluntary active euthanasia and passive physician-assisted suicide has become prominent issue in biomedical ethics); Gillett, *supra* note 75, at 313, 326 (arguing for continued recognition of distinction between killing and letting die, and for "common rejection of active euthanasia by health professionals"); Edmund D. Pellegrino, *Doctors Must Not Kill*, 3 J. CLINICAL ETHICS 95, 95 (1992) (defining active euthanasia as "intentional killing of a patient by a physician with the patient's consent," and passive euthanasia as "allowing a patient with an incurable disease to die either by withholding or withdrawing life-sustaining support"). But see JAMES RACHELS, *THE END OF LIFE* 106-14 (1986) (attacking traditional medical distinction between killing and letting die, and arguing for equivalence theory—that there exists no moral difference between two).

Although acknowledging some logical problems with the distinction between killing and letting die, Tom L. Beauchamp and James F. Childress, scholars from the Kennedy Institute of Ethics, formerly took the position that the distinction served valuable social functions, and that medical killing should, in accordance with traditional medical ethics, be prohibited. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 134-47 (3d ed. 1989). In the fourth edition of their book, *Principles of Biomedical Ethics*, Beauchamp and Childress reverse field and argue that passive and active voluntary euthanasia are not morally distinguishable, TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 219-41 (4th ed. 1994), and that "in general, we have thus far been able to respect the line between unjustifiable and justifiable passive euthanasia in medical practice, and we should similarly be able to hold the line between justified and unjustified assistance for suicide," *id.* at 240.

122. See, e.g., DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* 76 (1993) ("There is and will always remain a fundamental difference between what nature does to us and what we do to one another."); Daniel Callahan, *When Self-Determination Runs Amok*, 22 HASTINGS CENTER REP., Mar.-Apr. 1992, at 52, 53 (contending that "notion that there is no morally significant difference between omission and commission is just wrong").

123. See, e.g., DOUGLAS N. HUSAK, *PHILOSOPHY OF CRIMINAL LAW* 83 (1987); LEO KATZ, *BAD ACTS AND GUILTY MINDS* 140-43 (1987); F.M. Kamm, *Action, Omission and the Stringency of Duties*, 142 U. PA. L. REV. 1493, 1495 (1994); Michael S. Moore, *More on Act and Crime*, 142 U. PA. L. REV. 1749, 1772-88 (1994). Not all commentators hold omissions wholly blameless, but most view the culpability as different in scope. Cf. MODEL PENAL CODE § 2.01 (1985) (positing that liability cannot be based on omission unless duty is specifically imposed by law).

124. See W.P. KEETON ET AL., *PROSSER AND KEETON ON THE LAW OF TORTS* 373-74 (5th ed. 1984) (distinguishing nonfeasance from malfeasance in tort law).

125. See *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 196-97 (1989) (arguing that Framer's intent and past cases support proposition that Due Process Clause protects individuals from "affirmative" state action, and does not impose liability for inaction absent statute or special relationship between individual and State).

concurred that absolved the State from responsibility for bodily violations that it passively allowed to occur.¹²⁶

Yet, the pervasive dissatisfaction with the Court's state action jurisprudence suggests that the active/passive distinction is, at best, problematic. And the opponents of the distinction in the "right to die" field view its partisans as obscurantist to the point of pedantry.¹²⁷

The constitutional question is whether control of a citizen's body, dignity, and pain can be limited on such debated moral premises. The guidance of precedent is weak, because the cases that affirm the State's power to act from contested moral conviction, for the most part, do not involve suffering of a magnitude comparable to that imposed on Sue Rodriguez or Washington's Jane Roe.¹²⁸ The earlier argument that the abortion cases can be read to bar the State from imposing substantial, concrete, concentrated disadvantage on

126. *E.g.*, *Collins v. City of Harker Heights*, 112 S. Ct. 1061, 1069-70 (1992) (holding that municipality did not have affirmative duty under Due Process Clause to warn decedent about unsafe working conditions that caused his death); *DeShaney*, 489 U.S. at 195-96 (holding that Due Process Clause does not impose affirmative duty on State to protect individuals from private actor's criminal activity); *cf.* Louis M. Seidman, *Confusion at the Border: Cruzan, "The Right to Die" and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, 67-68 (observing that Justice Scalia's critique on "action/inaction distinction" in *Cruzan* implies State liability for "fatal nonfeasance"). It is only by abandoning this distinction that a court could recognize the claim of the plaintiffs in *Lee v. Oregon* that legalizing assisted suicide deprives them of their "right to life" without due process. *Lee* Complaint, *supra* note 13, at 30.

Any attack on the "action/inaction" distinction leads to curious reversals. Justice Scalia in *Cruzan* takes the position that there is no compelling difference between refusing treatment and committing suicide. But if this is so, then it would seem that the failure to allow assistance is equivalent to trapping Sue Rodriguez in an endless cycle of torture, and allowing Joshua DeShaney to be murdered is equivalent to murdering him. If the same act/omission principles are applicable at both individual and societal levels (and this is a big if), it suggests that a consistent position must draw a distinction between suicide and refusals of treatment or abandon the proposition that the State is not responsible for harms it allows to occur.

127. *E.g.*, RACHELS; *supra* note 121, at 119-21 (stating that active/passive distinction has no basis in physicians' professional conduct); Leslie Bender, *A Feminist Analysis of Physician-Assisted Dying and Voluntary Active Euthanasia*, 59 TENN. L. REV. 519, 531 (1992) ("It is unseemly for the legal system's analysis to turn on whether the physician's role was active or passive . . ."); Kadish, *supra* note 10, at 864-65 (questioning application of act/omission distinction in "right-to-die situations," and arguing that such application is "suspect" and "eccentric at best"); James Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78 (1975) (criticizing American Medical Association's policy statement against active euthanasia); Note, *supra* note 104, at 2029 (arguing that no inherent distinctions exist between letting patient die and assisting patient's death because both are included in patient's "single undivided interest in controlling what happens to her own body").

