Assisted Suicide and Disabled People

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A theme of this Symposium is to address current issues left open by the Americans with Disabilities Act ("ADA"). It is thus appropriate that one of the papers presented should treat the question of physician-assisted suicide. That question involves quality-of-life considerations of peculiar concern to people, like myself, with disabilities. The issue is current—the United States Supreme Court heard oral argument in Washington v. Glucksberg, ("Compassion in Dying")1 and Vacco v. Quill2 ("Quill") on January 8, 1997.

In Compassion in Dying, Judge Stephen Reinhardt, writing for the Ninth Circuit en banc, invalidated Washington's ban on assisted suicide as being outweighed by a supposed right to die of terminally ill individuals.3 Though rejecting such a right, Judge Roger Miner, writing for a panel of the Second Circuit in Quill, nonetheless, found that New York's distinction permitting withdrawal of life support but forbidding assisted suicide for the terminally ill lacked a rational basis and thus violated equal protection.4

The ADA does not treat the subject expressly. At first glance, section 501(d)—which protects disabled persons' rights to decline any proffered "accommodation, aid, service, opportunity, or benefit"5—might seem to support the right to forgo suicide prevention services and to choose physician-assisted death. Nevertheless, the Justice Department's authoritative regulatory gloss concluded that "medical treatment, including treatment for particular conditions, [presumably,
encompassing such services as the prescription of lethal medication] is not a special accommodation or service for individuals with disabilities under section 501(d) — thus, rendering that section inapposite to the question of physician-assisted suicide. Accordingly, I will proceed to analyze the soundness of the Ninth and Second Circuit decisions.

The state of Washington made it a felony for anyone knowingly to aid another's attempt to commit suicide. Writing for the Ninth Circuit en banc, Judge Reinhardt invalidated this provision as violative of the Due Process Clause of the Fourteenth Amendment. He reasoned that the claim for physician-assisted suicide, that the statute would bar, could only be judged in relation to the end for which such

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6. Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 28 C.F.R. pt. 36, app. B at 613 (1996); cf. id. § 36.203(c)(2) ("Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.").

7. This is not to say that the ADA is wholly irrelevant to the issue of physician-assisted suicide. If states permit terminally ill patients to seek their physicians' assistance in dying, that would clearly not be a policy modification required for their equal access to existing suicide prevention services. Neither might it be a permitted special benefit since it arguably rests on the assumption that such patients' lives are not worth saving. Cf. Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (invalidating Oregon's Death with Dignity Act under the Equal Protection Clause but not reaching the plaintiffs' ADA claim). As the House Judiciary Committee reported when considering section 501(d): "[N]othing in the ADA is intended to permit discriminatory treatment on the basis of disability, even when such treatment is rendered under the guise of providing an accommodation, service, aid or benefit to the individual with disability." H.R. REP. NO. 101-485, pt. 3, at 71-72 (1990).

It is to say, however, that, since the ADA does not directly address the issue of physician-assisted suicide, then, if the Supreme Court reverses the Second and Ninth Circuits in part because some Justices believe the states should more thoroughly address the subject before an approach is constitutionalized, it is unlikely that courts would use the Act to preclude such efforts, at least in the absence of an authoritative Justice Department application. See Excerpts from the Supreme Court Arguments on Physician-Assisted Suicide, WASH. POST, Jan. 9, 1997, at A16 ("[T]hat might be a . . . perfectly legitimate argument for saying that . . . the court should wait until it can know more . . . before it passes ultimate judgment."). Of course, if the Supreme Court affirms the decisions in Compassion in Dying and Quill, the ADA issue is likely moot.

8. I have found the following definition of "euthanasia" helpful: "an action or an omission which of itself or by intention causes [another's] death, in order that all suffering may in this way be eliminated." CONGREGATION FOR THE DOCTRINE OF THE FAITH, DECLARATION ON EUTHANASIA II, reprinted in 10 ORIGINS 154, 155 (Aug. 14, 1980). Thus, euthanasia can be active or passive, and voluntary, nonvoluntary, or involuntary on the part of the patient. In contrast, "assisted suicide" is where patients directly cause their own death but with assistance—as when their physicians prescribe for them lethal medication. Admittedly, the lines seem to blur when, for instance, a physician removes life-support at a competent patient's direction. However, this also illustrates the difficulties in holding the line against euthanasia that would arise, once physician-assisted suicide was sanctioned.