128. *Cf.* *Barnes v. Glen Theatre, Inc.*, 111 S. Ct. 2456, 2463 (1991) (allowing state's public indecency statute to require nude dancers to wear "pasties" and "G-strings"); *Employment Div., Dep't of Human Resources v. Smith*, 494 U.S. 872, 890 (1990) (upholding State's right to ban religious use of peyote); *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986) (permitting State to criminalize consensual sodomy); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 69 (1973) (allowing State to regulate obscene material in places of public accommodation); *Lottery Case*, 188 U.S. 321, 363 (1903) (permitting government to restrict transportation of lottery tickets from one state to another).

the basis of morally contested premises counts against the moral argument, although in weakened form, because here the morally contested principle is being deployed as an exemption rather than a basis for limiting action, and the doctor's action is not one that "defines the attributes of personhood."

A thought experiment suggests that moralism can warrant even quite substantial impositions. Federal law prohibits the sale of human organs for transplant¹²⁹ based, in part, on the widely held, but not universal, moral revulsion toward the commodification of human body parts.¹³⁰ Imagine a willing kidney seller and a dying kidney buyer approaching the court. The seller claims that the prohibition infringes on the right of the seller to control her own kidney; the buyer claims an infringement of the right to control her body by avoiding death. It is hard to picture a court striking the statute down as violative of the Constitution.

2. *Practical interests*

a. *Mistake, abuse, and the interests of others*

Even if the moral difference between active and passive euthanasia is insufficient to justify distinguishing voluntary euthanasia from refusal of life-sustaining treatment, there are weighty practical differences between the two practices in terms of the dangers they pose to the lives and welfare of persons other than the patient before the court. *Cruzan* held that the State's interest in "guarding against potential abuses" in the removal of life-sustaining treatment allowed Missouri to weight the scales against cessation of treatment by requiring hydration and nutrition of Nancy Cruzan in the absence of clear and convincing evidence of her wishes to refuse treatment.¹³¹ If the dangers of abuse were sufficiently greater, presumably the Court's reasoning would enable the State to prohibit the practice entirely. I have canvassed above¹³² the dangers of mistake, abuse,

129. 42 U.S.C. § 274e (1988).

130. See *Organ Transplants: Hearings Before the Subcomm. on Investigations and Oversight of the House Comm. on Science and Technology*, 98th Cong., 1st Sess. 356, 357 (1983) (statement of Dr. James F. Childress, professor of religious studies and medical education) (observing that sale and purchase of organs poses serious ethical issues for society). A number of state statutes also forbid organ sales. See, e.g., CAL. PENAL CODE § 367f(a) (West 1988) (barring acquisition, sale, promotion, or transfer of any human organ for valuable consideration); ILL. ANN. STAT. ch. 720, para. 5/12-20(a) (Smith-Hurd 1993) (classifying sale or purchase of body parts as Class A misdemeanor for first conviction and Class 4 felony for subsequent convictions); MD. CODE ANN. HEALTH-GEN. § 5-408(a) (1994) (prohibiting sale or purchase of body or body part).

131. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 284-85 (1990).

132. See *supra* text accompanying notes 48-83.

and corrosion of medical relationships that extend the argument against assisted suicide and voluntary euthanasia beyond an unadorned claim regarding the sanctity of human life. These arguments suffice to rebut the claim that the prohibitionists are attempting to engage in a "plenary override" of bodily autonomy.

To be sure, each of the dangers of mistake or abuse attributed to the prospect of voluntary active euthanasia has a counterpart in specters that can be raised regarding the right to refuse life-saving treatment.¹³³ But a right to refuse treatment puts at risk only the lives of those who would die without treatment. While this is a considerable number of people, the approval of active euthanasia or assisted suicide would extend the risk to the entire population. Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy.¹³⁴ The quantitative distinction between some and all can be a legitimate predicate for the qualitative distinction between permission and prohibition.¹³⁵

133. For example, Daniel Callahan argued that a failure to retain a prohibition on cessation of feeding put at risk the obligation to care for the poor. Daniel Callahan, *On Feeding the Dying*, 13 HASTINGS CENTER REP., Oct. 1983, at 22. More recently, commentators have suggested that both advance directives by patients declining expensive life-sustaining treatment and do-not-resuscitate orders may be effective cost reduction measures. *E.g.*, Christopher V. Chambers et al., *Relationship of Advance Directives to Hospital Charges in a Medicare Population*, 154 ARCHIVES INTERNAL MED. 541, 541 (1994) (finding that mean charges for patients without advance directives were more than three times mean charges of patients with advance directives, and concluding that "enormous cost savings to society may accrue if discussions take place"); see Donald J. Murphy et al., *New Do-Not-Resuscitate Policies: A First Step in Cost Control*, 153 ARCHIVES INTERNAL MED. 1641, 1641-43 (1993) (arguing that do-not-resuscitate policies should be imposed upon patients with poor prognosis after cardiopulmonary resuscitation as means of cost savings); see also *People v. Kevorkian*, Nos. 99591, 99674, 99752, 99758, 99759, 1994 WL 700448, at *26 (Mich. Dec. 13, 1994) (Levin, J., concurring in part and dissenting in part) ("The legitimate concerns about involuntary euthanasia apply with at least as much force to the withdrawal of life support").

134. The New York Task Force on Life and the Law points out that denial of a right of refusal "might deter individuals from seeking medical treatment in the first place." TASK FORCE ON LIFE AND THE LAW, *supra* note 47, at 75. Denial of assisted suicide might have some of the same effects, diluting the State's interest in prohibiting refusals of treatment as a way of sustaining life.

135. The Dutch experience, in fact, has been that withdrawal of life-sustaining treatment accounts for 17.5% of deaths, while euthanasia and assisted suicide account for only 2.3% of deaths. van der Maas et al., *supra* note 60, at 671. However, under the Dutch system of medical care, which provides free and comprehensive care, Dutch doctors are paid on the basis of the number of patients and procedures. Zbigniew Zylicz, *The Story Behind the Blank Spot*, 10 AM. J. HOSPICE PALLIATIVE CARE, July-Aug. 1993, at 30, 31. This system furnishes substantially less incentives to end costs by ending life than the emerging capitated system in the United States. Moreover, euthanasia in the Netherlands is administered predominantly by family physicians who have personal relationships with their patients. See de Wachter, *supra* note 60, at 24 (stating that relationship between patient and family doctor in Dutch society is strong due to emphasis on continuity of care and readily available nursing and domestic care). Because of the current health care system, such physicians are not available to large segments of the American

b. Fair allocation of burdens: of scapegoats and sacrifices

The consequentialist arguments for prohibition for the most part do not rest on issues about the welfare of the patient before the court. Rather they rely on the risks of abuse and mistake in other cases, and the importance of providing support for life-preserving choices elsewhere. In prohibiting assisted suicide and euthanasia, the State is choosing to protect the welfare of others at the cost of the plaintiff's control over her own body. This sacrifice of the dignity and pain of one innocent citizen for the benefit of others raises moral difficulties. As one Canadian Supreme Court Justice put the matter:

The argument is essentially this. There may be no reason on the facts of Sue Rodriguez's case for denying to her the choice to end her life Nevertheless, she must be denied that choice because of the danger that other people may wrongfully abuse the power they have over the weak and ill, and may end the lives of these persons against their consent. Thus, Sue Rodriguez is asked to bear the burden of the chance that other people in other situations may act criminally to kill others or improperly sway them to suicide. She is asked to serve as a scapegoat.¹³⁶

The choice presented to the court is not between the bodily welfare of one individual and another, but rather between the concrete suffering of a real person and the hypothetical welfare of an undefined class who may or may not find themselves at risk. As Canadian Chief Justice Lamer put the matter, "The truth is that we simply do not and cannot know the range of implications that allowing some form of assisted suicide will have for persons with physical disabilities. What we do know and cannot ignore is the

population. See David W. Baker et al., *Regular Source of Ambulatory Care and Medical Care Utilization by Patients Presenting to a Public Hospital Emergency Department*, 271 JAMA 1909, 1919, 1910 tbl. 1 (1994) (reporting that in study of 1190 patients presenting to emergency room, 28% had no regular source of medical care, and 16% used emergency rooms as regular sources of medical care); Medicaid Access Study Group, *Access of Medicaid Patients to Outpatient Care*, 330 NEW ENG. J. MED. 1426, 1427-28 (1994) (reporting that Medicaid patients have difficulty finding primary care physicians); Erik Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L. REV. 449, 451-52, 464-65 (1994) (articulating concerns that emergency rooms provide substantial portion of primary care for uninsured individuals, and often provide inadequate attention); Kimberly J. Rask et al., *Obstacles Predicting Lack of a Regular Provider and Delays in Seeking Care for Patients at an Urban Public Hospital*, 271 JAMA 1931, 1931 (1994) (reporting that in study of 3897 patients seeking care at urban public hospital, 61.6% reported no regular sources of care); Sidney D. Watson, *Health Care in the Inner City, Asking the Right Question*, 71 N.C. L. REV. 1648, 1649 (1993) (noting that office based primary care physicians are disappearing in poor urban areas, and inner city residents rely on shrinking bases of emergency rooms and public clinics for primary care).

136. *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 417-18 (Can. 1993) (McLachlin, J., dissenting).

anguish of those in the position of Ms. Rodriguez."¹³⁷ Can the State impose continued anguish upon some in order to avoid risk to others without transgressing constitutional limits?

It is clear under the general constraints of substantive due process that relatively minor intrusions on the bodies of innocent citizens are constitutionally acceptable in the service of substantial public ends. Individuals are regularly required in minor ways to be "sacrificed" for public ends. For example, in *Jacobson v. Massachusetts*,¹³⁸ the Court recognized the right of a State to require smallpox vaccination to preserve the health of the community despite objections under the Due Process Clause.¹³⁹ In *Schmerber v. California*,¹⁴⁰ the Court held that the State's power to demand blood samples of allegedly drunk drivers did not violate the Fourth Amendment.¹⁴¹

More extensive impositions can also be justified to achieve comparably more weighty gains to bodily security of others or public welfare. *Whalen v. Roe*¹⁴² affirmed the power of New York to require centralized reporting of controlled substance prescriptions despite a showing that the reporting requirement would "unquestionably" induce some individuals "to avoid or to postpone needed medical attention."¹⁴³ Similarly, *United States v. Rutherford*¹⁴⁴ upheld the prohibition of Laetrile against a challenge by a class of terminally ill cancer patients who desired to use the unapproved drug for treatment of their disease.¹⁴⁵ Despite the fact that the drug was harmless, and although the patients were informed and eager to make use of it, the Court upheld the ban on the ground that "if an individual suffering from a potentially fatal disease rejects conventional therapy in favor of a drug with no demonstrable curative properties, the consequences

137. *Id.* at 376 (Lamer, C.J.C., dissenting).

138. 197 U.S. 11 (1905).

139. *Jacobson v. Massachusetts*, 197 U.S. 11, 38-39 (1905).

140. 384 U.S. 757 (1966).

141. *Schmerber v. California*, 384 U.S. 757, 771 (1966). In *Jacobson* there is some argument that the vaccination is necessary to prevent the citizen himself from doing harm to others. This is a bit strained, as the "harm" would come in the form of involuntarily becoming the carrier of smallpox. The drunk driving suspect in *Schmerber*, the potential drug users in *Whalen v. Roe*, 429 U.S. 589 (1977) and *United States v. Rutherford*, 442 U.S. 544 (1979), like the potential draftee, represent no direct threat to the public health.

142. 429 U.S. 589 (1977); see *id.* at 603 (stating that even if use of certain dangerous drugs were completely forbidden by State, no violation of Fourteenth Amendment would have occurred); cf. *Minnesota ex rel. Whipple v. Martinson*, 256 U.S. 41, 45 (1921) (upholding regulation of morphine).

143. *Whalen*, 429 U.S. at 589, 603-04 (holding that effects of such reporting requirements for dangerous but legitimate drugs on patient's reputation or independence was insufficient to violate Fourteenth Amendment).

144. 442 U.S. 544 (1979).