10. Id. at 838.
assistance would serve as a means. Characterizing that end as "suicide," he thought, was too narrow since the goal should encompass other forms of consensual life terminations, including the declination or withdrawal of life-sustaining treatment, which he believed the law did not consider suicide today. Judge Reinhardt settled on labeling the end, and the corresponding claimed constitutional right, as "controlling the time and manner of one's death," "hastening one's death," and, most broadly, as "the right to die."

By this technique, Judge Reinhardt attempted to strengthen the claim for physician-assisted suicide by increasing its level of generality, something like when specific governmental activities are linked to the national security as a means of heightening their importance. The legitimacy of this approach, of course, depends on whether assisting suicide and declining treatment are sufficiently similar to justify categorizing them together. Before discussing that point, however, I will first address Judge Reinhardt's claimed "right to die" directly.

The Fourteenth Amendment prohibits the states from denying life, liberty, or property without due process of law. As a textual matter, it seems contradictory to construe a provision protecting life to include a right to make oneself dead. Of course, Judge Reinhardt's focus was not on "life" in the Fourteenth Amendment but on its protection of "liberty," arguing that it should include at least the terminally ill person's right to choose death. Logically, however, liberty presupposes life itself since there can be no liberty without life. Death, as Justice Brennan plainly observed, forecloses the very right to have rights themselves. Thus, liberty and a right to die seem mutually exclusive.

Moreover, a right to die could sweep within its sanction all consensual acts as of lesser harm to the individual than death—thus, constitutionalizing John Stuart Mill's notable principle:

[T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilised commu-

11. Id. at 801.
12. See id. at 802.
13. Id.
15. See Compassion in Dying, 79 F.3d at 793.
nity, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.\textsuperscript{17}

Rejecting claims that consensual acts were per force protected by the Fourteenth Amendment,\textsuperscript{18} the Supreme Court has instead followed the course that Justice Harlan approved in \textit{Griswold v. Connecticut}:\textsuperscript{19}

[S]ociety is not limited in its objects only to the physical well-being of the community, but has traditionally concerned itself with the moral soundness of its people as well. Indeed to attempt a line between public behavior and that which is purely consensual or solitary would be to withdraw from community concern a range of subjects with which every society in civilized times has found it necessary to deal.\textsuperscript{20}

Undoubtedly, certain consensual acts have been placed under due process protection. Judge Reinhardt would add the right to die to that list, despite its excessive breadth, because it fell within the language in Justice O'Connor's plurality opinion in \textit{Planned Parenthood v. Casey}:\textsuperscript{21}—language that he believed, fashioned criteria for designating what matters warranted protection.\textsuperscript{22} After listing certain nontextual rights that the Supreme Court had previously recognized—including "marriage, procreation, contraception, family relationships, child rearing, and education"\textsuperscript{23}—Justice O'Connor stated in \textit{Casey}:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.\textsuperscript{24}

Few would quibble that "personal dignity and autonomy" are not "central to the liberty protected by the Fourteenth Amendment." However, these terms are not self-defining. "Personal" and "intimate" are adjectives too subjective and malleable to provide any

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\begin{enumerate}
\item[17.] \textsc{John Stuart Mill}, \textit{On Liberty} 13 (Currin V. Shields ed., The Liberal Arts Press, Inc. 1956) (1859).
\item[22.] \textit{See id.}
\item[24.] \textit{Id.}
\end{enumerate}
\end{footnotesize}
greater precision. In fact, Justice O'Connor relied on "reasoned judgment" as her standard, as it was elucidated by Justice Harlan in *Griswold v. Connecticut*:

The best that can be said is that through the course of this Court's decisions [due process] has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. . . . The balance of which I speak is the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing. A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound. Since *Griswold*, the Court has affirmed the primary role of tradition in identifying nontextual rights, characterizing them as those liberties that are "deeply rooted in this Nation's history and tradition." Whatever deficiencies the claimed abortion right might have in this regard, Justice O'Connor chose to discount this right in favor of the concerns that informed stare decisis, concerns not present when the issue is the right to die.