145. *Rutherford*, 442 U.S. at 553-58.

can be irreversible."¹⁴⁶ The Constitution does not prohibit the imposition of involuntary military service,¹⁴⁷ though the conscript risks his life, and Justice Holmes viewed that imposition as precedent for imposition on the bodies of civilians.¹⁴⁸

Under more specific strictures of the Fourth Amendment, "[w]here the officer has probable cause to believe that the suspect poses a threat of serious physical harm, either to the officer or to others, it is not constitutionally unreasonable to prevent escape by using deadly force."¹⁴⁹ For less serious assaults, the issue is whether the officer's

146. *Id.* at 556. Although the Supreme Court declined to reach the constitutional issue, the Tenth Circuit on remand rejected a constitutional challenge out of hand by finding that "selection of a particular treatment, or at least a medication is within the area of government interest in protecting public health." *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir.), *cert. denied*, 449 U.S. 937 (1980); *see also Carnohan v. United States*, 616 F.2d 1120, 1122 (9th Cir. 1980) (noting that individual's privacy and liberty rights, although protected by Constitution, do not enable them to ignore valid acts of police power governing acquisition of laetrile); *People v. Privitera*, 591 P.2d 919, 925-26 (Cal.) (holding that state prohibition on sale and prescription of unapproved drug, laetrile, did not violate right of privacy protected by Constitution because it was reasonably related to concerns of health and safety), *cert. denied*, 444 U.S. 949, and *cert. denied*, 444 U.S. 949 (1979).

The Court's decision in *Collins v. City of Harker Heights*, 112 S. Ct. 1061 (1992), does not foreclose a claim that the Constitution bars sacrifice of personal safety for public welfare, but it is hardly strong support. Narrowly read, *Collins* rejects a claim that a city's deliberate indifference to the safety of its employees violates the Constitution. *Id.* at 1069. The Court in *Collins* read the complaint to exclude claims that the city had "deliberately harmed" the decedent, or that it "knew or should have known that there was a significant risk" of harm, *id.*, and implicitly acknowledged that a government action may violate the Due Process Clause because it is "arbitrary" or "conscience shocking," *id.* at 1070. On the other hand, the Court emphasized its reluctance "to expand the concept of substantive due process." *Id.* at 1068. "Our refusal to characterize the city's alleged omission in this case as arbitrary in a constitutional sense rests on the presumption that the administration of Government programs is based on a rational decisionmaking process that takes account of competing social, political and economic forces." *Id.* at 1070. The implication is that competing "social, political, and economic forces" can legitimately allocate lethal risks..

147. *See Selective Service Draft Cases*, 245 U.S. 366, 381, 387-89 (1918) (noting that when Constitution was adopted, power of Congress to form army by using state quotas was recognized, and holding that "supreme and noble duty of contributing to the rights and honor of the nation" did not violate prohibition against involuntary servitude).

148. *See* *Buck v. Bell*, 274 U.S. 200, 207 (1927) (holding that order to sterilize patient of State Colony for Epileptics and Feeble Minded did not violate Fourteenth Amendment, and noting that "[w]e have seen more than once that the public welfare may call upon the best citizens for their lives. . . . The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes.").

"[G]iven the requirements of the prison environment," the Court has upheld a policy permitting involuntary administration of antipsychotic drugs, despite the possibility of serious side effects, to a convicted prisoner "who has a serious mental illness" and "is dangerous to himself or others," where "the treatment is in [his] medical interest." *Washington v. Harper*, 494 U.S. 210, 226-33 (1990). The Court has also suggested in dictum that similar administration would be appropriate in the case of prisoners awaiting trial if it was "essential for the sake of [the prisoner's] own safety or the safety of others," or necessary to allow a prisoner to stand trial. *Riggins v. Nevada*, 112 S. Ct. 1810, 1815 (1992); *cf. Youngberg v. Romeo*, 457 U.S. 307, 319 (1982) (holding that person's "liberty interests require State to provide [mentally retarded who are involuntarily committed to its institutions] minimally adequate or reasonable training to ensure safety and freedom from undue restraint").

149. *Tennessee v. Garner*, 471 U.S. 1, 11 (1985).

action is that "of a reasonable officer on the scene," taking into account "the severity of the crime at issue, whether the suspect poses an immediate threat to the safety of the officers or to others, and whether he is actively resisting arrest or attempting to evade arrest by flight."¹⁵⁰ Bodily intrusions in search of evidence are permissible where they are not "unreasonable," weighing the "magnitude of the intrusion" against the "community's interest in fairly and accurately determining guilt or innocence."¹⁵¹

Still, the Constitution does place outer limits on the right of the State to impose on the bodies of its citizens where the impositions are grave. The Court in *Jacobson v. Massachusetts* acknowledged that a different result could be required if vaccination of an individual would be "cruel and inhuman," or would "seriously impair his health."¹⁵² The Due Process Clause prohibits bodily impositions that "shock[] the conscience" of the court; the police cannot pump the stomach of a criminal suspect to recover swallowed capsules¹⁵³ and the government cannot inflict needless suffering "contrary to contemporary standards of decency."¹⁵⁴ The prohibition on "unrea-

150. *Graham v. Connor*, 490 U.S. 386, 396 (1989).

151. Compare *Winston v. Lee*, 470 U.S. 753, 759, 761-62 (1985) (holding unconstitutional order requiring surgery to recover bullet in suspect's chest) with *Schmerber v. California*, 384 U.S. 757, 771 (1966) (upholding compulsory blood tests for drunk driving, which "involve[d] virtually no risk, trauma, or pain" and were "highly effective means of determining" intoxication).

152. *Jacobson v. Massachusetts*, 197 U.S. 11, 39 (1905).

153. *Rochin v. California*, 342 U.S. 165, 172 (1952).

154. *Helling v. McKinney*, 113 S. Ct. 2475, 2480 (1993). The Eighth Amendment prohibits state officials from denying prisoners their "basic human needs, one of which is 'reasonable safety,'" *id.* at 2481, or subjecting prisoners to a "substantial risk of serious harm" coupled with "deliberate indifference" to inmate health and safety," *Farmer v. Brennan*, 114 S. Ct. 1970, 1977, *on remand*, 28 F.3d 1216 (7th Cir. 1994). The Eighth Amendment further prohibits denial of medical treatment for "serious medical needs" because such denial may inflict "pain and suffering which no one suggests would serve any penological purpose." *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976); see also *Hudson v. McMillian*, 112 S. Ct. 995, 1000 (1992) (noting that prisoner's medical needs must be "serious" to satisfy deliberate indifference standard necessary to show violation of Eighth Amendment). Presumably rights of the incarcerated against imposition of harm cannot be less than those of inmates. Cf. *Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244 (1983) (noting that due process rights of person who is hurt during his arrest should be "at least as great as Eighth Amendment protections available to a convicted prisoner"); *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982) (stating that due process rights that protect inmates from bodily restraint must also apply to those who are involuntarily confined); *Bell v. Wolfish*, 441 U.S. 520, 535-36 & nn.16-17 (1979) (noting that, under Eighth Amendment, inmate's punishment may not be "cruel and unusual," but that due process rights of pretrial detainee mandate that he not be punished at all).

The Court has held that *Estelle* imposed no duty to protect from danger those citizens who are not in State custody because the State "played no part in [the danger's] creation, nor did it do anything to render him any more vulnerable to [the danger]," and imposed no limitation on his "freedom to act on his own behalf." *DeShaney v. Winnebago County Dep't of Social Servs.*, 489 U.S. 189, 200-01 (1989). Where the State actively interferes with a citizen's freedom of action (as in the prohibition on assisted suicide), and that interference makes the citizen "vulnerable" to physical suffering, the State's action must at least be judged by the standards that

sonable searches and seizures"¹⁵⁵ precludes disproportionately intrusive law enforcement activities; police cannot use either deadly force to capture nonviolent offenders or "objectively unreasonable" force against any citizen.¹⁵⁶ The interest in obtaining moderately relevant trial evidence cannot justify involuntary surgery.¹⁵⁷ And at least Justice O'Connor believes that involuntary medical experiments upon unconsenting soldiers for the purpose of simply gathering information, though undertaken for the military benefit of the nation at large, are constitutional violations of the first order.¹⁵⁸

All of these limitations are explicable under a rubric of proportionality, and it is precisely the fact that the evil of the deaths of the victims of mistake and abuse is of the same potential level of importance as the suffering of those who seek euthanasia that makes the choice morally problematic.¹⁵⁹ Sue Rodriguez in Canada and Jane Roe in Washington are not being required to sacrifice their suffering on the altar of an ephemeral public goal. Neither are their plights at odds with established contemporary standards of decen-

constrain it in punishing convicted prisoners.

155. U.S. CONST. amend. IV.

156. *Graham v. Connor*, 490 U.S. 386, 388, 397 (1989) (noting that correct standard governing claims of excessive force in effecting "arrest, investigatory stop, or other 'seizure' of . . . person" is "objective reasonableness" found in Fourth Amendment); *Tennessee v. Garner*, 471 U.S. 1, 11 (1985) (noting that state statute that allowed use of deadly force in order to prevent suspected felon from escaping violated Fourteenth Amendment).

157. *Winston v. Lee*, 470 U.S. 753, 767 (1985) (holding that order requiring suspect to undergo surgery to recover bullet in his chest was unconstitutional).

158. *United States v. Stanley*, 483 U.S. 669, 709 (1987) (O'Connor, J., concurring in part and dissenting in part). The Government contended that its officers and agents administered LSD to 1000 soldiers, in addition to Respondent, "for the purpose of 'ascertain[ing] the effects of the drug on their ability to function as soldiers' and 'to evaluate the validity of the traditional security training . . . in the face of unconventional, drug enhanced interrogations.'" Brief for United States at 3 n.1, *United States v. Stanley*, 483 U.S. 669 (1987) (No. 86-393) (citation omitted); see also *Stanley*, 483 U.S. at 695-96 n.14 (Brennan, J., concurring in part and dissenting in part) ("[T]he standards that the Nuremberg Military Tribunals developed to judge the behavior of the defendants stated that 'voluntary consent of the human subject is absolutely essential . . . to satisfy moral, ethical and legal concepts.'"); *id.* at 710 (O'Connor, J., concurring in part and dissenting in part) (stating that due process rights guarantee that if Nuremberg Trial standard is not met, society must at least require perpetrators to compensate victims).

159. There are, of course, imponderables on both sides of the balance. No one really knows either how many nonvoluntary deaths would occur, or how many vulnerable people would be pressured to seek assisted suicide if the prohibition were eliminated, or how many sufferers would benefit. The procedural protections of a narrowly drawn assisted suicide statute could reduce the risk of erroneous deaths and dilute the incentives for abuse. On the other hand, in many cases, physical suffering can be alleviated by means short of death, and medical assistance is not required for suicide.

Leaving numbers aside, in choosing between suffering for some and death for others it is possible that avoiding death may be the more important priority. At the current level of knowledge, a State can legitimately judge that the risk of death avoided by the prohibition is commensurable with the suffering imposed.

cy.¹⁶⁰

Yet there is another class of cases that seems to establish a separate constitutional limitation on imposition of substantial bodily intrusion that cannot be outweighed by a proportional gain to others. The paradigm is an issue that has never reached the Supreme Court directly, but that has regularly occupied criminal law scholars and bioethicists: May the State require a citizen to donate a nonessential body part to save the life of another? The consensus is that it may not, even if the risk to the donor is minimal and the invasion is necessary to save the life of a concrete human being.¹⁶¹ The fact that a lobe of my liver, or one of my kidneys, or even my renewable bone marrow could save my neighbor's life does not license the State to extract those items against my will. Similarly, while *Roe* and *Casey* both allow the State to prohibit abortions of viable fetuses, they make exceptions for abortions that seek to preserve the health of the mother.¹⁶² An intervening abortion case held that a State may not require a trade-off between an increased risk to the woman's health and an increased chance of fetal survival; the woman's health is

160. Although the desire to torture a witness in order to require her to divulge the location of a hidden terrorist bomb endangering a larger number of victims would not violate norms of proportionality, I would still expect such actions to be held unconstitutional. Cf. *Rochin v. California*, 342 U.S. 165, 172 (1952) (condemning stomach pumping to produce evidence of possession of "preparation of morphine" as "too close to the rack and thumb-screw").

The difference between that situation and *Rodriguez* is twofold. First, the direct imposition of suffering by the State seems more at odds with decency than the refusal to allow termination of suffering. This is not, however, a bright line distinction. For example, it is conceivable that a State's refusal to allow a witness to drink water could be classified as both a direct imposition and a refusal to end suffering. Second, the historical prohibition and contemporary revulsion toward torture is better grounds for a claim of violating "contemporary standards of decency" than the controversial claim that suicide to end suffering is a moral right.