Our tradition provides scant support for a right to die, as it applies to suicide or aid to that end. At common law, suicide was a crime:

Although the States abolished the penalties imposed by the common law (*i.e.*, forfeiture and ignominious burial), they did so to spare the innocent family and not to legitimize the act. Case law at the time of the adoption of the Fourteenth Amendment generally held that assisting suicide was a criminal offense. . . . And most States that did not explicitly prohibit assisted suicide in 1868 recognized, when the issue arose in the 50 years following the Fourteenth Amendment's ratification, that assisted and (in some cases) attempted suicide were unlawful.

25. See id. at 849.
26. Id. at 850 (quoting Griswold v. Connecticut, 381 U.S. 479, 500 (1965) (Harlan, J., concurring)).
28. See Casey, 505 U.S. at 853 ("While we appreciate the weight of the arguments made on behalf of the State in the cases before us, arguments which in their ultimate formulation conclude that *Roe* should be overruled, the reservations any of us may have in reaffirming the central holding of *Roe* are outweighed by the explication of individual liberty we have given combined with the force of *stare decisis*."").
30. Id. at 294-95 (citing Thomas Marzen et al., *Suicide: A Constitutional Right?*, 24 DUO. L. REV. 1, 76-100, 148-242 (1985)).
Today, Oregon, alone of the fifty states, sanctions assisted suicide.\textsuperscript{31} As an influential study of legal constraints on suicide concluded, "there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.'"\textsuperscript{32}

In \textit{Glucksberg}, Judge Reinhardt discounted the role of tradition as a static adherence to the past\textsuperscript{33}—thus, mistakenly confusing it with an exclusive reliance on original intent.\textsuperscript{34} Tradition, however, as Justice Harlan observed, is "a living thing"\textsuperscript{35}—not confined merely to what the framers intended but augmented by the evolving maturation of a people.

Nor should public opinion trump long-standing tradition, as Judge Reinhardt implied,\textsuperscript{36} since constitutional strictures require more stability than shifting opinion polls provide and a prudence that comes only with the test of time. Ultimately, a constitutionalism that relies on current trends denies the basic need of society for continuity as well as for change.

However, even if current trends are proper guides for the Court as well as for Congress, it is notable that, "[s]ince 1994, at least seventeen states have rejected legislative proposals to legalize assisted suicide."\textsuperscript{37} Moreover, well-publicized referenda in both Washington and California that would have weakened state laws against assisted suicide were recently defeated.\textsuperscript{38}

Judge Reinhardt further reasoned that, whether one died from rejecting life support or from ingesting lethal medication, the end was

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\item \textsuperscript{31} But see Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (enjoining Oregon's Death with Dignity Act on equal protection grounds).
\item \textsuperscript{32} Marzen et al., supra note 30, at 100 (internal quotations omitted) (quoted in \textit{Cruzan}, 497 U.S. at 295 (Scalia, J., concurring)).
\item \textsuperscript{33} See Compassion in Dying v. Washington, 79 F.3d 790, 805-06 (9th Cir. 1996).
\item \textsuperscript{34} At bottom, a narrow reliance on original intent denies that the People can manifest their will—not just expressly, as through the amendment process, but also through actions, when repeated to form customs or tradition. As St. Thomas Aquinas observed centuries ago, "when a thing is done again and again, it seems to proceed from a deliberate judgment of reason." \textit{St. Thomas Aquinas, The Summa Theologica}, Ia-IIae (First Part, Part II), Q. 97, A.3, 80 (Fathers of the Dominican Province trans., Burns Oates & Washbourne Ltd. 1927).
\item \textsuperscript{36} See Compassion in Dying, 79 F.3d at 810.
\item \textsuperscript{38} See Compassion in Dying, 79 F.3d at 810.
\end{itemize}
the same, and, thus, a right to die had implicitly been accepted by the Supreme Court in *Cruzan v. Director, Missouri Department of Health.* Similarly, though rejecting such a right, Judge Miner in *Quill* nonetheless concurred that an action-omission distinction, between administering deadly drugs and withholding life support, was untenable after *Cruzan* since, in both instances, the objective was death.