161. *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 92 (1978), is the only case in which that issue has been directly addressed. Cf. *Curran v. Bosze*, 566 N.E.2d 1319, 1331 (Ill. 1990) (refusing to require marrow transplant from minor where transplant was not in child's best interests); *In re Guardianship of Pescinski*, 226 N.W.2d 180, 181 (Wis. 1975) (refusing to require kidney donation by incompetent where incompetent did not consent and transplant was not in his best interests). But cf. *Strunk v. Strunk*, 445 S.W.2d 145, 148 (Ky. Ct. App. 1969) (authorizing kidney transplant from mentally incompetent 28-year-old to his brother under substituted judgment rule). On the parallel issue of cesarian sections, compare *In re A.C.*, 573 A.2d 1235, 1252 (D.C. Cir. 1990) (refusing to order cesarean section and expressing "doubt that there could ever be a situation extraordinary or compelling enough to justify a . . . [cesarean] section[] against that person's will") and *In re Baby Boy Doe*, 632 N.E.2d 326, 334 (Ill. App. Ct. 1994) (refusing to order cesarean section to save child's life, and reading *Roe* and *Casey* to preclude those intrusions for benefit of fetus that endanger woman's health) with *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 460 (Ga. 1981) (per curiam) (upholding court-order cesarean that would preserve life of viable fetus) and *In re Madyun Fetus*, 114 Daily Wash. L. Rep. 2233, 2240 (D.C. Super. Ct. July 26, 1986) (noting that hospital can perform cesarean section over objections of mother when risks to fetus are significant and those to mother are minimal).

162. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2821-22 (1992) (noting that "essential holding of *Roe* forbids a state from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health"); *Roe v. Wade*, 410 U.S. 113, 164-65 (1973).

constitutionally paramount.¹⁶³ In view of these cases, one might ask how the State can, in the even more diffuse interest of saving the lives of an unknown set of potential victims of abuse or mistake, and of engendering the patients' trust in the medical profession, be allowed to trap Ms. Rodriguez in a life of what she regards as unbearable suffering.

The answer comes in reconciling the "transplant" and "no trade-off" cases with cases that allow the State, in the interest of public welfare and safety, to impinge substantially upon the bodily integrity of individual citizens. When the police shoot a fleeing suspect in a violent felony, seek a blood sample from a suspected drunk driver, or enforce a prohibition against the unregistered prescription of drugs, the protection that they afford is to the public at large, rather than to any individual citizen. The authorities have not chosen the safety of any other individual as paramount to that of the suspect or patient; rather, they vindicate an impersonal aggregate interest. By contrast, a compelled bone marrow transplant makes the donor's body a means to the survival of some other individual; the State has said, in effect, that it values one citizen more than the other. The State may conscript its citizens to serve in the public interest, but it may not conscript them to serve one another.¹⁶⁴

The prohibition of assisted suicide is not a direct reallocation of rights from one citizen to another; it is a tragic sacrifice of the suffering of one for the aggregate good of the whole.

163. *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 768-69 (1986) (affirming court of appeals' determination that such "trade-off" was unconstitutional).

164. This may sound like a resurrection of the "public use" requirement of the Takings Clause, U.S. CONST. amend. V ("nor shall private property be taken for public use without just compensation"), or the "public purpose" requirement of substantive due process, *see, e.g., Thompson v. Consolidated Gas Utils. Corp.*, 300 U.S. 55, 80 (1937) (requiring that, when private property is taken, there must be, in addition to compensation, "public purpose" to justify taking). It is.

My embarrassment in invoking this device is mitigated by three facts. First, I can see no other way of reconciling the bone-marrow and fleeing-felon intuitions. Second, while property is protected only against takings without compensation, physical autonomy is protected by the absolute prohibitions of the Thirteenth Amendment, which completely disallows the existence of "slavery or involuntary servitude except as punishment for crime." The decline of the public use requirement in the property area does not necessarily undercut its propriety in the area of bodily autonomy. Indeed, it was precisely the fact that the citizen was required to contribute to the public purpose of "the defense of the rights and honor of the nation, as the result of a war declared by the great representative body of the people" which overcame Thirteenth Amendment objections in the Selective Draft Law Cases, 245 U.S. 366, 390 (1918). Finally, it seems more plausible to claim that the body is a pre-political entitlement than property, because property is a creation of the State.

IV. EQUALITY AND THE "RIGHT TO CHOOSE"

The argument for a constitutional right of women to choose an abortion is incomplete unless we recognize precisely that it is choice for women that is at issue. Requiring women to bear unwanted children threatens to lock them into a traditional and subordinate role, embodies assumptions about their inability to make autonomous moral choices, and burdens women as a group with obligations that have no counterpart in the burdens that the State demands from men. A broad spectrum of scholars have viewed the argument from an equality standpoint as a crucial building block in the defense of abortion rights.¹⁶⁵ Justice Blackmun's concurrence in *Casey* explicitly adopted this theme,¹⁶⁶ the joint plurality opinion played it in an undertone,¹⁶⁷ and Justice Ginsburg in her prior scholarly incarnation suggested that it is the principle of women's equality that provides the firmest grounding for the right to reproductive choice.¹⁶⁸

165. See, e.g., SUNSTEIN, *PARTIAL CONSTITUTION*, *supra* note 16, at 270-85 (noting that, by using equality argument, one can "acknowledge[] the possibility that fetuses are in important respects human beings" and still assert that abortions must be prohibited); TRIBE, *CLASH OF ABSOLUTES*, *supra* note 16, at 105 (stating that, without access to abortions, women suffer substantial burden in their ability to participate equally in society); Estrich & Sullivan, *supra* note 16, at 151 (noting that prohibition of abortions directly affects only women); Ginsburg, *supra* note 16, at 383 (noting that abortion controversy includes woman's "ability to stand in relation to man, society, and the state as an independent, self-sustaining, equal citizen"); Karst, *supra* note 16, at 58 (stating that control over one's reproductive rights means control over one's future); Law, *supra* note 16, at 1009 (stating that issue of equality is raised when laws differentiate based on biological characteristics); MacKinnon, *supra* note 16, at 1308-24 (noting that "any forced pregnancy will always deprive and hurt one sex only as member of her gender"); Regan, *supra* note 16, at 1571 (viewing abortion controversy in context of samaritan laws); Siegel, *supra* note 16, at 353 (stating that laws restricting abortions are inconsistent with constitutional principle of equal protection); Strauss, *supra* note 16, at 18-22 (noting that if abortion question is left to political process, result may well be subordination of women); Sunstein, *Neutrality*, *supra* note 16, at 31-44 (arguing, *inter alia*, that prohibitions on abortions are form of sexual discrimination and are derived from stereotypes that run counter to constitutional principles); see also GUIDO CALABRESI, *IDEALS ATTITUDES AND THE LAW* 101 (1985) ("For me, the essence of the argument in favor of abortion is an equality argument.").