The question before the *Cruzan* Court, however, was "simply and starkly" whether states could require clear and convincing evidence of incompetent patients' wishes before permitting removal of life support and not whether due process protected some right to die. In deciding that issue, Chief Justice Rehnquist, writing for the Court, assumed, without deciding, that such patients had a liberty interest in refusing lifesaving hydration and nutrition. While Justice O'Connor, who joined the five-Justice majority opinion and filed a separate concurrence, would have embraced that interest expressly, it was clear that the focus for both Justices was on the patient's right to reject forced, invasive, or burdensome treatment and not on some right to choose death.

This distinction was well put by the New York State Governor's Task Force on Life and the Law in 1994:

>T]he fact that the refusal of treatment and suicide may both lead to death does not mean that they implicate identical constitutional concerns. The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity. . . . It is this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the

39. See id. at 824 ("[W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.").


41. See Quill v. Vacco, 80 F.3d 716, 724-25 (2d Cir. 1996).

42. See id. at 729.

43. *Cruzan,* 497 U.S. at 277.

44. See id. at 279.

45. See id. at 287.

46. See id. at 278-79 (Rehnquist, J., concurring); see id. at 288-89 (O'Connor, J., concurring).

In that regard, Justice O'Connor emphasized that many patients needed to be restrained forcibly from removing nasal feeding tubes, id. (referring to David Major, *The Medical Procedures for Providing Food and Water: Indications and Effects, in By No Extraordinary Means: The Choice To Forgo Life-Sustaining Food and Water* 25 (Joanne Lynn, M.D. ed., 1986)), while other techniques for providing food and fluids required surgical implantation, see id. at 289.
constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.47 Moreover, if a right to die were recognized, it could not be cabined to the terminally ill. Attempts to define “terminally ill” have elsewhere proven difficult. For example, time restrictions, such as death within six months, are problematic since predictions about the duration of a terminal condition are merely estimates.48 As the ABA Commission on Legal Problems of the Elderly concluded in 1992, “seventeen years of experience with State Living Will statutes that have used ‘terminal condition’ as a prerequisite to patient directives have demonstrated that ‘terminal’ lacks any truly objective, operational definition.”49

Even assuming a manageable definition were possible, however, “[t]he attempt to restrict such [right] to the terminally ill is illusory.”50

47. Brief of United States Catholic Conference et al., as Amici Curiae in Support of Petitioners, Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) (No. 95-1858), available in 1996 WL 656248, at *11 (citing NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 71 (1994)). Admittedly, this distinction fails where the choice is to reject artificial feeding for permanently unconscious patients—for whom such treatment is likely not burdensome, is beneficial in sustaining life, and where, if such treatment were denied, the resulting starvation and dehydration, and not the underlying pathology, would be the cause of death. Rather than have such exceptional cases nullify a distinction that makes sense where treatment is actually burdensome, and that has a long lineage in the law, the Supreme Court, when the issue is presented directly, should reject the right assumed in Cruzan to withdraw food and fluids for those in persistent vegetative states. If states continued to license such withdrawal, however, then the states could still rationally distinguish assisted suicide, as posing a broader threat to their interest in preventing abuse, and the consequences of erroneous diagnosis than would permission limited to those patients already on life support. In any event, as Judge Noonan observed for the original Ninth Circuit panel in Compassion in Dying that Judge Reinhardt later reversed:

[The far more relevant part of the opinion in Cruzan was the Court's confirmation] that “there can be no gainsaying” a state’s interest “in the protection and preservation of human life” and, as evidence of that legitimate concern, . . . [that] “the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.”

Compassion in Dying v. Washington, 49 F.3d 586, 591 (9th Cir. 1995) (quoting Cruzan, 497 U.S. at 280).

48. Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the Comm. on the Judiciary House of Representatives, 104th Cong. 349, 357-58 (1996) (prepared testimony of Leon R. Kass, M.D.) [hereinafter Assisted Suicide Hearing]. Judge Reinhardt favorably cited the Uniform Rights of the Terminally Ill Act, under which a “terminal illness” is a medical condition that is “incurable and irreversible, that is, without administering life-sustaining treatment the condition, will, in the opinion of the attending physician, result in death in a relatively short time.” Compassion in Dying v. Washington, 79 F.3d 790, 831 n.117 (9th Cir. 1996). Under this approach, diabetics would be terminally ill since, without administration of insulin, they would die in a relatively short time.

49. ABA Commission on Legal Problems of the Elderly, Memorandum in Opposition to Resolution No. 8 on Voluntary Aid in Dying, 8 ISSUES L. & MED. 117, 120 (1992) [hereinafter ABA Memorandum].