166. *Casey*, 112 S. Ct. at 2846-47 (Blackmun, J., concurring) ("The assumption—that women can simply be asked to accept the 'natural' status and incidents of motherhood—appears to rest upon a conception of women's role that has triggered the protection of the Equal Protection Clause.").

167. See *id.* at 2807 ("Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society."). The joint opinion acknowledged that women's control over their reproductive systems has facilitated gender equality in economic and social spheres, *id.* at 2809, and struck down the husband notification requirement as resting on views of the role of women that violated constitutional principles, *id.* at 2831. "A state may not give to a man the kind of dominion over his wife that parents exercise over their children." *Id.* at 2830.

168. Ginsburg, *supra* note 16, at 375, 386 (stating that *Roe* decision should have emphasized sexual equality grounded in Constitution rather than autonomy based on medicine).

If *Roe* and *Casey* are cases about women's equality, they cannot stand for the proposition that assisted suicide is a constitutional right. The class of individuals who seek physician-assisted suicide is not defined by sex, nor does it constitute a social group that has been recognized as demanding special judicial solicitude. The prohibition of assisted suicide may visit devastating suffering on individuals, but it does not deform the social structure, for all citizens risk mortal illness. Individuals who seek to exercise the "right to die" are not drawn from any particular social or economic group. The capacity of debilitating illnesses to devastate the lives of members of all social groups gives apparent force to Justice Scalia's argument in *Cruzan* that, in these matters, the political process is at least as likely as the judicial to give the right answer because "the democratic majority [is required] to accept for themselves and their loved ones what they impose on you and me."¹⁶⁹

Under current American constitutional norms, this would be the end of the matter. The prohibition on assisted suicide involves, in current parlance, neither "suspect classification" nor "discriminatory intent," and anything from moral preference to aesthetic taste will meet an equal protection challenge that lacks these characteristics.¹⁷⁰ Concerns about equality and subordination¹⁷¹ are not

The role of women's equality in the abortion controversy is more broadly recognized as a deciding factor in the scholarly community than on the Court. Justice Scalia's opinion in *Bray v. Alexandria Women's Health Clinic*, mustered a five member majority to reject the proposition that, under § 1985(3) of the U.S. Code, opposition to abortion constituted "class-based, invidiously discriminatory animus." *Bray v. Alexandria Women's Health Clinic*, 113 S. Ct. 753, 758 (1993) (citing 42 U.S.C. § 1985(3) (1988)). That opinion went to some lengths to reaffirm the holding that discrimination on the basis of pregnancy and child-bearing do not constitute invidious sex discrimination as a constitutional matter.

In her dissent, Justice O'Connor characterized a conspiracy to interfere with abortion rights as invidious sex discrimination under § 1985(3) although not necessarily as a matter of constitutional law. *Id.* at 801-04 (O'Connor, J., dissenting). The opinions in *Bray* of Justice Souter, who concurred in part in the judgment and dissented in part, *id.* at 769, 777, and of Justice Stevens, who dissented, *id.* at 779, 785-92, seem to acknowledge the element of gender-based discrimination in efforts to interfere with abortions.

The substitution of Justice Ginsburg for Justice White may tip the balance of the Court, assuming that Justice Breyer agrees with his predecessor, Justice Blackmun.

169. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2863 (1990) (Scalia, J., concurring).

170. A full analysis in terms of women's equality should account for the predominance of women in the groups likely to be affected by the prohibition of physician-assisted suicide. The predilection of men for modes of suicide that do not require the assistance of physicians (guns rather than drugs, for example), and the higher proportion of women surviving to older ages in states of extreme morbidity combine to suggest that the prohibition interferes with the suicides of more women than men. *But cf.* van der Maas et al., *supra* note 60, at 671 (noting that 61% of Dutch euthanasia/assisted suicides were male). It is substantially harder in euthanasia cases than in the abortion cases, however, to link this interference uniquely to women's biological characteristics, or to the stereotypical attitudes regarding women's roles that characterize the abortion debate.

exhausted, however, by the vision of the current majority of the Supreme Court.

It is clear that the effect of the prohibition bears more heavily on the less physically able. The Canadian Supreme Court reviewed its prohibition under a Charter provision that forbids "discrimination based on . . . mental or physical disability."¹⁷² Access to efficacious means of suicide for the physically able is not difficult: firearms (in America), plastic bags, and high bridges are readily at hand in most locales. Legally, self-regarding uses of such means are no longer criminal offenses in American jurisdictions¹⁷³ (although the effort to use them may be grounds for involuntary commitment).¹⁷⁴ By contrast, for many individuals who suffer from severe physical conditions that impel them to seek suicide, their debilitating illnesses make their unilateral use of conventional methods impossible.¹⁷⁵ If it is unfair that women should alone be made to bear the burden of our respect for the sanctity of life of the fetus, is it not equally unfair that the costs of suffering in the interests of the "sanctity of human life" at its end should rest disproportionately on the physically impaired?¹⁷⁶ We do not hold the able-bodied captive in suffering to vindicate a social commitment to human life; perhaps we should not so hold the handicapped.

There is more than a hint of paradox to these arguments. A policy that keeps more handicapped than physically able persons alive is, on its face, a doubtful candidate for condemnation as discrimination on the basis of disability. In contrast to the prohibition on abortion, which resulted in the deaths of thousands of women who sought the

171. The argument in *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1466-67 (W.D. Wash. 1994), that the opportunity to end one's life is a "fundamental interest" calling forth heightened equal protection scrutiny seems to be premised on the trial court's earlier conclusion that such an interest is indeed "fundamental" and constitutionally protected under the reasoning of *Roe* and *Casey*. If, as I have argued, the abortion cases cannot generate the initial constitutional protection, the argument for heightened equal protection scrutiny falls as well.

172. CANADIAN CHARTER OF RIGHTS AND FREEDOMS § 15(1).

173. See *supra* note 43.

174. See, e.g., *Radmore v. R.N.*, 450 N.W.2d 758, 759-60 (N.D. 1990) (stating that North Dakota law allows involuntary commitment when there exists clear and convincing evidence that person needs treatment, and noting that definition of such need includes "suicidal threats, attempts, or significant depression relevant to suicidal potential").