50. Compassion in Dying, 49 F.3d at 591.
As Judge Noonan wrote for the original Ninth Circuit panel in *Compassion in Dying* that Judge Reinhardt later reversed:

The category created is inherently unstable. The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtainable ability to believe and to act on one’s deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult.51

Language in Judge Reinhardt’s opinion intensifies the concern that a right to die would extend beyond those terminally ill. He wrote, for example, that the recognition of that right was “strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults . . . as well [as] by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness.”52 He further explained that terminally ill patients should have the right to choose death because their “pain . . . [and] suffering . . . is too intimate and personal for the State to insist on,”53 because they “cannot be cured,”54 and because they “can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends”55—clearly, considerations not limited to the terminally ill alone.

In addition, since Judge Reinhardt thought it “less important who administer[ed] the medication than who determine[ed] whether the terminally ill person’s life shall end,”56 the difference between assisted suicide and active euthanasia evidently carried little weight for him. Although he considered “the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual’s life,”57 he would not limit the prerogative to competent patients since, as he made clear, “a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.”58

Such prospects for expansion are not academic but have occurred over the past two decades in the Netherlands. Beginning with legal

51. Id. at 590-91.
52. *Compassion in Dying*, 79 F.3d at 816.
53. Id. at 834 (citations omitted).
54. Id. at 821.
55. Id.
56. Id. at 832.
57. Id.
58. Id. at 832 n.120.
acquiescence in physician-assisted suicide for competent, terminally ill patients, the Dutch have moved to permitting an estimated 2.9% of all deaths per year from active euthanasia. Moreover, the Dutch government reported approximately one thousand cases of nonvoluntary euthanasia in 1990. Assisted suicide or euthanasia are now accepted for both quadriplegic and severely depressed persons with no terminal condition at all. As Dr. Herbert Hendin of the American Suicide Foundation summarized for the House Judiciary Committee Subcommittee on the Constitution:

Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical help i.e. euthanasia to those who could not affect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination.


60. See ABA Memorandum, supra note 49, at 119. Based on published Dutch government statistics, one influential observer estimates that up to 7% of all deaths in the Netherlands results from euthanasia: "In the U.S., these numbers would mean a rate of euthanasia resulting in 140,000 deaths per year as the direct and intentional result of physician intervention." Carlos F. Gomez, Euthanasia: Consider the Dutch, COMMONWEAL, Sept. 1992, at 7 (Special Supp.).

61. See ABA Memorandum, supra note 49, at 119 ("[A]lthough the required conditions for euthanasia in the Netherlands include explicit and repeated requests by the patient for euthanasia, a recent Dutch government study estimates that .8% (or 1,030 deaths) of life-terminating acts in 1990 were done without explicit and persistent requests."). This number increases significantly if deaths from the intentionally lethal administration of morphine by physicians (which the Dutch do not count as euthanasia) are included. See Bopp & Coleson, supra note 59, at 268 n.41; see also Brief of United States Catholic Health Ass'n, as Amicus Curiae in Support of Petitioners, Vacco v. Quill, 80 F.3d 716 (2d Cir. 1996), cert. granted, 117 S. Ct. 36 (1996) (No. 95-1858) and Washington v. Glucksberg, 79 F.3d 790 (9th Cir. 1996), cert. granted sub nom. 117 S. Ct. 37 (1996) (No. 96-110), available in 1996 WL 656343.

62. See Richard Doerflinger, Assisted Suicide: Pro-choice or Anti-Life?, 19 HASTINGS CENTER REF. 16, 18 (Jan.-Feb. 1989) (Special Supp.).