175. But cf. *Bernat et al.*, *supra* note 44, at 2723 (suggesting that if patients are educated about option to refuse hydration and nutrition, they will better control their futures).

176. See, e.g., *Rodriguez v. British Columbia*, 107 D.L.R.4th 342, 358-59, 363-69 (Can. 1993) (Lamer, C.J.C., dissenting) (stating that "persons with disabilities who are or will become unable to end their lives without assistance are discriminated against . . . since, unlike persons capable of causing their own deaths, they are deprived of the option of choosing suicide"). This claim is not literally true as long as the patient has the right to decline hydration. What patients are deprived of is an option of choosing a quick and painless suicide.

services of dangerous illicit practitioners to evade the law,¹⁷⁷ the claim is that the prohibition of assisted suicide and euthanasia preserves the lives of a vulnerable minority. Indeed, if the issue is whether handicapped persons as a group suffered a net gain or loss to their interests from the prohibition, analogous to the effect of abortion on the "ability of women to participate equally in the economic and social life of the nation,"¹⁷⁸ comparing the losses in terms of extended suffering with the gains in terms of extended life does not clearly indicate an invidious inequality.

In the Canadian litigation, one advocacy group for the handicapped argued that the prohibition was necessary to protect the interests of the handicapped as a group threatened with the risk of discriminatory manipulation by others:

[T]he negative stereotypes and attitudes which exist about the lack of value and quality inherent in the life of a person with a disability are particularly dangerous in this context because they tend to support the conclusion that a suicide was carried out in response to those factors rather than because of pressure, coercion or distress.¹⁷⁹

A recent New York report expressed similar concern that "those who will be most vulnerable to abuse, error or indifference are the poor, minorities, and those who are least educated and empowered" and that "establishing a quick, painless death as a state sanctioned option may mean that society becomes less committed to creating ways for patients, especially those who are socially disadvantaged, to live longer and better."¹⁸⁰ There is a disturbingly recurrent finding that groups of lower socio-economic status are more likely to be at risk for inade-

177. See, e.g., Mark A. Graber, *The Ghost of Abortion Past: Pre-Roe Abortion Law in Action*, 1 VA. J. SOC. POL'Y & L. 309, 318 (1994) ("Evidence indicates that five to ten thousand women died each year from complications resulting from illegal abortions during mid-twentieth century.").

178. *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2797 (1992).

179. *Rodriguez*, 107 D.L.R.4th at 375 (quoting Coalition of Provincial Organizations of the Handicapped).

180. TASK FORCE ON LIFE AND THE LAW, *supra* note 47, at 120; see also *id.* ("[T]he risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group."); *id.* at 124-25 (suggesting that most adverse impact is on patients likely to be considered "hopeless," including AIDS patients, patients who pose health risk such as multi-drug-resistant tuberculosis patients, patients who are least compliant, such as mentally ill or drug addicted, and that "suicide and euthanasia will be practiced through the prism of social inequality and prejudice Those who will be most vulnerable to abuse error or indifference are the poor, minorities, and those who are least educated and empowered."). But cf. Kathryn A. Koch et al., *Changing Patterns of Terminal Care Management in an Intensive Care Unit*, 22 CRITICAL CARE MED. 233, 239 (1994) (observing that withdrawal of care is most frequent among white women and men, followed by African American men and African American women).

quate pain control.¹⁸¹ And in Oregon, the plaintiffs have challenged the State's newly enacted initiative permitting assisted suicide as denying the class of persons suffering from the disability of "terminal illness" protection against risks of depressive suicide and undue influence, in violation of both the Equal Protection Clause and the Americans with Disabilities Act.¹⁸²

To be sure, as Canadian Chief Justice Lamer argued, the "right to choose" the manner of their death is, for some handicapped persons, an unambiguous "advantage," and there is weight to the argument that "limitations on [autonomy and self determination] should be distributed with a measure of equality."¹⁸³ A belief that abortion is in the interests of all women as a group is not necessary to sustain *Roe* and *Casey*; a conviction that the State's policy is a differential imposition on women's autonomy is sufficient. But in the issues we are addressing, "autonomy" for some among the vulnerable means a probability of unwilling death for others.

CONCLUSION

The laws of the State embody ideals, and part of the tragedy of liberal society is that not all attractive ideals are compatible. The problem of assisted suicide is one among many that requires the State to establish some legitimate ideals at the expense of others.

To allow assisted suicide is to permit acts of compassion. It is to have faith in the ability of doctors to be humane to patients. It allows citizens to exert control over their lives in the service of the goals that they have chosen. The watchwords of such a regime are autonomy and faith in individual choice.

To prohibit assistance enshrines the State's responsibility to protect the vulnerable and to affirm their connection to society. It embodies the belief in the equal and ultimate worth of all members of the polity. When a patient asks "May I die?" she may be seeking assurance that her doctors and family still value her. When the State says "legally, you may not," it tells the sufferer that she is still a valued member of the community. It expresses a faith, as well, in the human ability to redeem a life even in its last moments: a belief that dignity can come not only from consistently executing a life plan but from a

181. See *supra* note 74. These results are also ambiguous about the effect of suicide on group welfare. If members of lower status groups are more often left without adequate pain treatment, they will more often choose unnecessary suicide. On the other hand, if suicide is unavailable, they will more often suffer pain.

182. *Lee Complaint*, *supra* note 13.

183. *Rodriguez*, 107 D.L.R.4th at 366-67.

spontaneous moment of transcendence.

The Constitution does not prevent the State from embracing the ideals of autonomy and compassion. In the current political climate, a combination of civil disobedience, prosecutorial discretion, ballot initiatives, and legislative proposals exert pressure to allow doctors to provide lethal assistance that has been hitherto forbidden. Should these pressures triumph, the Constitution would not impel courts to invalidate such a permissive stance despite its risks of rejection and death.

But the choice embedded in today's legal structure is also constitutionally legitimate. The very real costs to the liberty of some citizens do not constitutionally require the State to abandon its policy of protecting the vulnerable in choosing to live. By prohibiting physicians from providing lethal assistance to their patients, the State is permitted to establish that no patient has an obligation to die.