63. See Hendin, supra note 59, at 123.

64. Assisted Suicide Hearing, supra note 48, at 127-38 (prepared testimony of Herbert Hendin, M.D.). Though the Dutch experience should not be uncritically applied, it is noteworthy that, "[u]nlike the United States, virtually all [Dutch] citizens have access to primary health care." ABA Memorandum, supra note 49, at 119. This expansion thus occurred in a society where the cost-cutting pressures our country is now experiencing are not present.
Notably, a comparable expansion has occurred in cases in the United States affirming a right to refuse life support: beginning with a right of competent terminally ill patients;\textsuperscript{65} to a right of competent, severely disabled, but not terminally ill persons;\textsuperscript{66} to a right of incompetent patients, with or without clear and convincing evidence of their prior wishes;\textsuperscript{67} to the right of a person who had never been competent;\textsuperscript{68} and even to a case involving a minor.\textsuperscript{69} Assisted suicide, once sanctioned, could likewise expand since, as Justice Cardozo cautioned, any principle tends "to expand itself to the limit of its logic."\textsuperscript{70}

Given his observation that the Supreme Court had "expressed a strong reluctance to find new fundamental rights,"\textsuperscript{71} Judge Reinhardt instead labeled the right to die a "liberty interest" which, though not warranting strict scrutiny, was nonetheless "subject to a balancing test" to be weighed against competing government interests.\textsuperscript{72} In striking that balance, he deliberately discounted the state's interest in the preservation of life by the quality of the life involved. As he

\textsuperscript{65} See Brief of Gary Lee, M.D., et al., as Amici Curiae in Support of Petitioners, Washington v. Glucksberg, 79 F.3d 790 (9th Cir. 1996), cert. granted sub nom. 117 S. Ct. 37 (1996) (No. 96-110) and Vacco v. Quill, 80 F.3d 716 (2d Cir. 1996), cert. granted, 117 S. Ct. 36 (1996) (No. 95-1858), available in 1996 WL 647921, at *25 (citing Tune v. Walter Reed Army Medical Hosp., 602 F. Supp. 1452 (D.D.C. 1985) (holding that "competent adult patients with terminal illnesses have a right to determine for themselves whether or not they wish their lives to be prolonged by artificial life support systems")).

\textsuperscript{66} Id. at *25-26 (citing Bouvia v. Superior Court, 179 Cal. App. 3d 1127 (1986) (holding that "no compelling state interest in the preservation of human life exists that would outweigh a competent but disabled person's right to terminate treatment because 'the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration'") and McKay v. Bergstedt, 801 P.2d 617 (1990) (ratifying "the right to die for competent persons with disabilities who were dependent on life-sustaining treatment in order to live," e.g. those having an "artificial survival" or lives "irreparably devastated by injury or illness")).

\textsuperscript{67} Id. at *26-27 (citing Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (1986) (holding that "casual remarks made by a patient prior to the onset of any illness could be sufficient evidence to find that the now incompetent patient would, if competent, decline to receive nutrition and hydration by tube"), Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990) (upholding state requirement that wishes prior to vegetative-state be proved by clear and convincing evidence, but not requiring same standard for all states), and In re Jobes, 529 A.2d 434 (1987) (holding that surrogate decision maker "may withhold feeding by tube even when the incompetent patient has not left clear and convincing evidence of her intent")).

\textsuperscript{68} Id. at *28 (citing In re Sue Ann Lawrance, 579 N.E.2d 32 (1991) (holding that Indiana Health Care Act "permits families to decide, in consultation with a physician, to withdraw life-sustaining treatment . . . from never-competent patients in persistent vegetative state")).

\textsuperscript{69} Id. (citing In re Swan, 569 A.2d 1202 (1990) (holding that "pre-accident declarations made by a minor later left in a persistent vegetative state . . . may be found sufficient to satisfy a determination that clear and convincing evidence exists of the minor's decision to discontinue life-sustaining treatment and feeding tubes")).

\textsuperscript{70} BENJAMIN N. CARDOZO, NATURE OF THE JUDICIAL PROCESS 51 (1949).

\textsuperscript{71} Compassion in Dying v. Washington, 79 F.3d 790, 803 (9th Cir. 1996).

\textsuperscript{72} Id. at 804.
wrote: The state's interest in preserving life "is not . . . of the same strength in each case. To the contrary, its strength is dependent on relevant circumstances, including the medical condition and the wishes of the person whose life is at stake."73

Although Judge Reinhardt stated that "the state may still seek to prolong the lives of terminally ill or comatose patients," he, nonetheless, concluded that "the strength of the state's interest is substantially reduced in such circumstances."74

Judge Miner also rested his decision squarely on quality-of-life considerations—but in the context, not of due process, but of equal protection. Unlike Judge Reinhardt, he declined to find a right to die but purported to apply rational basis scrutiny to New York's distinction between denying terminally ill patients assisted suicide and permitting their refusal of life support.75 That standard is satisfied "if any state of facts reasonably may be conceived to justify [the distinction.]"76 However, Judge Miner found a rational basis wholly lacking. As he maintained: "[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. . . . The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.'"77

However, if the state has no rational interest in preserving such diminished life, then Judge Miner's reasoning would equally justify involuntary euthanasia.

Simply put, both Judges Reinhardt and Miner are saying that there are lives which the state has little or no interest in saving. I can think of no more profound rejection of the purpose animating the Fourteenth Amendment itself. Due process and equal protection, though not coextensive,78 coalesce in forbidding the state from denying the equal dignity of the human person. This does not mean that states

73. Id. at 817.
74. Id. at 820. Notably, Cruzan provides no support for this strategy, since, as Judge Reinhardt himself admitted, "[that] Court explicitly did not decide—when, whether, and under what circumstances Nancy Cruzan's exercise of a liberty interest could be prohibited by the state." Id. at 815 n.68.
75. See Quill v. Vacco, 80 F.3d 716, 727 (1996).
76. McGowan v. Maryland, 366 U.S. 420, 426 (1961). For example, reducing the chance of misdiagnosing terminal conditions by limiting the choice to those already on life support should constitute such a rational distinction.
77. Quill, 80 F.3d at 729-30.
78. See Bolling v. Sharpe, 347 U.S. 497, 499 (1954) ("The 'equal protection of the laws' is a more explicit safeguard of prohibited unfairness than 'due process of law,' and, therefore, we do not imply that the two are always interchangeable phrases.").
must treat all equally in every respect. Nor does it mean that what constitutes dignity is static—the Fourteenth Amendment, for instance, recognized that dignity required more than just the prohibition of slavery. But central to that dignity guaranteed by the Fourteenth Amendment is respect for life—without which there can be no liberty, no pursuit of happiness, and even no humanity itself. Since we all have an equal claim to dignity by virtue of the fact that we are all created human, the state must respect each of our lives equally.

It is said, in response, that we can alienate that right—that we can consent to end an existence that, fundamentally, we cannot create. However, equal respect for life would require, at the least, that states respect that choice equally. If so, then, as Judge Noonan observed, "the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. . . . The conclusion is a reductio ad absurdum."81

Such quality-of-life considerations are particularly ominous for people with disabilities. One need not dwell on the euthanasia program in Nazi Germany, where a quarter of a million people were slaughtered in medical killing centers as "useless eaters,"82 to know that those with disabilities have suffered much during this century. In this

79. I will not discuss here whether one can forfeit this guarantee as a consequence of aggression.
80. See Slaughter-House Cases, 83 U.S. (16 Wall.) 36, 70 (1872)
These circumstances [where newly emancipated slaves were denied contract, property, and other rights in the post-bellum South] . . . forced upon the statesmen who had conducted the Federal government in safety through the crisis of the rebellion, and who supposed that by the thirteenth article of amendment they had secured the result of their labors, the conviction that something more was necessary in the way of constitutional protection to the unfortunate race who had suffered so much. They accordingly passed . . . the fourteenth amendment.

Id.
81. Compassion in Dying v. Washington, 49 F.3d 586, 591 (9th Cir. 1995).
82. See generally Hugh G. Gallagher, By Trust Betrayed: Patients, Physicians, and the License To Kill in the Third Reich (1990). As Leo Alexander, chief medical consultant at Nuremberg, observed of the Nazi atrocities:
Whatever proportions these crimes finally assumed, it became evident to all who investigat ed them that they had started from small beginnings, . . . at first merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Aryans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.

country, for example, as Justice Marshall observed, retarded people were "subject to a 'lengthy and tragic history' . . . of segregation and discrimination that can only be called grotesque. . . . [This] regime . . . in its virulence and bigotry rivaled, and indeed paralleled, the worst excesses of Jim Crow." Justice Holmes perhaps best exemplified this attitude when he sanctioned the forced sterilization of Carrie Buck:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough.

As a Chicago ordinance once evidenced when it forbade those "diseased, maimed, mutilated, or in any way deformed so as to be an unsightly or disgusting object . . . [from exposing themselves] to public view," we disabled are a distressing reminder to able-bodied people of their own frailty.

These fears are epitomized by the way our society interprets a seriously disabled person's desire to die: "When the nondisabled say they want to die, they are labeled as suicidal; if they are disabled, it is treated as 'natural' or 'reasonable.'" As Carol Gill has observed:

[The nondisabled public] readily conclude[s] that the disabled person's wish to die is reasonable because it agrees with their own pre-conception that the primary problem for such individuals is the unbearable experience of a permanent disability (and/or dependence on life-aids) [rather than treatable conditions, often including depression occasioned by social prejudice]. If permanent disability is the problem, death is the solution.

87. Compassion in Dying v. Washington, 49 F.3d 586, 593 (9th Cir. 1995).
88. Carol J. Gill, Suicide Intervention for Persons with Disabilities: A Lesson in Inequality, 8 Issues L. & Med. 37, 39 (1996). Gill resists this conclusion, asserting:

Disability is no more a sufficient or acceptable reason for wanting to die than romantic failure would be for an adolescent . . . [I]f important people in the environment address
Such depreciation of disabled life is accelerated by our fixation with efficiency. As John Paul II has admonished, “prosperous societies, marked by an attitude of excessive preoccupation with efficiency [see] . . . elderly and disabled people as intolerable and too burdensome.”

In other words, for societies, like ours, “organized almost exclusively on the basis of criteria of productive efficiency, . . . [a life with disability] no longer has any value.”

Such criteria would undoubtedly confirm the reasonableness of a severely disabled person’s choice to die—especially, “[i]n this age of soaring health care costs, . . . [where] the right-to-die option will inevitably be transformed into a means of rationing health care.”

Moreover, “once the choice of a quick and painless death is officially accepted as rational,” it follows that “resistance to this choice may be seen as eccentric or even selfish.”

Judge Reinhardt claimed in response that disabled persons’ dignity would be vindicated by recognizing their equal right to make themselves dead. On a par with the Lochner Court’s contention that fair labor laws denied workers their freedom of contract, this claim merits the exercise, in reply, of “one of the sovereign prerogatives of philosophers—that of laughter.”

More generally, Judge Reinhardt dismissed concerns about the consequences of legalizing assisted suicide by noting that “[r]ecognition of any right creates the possibility of abuse.” He contended, for example: “The legalization of abortion has not undermined our commitment to life generally[;] . . . [s]imilarly, there is no reason to believe that legalizing assisted suicide will lead to the horrific consequences its opponents suggest.”

Of course, there are those, like myself, who believe that the push for assisted suicide illustrates just how Roe v. Wade has undermined . . . [the] sense of hopelessness, rather than acquiesce to it, the individual has a fighting chance of mastering despair.

Id. at 50.


90. Id.

91. Evan Kemp, Jr., Could You Please Die Now? Disabled People Like Me Have Good Reason To Fear the Push for Assisted Suicide, WASH. POST, Jan. 5, 1997, at Cl.

92. Doerflinger, supra note 62, at 17 (footnote omitted).

93. Compassion in Dying v. Washington, 79 F.3d 790, 825 (9th Cir. 1996).


96. Compassion in Dying, 79 F.3d at 831.

97. Id.

that commitment to life. Once we exclude some human lives from legal protection, it is not hard to make other exceptions, especially for lives we consider dependent.99

I would prefer in the end to align myself with Joseph Cardinal Bernardin who, in an open letter to the Supreme Court last November just before his death from cancer, wrote that "creating a [new] right to assisted suicide 'would endanger society and send a false signal that a less than "perfect" life is not worth living.'"100 He closed with this warning: "In civilized society the law exists to protect life. When it begins to legitimate the taking of life as a policy, one has a right to ask what lies ahead for our life together as a society."101

Etymologically, the term "compassion" means to "suffer with."102 "True 'compassion' leads to sharing another's pain; it does not kill the person whose suffering we cannot bear."103


Roe conditioned human worth on viability, on reaching that stage of development beyond an intrinsic dependence on another. Yet, in saying human worth transcends disability, we acknowledge that it does not hang on how far we have developed or on how dependent we remain.

We are equal because we are all created human, and endowed with the inalienable right to pursue realization of our human potential. Though that potential may develop in radically different ways, we are all intrinsically dependent on one another for its growth.


101. Id.


103. Evangelium Vitae, supra note 89, at 713.