

**MORAL AND LEGAL ISSUES SURROUNDING TERMINAL SEDATION
AND PHYSICIAN ASSISTED SUICIDE**

by

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Moral and Legal Issues Surrounding Terminal Sedation and Physician Assisted

Suicide

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Assisted suicide has been an issue for terminally ill patients for many years. This is because patients who suffer from terminal illnesses are forced to make difficult choices at the end of their lives. Currently, a terminally ill patient has three options in dealing with the extreme physical pain of his or her illness. First, he or she can choose being heavily medicated, which alleviates pain but significantly reduces awareness. Second, the patient can choose to forego, or greatly reduce the dosage, of the pain medication in order to stay alert to their surroundings. The final option most terminally ill patients have to deal with extreme pain is to end their life. Most patients who choose this option are forced to end their life on their own, without the assistance or advice of a physician, and, more often than not, before they are ready to die. This heartbreaking situation occurs because in all but one state, physician-assisted suicide is illegal. Recent Supreme Court decisions have upheld the ban on physician-assisted suicide in the other 49 states. In this paper, I will examine specific Supreme Court cases of physician assisted suicide, analyze why physician assisted suicide is traditionally treated as legally and morally impermissible, and give reasons why physician assisted suicide should be a legal and morally acceptable alternative for terminally ill patients.

CONTENTS

CHAPTER

I.	INTRODUCTION.....	1
	Introduction and Purpose of Study.....	1
II.	WASHINGTON V. <i>GLUCKSBERG</i> AND <i>VACCO V. QUILL</i>	3
	Introduction.....	3
	Background Information of <i>Washington v. Glucksberg</i>	3
	Due Process and <i>Washington v. Glucksberg</i>	7
	Background Information of <i>Vacco v. Quill</i>	9
	<i>Vacco v. Quill</i> and the Equal Protection Clause.....	11
	The Supreme Court and Intent of the Physician.....	13
II.	TERMINAL SEDATION.....	22
	Introduction.....	22
	Terminal Sedation.....	22
	Causation and Intent.....	24
	Court Support of Terminal Sedation.....	25
	Terminal Sedation – A Type of Euthanasia?.....	27
	Terminal Sedation – A Morally Inferior Alternative To Physician-Assisted Suicide.....	29
	Conclusion.....	32
III.	“THE PHILOSOPHER’S BRIEF”.....	33

Introduction.....33

Summary of Amici’s Argument.....33

The Fourteenth Amendment and the Liberty Interest in
Washington and Vacco.....35

Precedent of a Liberty Interest: *Cruzan* and *Casey*.....38

State Interest Does Not Justify A Blanket Prohibition on
Physician-Assisted Suicide.....44

Conclusion.....53

IV. THE DOCTRINE OF DOUBLE EFFECT.....55

Introduction.....55

The Doctrine of Double Effect.....56

Responsibility and Duty.....59

Analyzing The Doctrine of Double Effect:
The “Closeness” Principle.....64

Ann Davis and Problems With The Doctrine of
Double Effect.....65

Conclusion.....68

V. INTRODUCING VS. REDIRECTING HARM.....70

Introducing and Redirecting Harm.....70

The Moral Difference Between Introducing
and Redirecting Harm.....73

Harming vs. Wronging.....75

Killing, Harming, and Wronging.....76

Conclusion – What This Means For Our Earlier
Cases and Physician-Assisted Suicide.....78

VI.	WHAT WE VALUE ABOUT LIFE.....	80
	Introduction.....	80
	The Sanctity of Life – Determining What Is Valuable About Life.....	80
	A Life Worth Living.....	83
	Paternalism and A Life Worth Living.....	86
	Questions of Autonomy.....	89
	What This Means For Physician-Assisted Suicide.....	92
VII.	THE MORAL PERMISSIBILITY OF PHYSICIAN-ASSISTED SUICIDE.....	94
	Conclusion.....	94
	BIBLIOGRAPHY.....	98

CHAPTER I

INTRODUCTION

Introduction and Purpose of Study

In this country, assisted suicide has always been a controversial issue. However, with the recent publicity surrounding court cases such as *Cruzan v. Director, Missouri Dept. of Health, People v. Kevorkian*, and laws such as the Oregon Death With Dignity Act, it is no wonder that the assisted suicide debate is at the forefront of biomedical issues. Death, and the process of dying, is perhaps the most frightening part of life. We fear many things about death; its uncertainty, the prospect of dying

alone, dying without comfort, and losing the ability to control our own body.

However, what we fear most about dying is the thought of being in pain.

Unfortunately, for people facing terminal illness the end of their life is guaranteed to be painful. People in this situation have few options as to how they can approach the end of their life. Most current pain-care management options do not manage pain effectively, and merely sedate the patient in order to keep them from pain. Unless terminally ill patients live in the state of Oregon, physician assisted suicide is not an available option. Patients must live out the rest of their days either sedated, in extreme pain, or end their lives without the assistance of a physician.

Due to advances in modern healthcare, it is rare for people to suffer from diseases like polio, cholera, and tuberculosis. Instead, an ever-increasing number of people are dying from terminal illnesses such as cancer, multiple sclerosis, and amyotrophic lateral sclerosis. It seems only right and proper that people in this position have the right to choose to die in a humane and dignified manner. Physician assisted suicide seems to solve this problem as it is both humane and dignified, and preserves the patient's autonomy as it empowers them to choose the time and manner of their death. However, many people find physician assisted suicide morally impermissible. I will examine specific cases of physician assisted suicide, analyze why physician assisted suicide is traditionally treated as morally impermissible, and give reasons why physician assisted suicide should be a morally acceptable alternative for terminally ill patients.

CHAPTER II

WASHINGTON v. GLUCKSBERG AND VACCO v. QUILL

Introduction

In *Washington v. Glucksberg* and *Vacco v. Quill*, the Supreme Court made landmark decisions regarding the controversial issue of physician-assisted suicide. Both of these cases involved plaintiffs who were seeking to prove that state laws banning physician-assisted suicide were unconstitutional. In each of these cases, it is important to follow the progression of these cases from District Courts to the Supreme Court. What is so important to understand, is not only the decisions of these courts, but the reasoning behind them. Below, I will discuss each case and examine the foundation of the Supreme Court's final decisions.

Background Information of *Washington v. Glucksberg*

The respondents in *Washington v. Glucksberg* are three terminally ill patients along with four physicians who practice in the state of Washington and occasionally treat terminally ill patients. The petitioners in this case are the state of Washington and its Attorney General. The respondents sought to declare a Washington state law banning physician-assisted suicide as unconstitutional based on the Due Process Clause and the Equal Protection Clause.

In 1994, the "respondents, along with three gravely ill, pseudonymous plaintiffs who have since died and *Compassion in Dying*, a nonprofit organization that counsels

people considering physician assisted suicide, sued in the United States District Court, seeking a declaration that Wash Rev. Code 9A.36.060(1) (1994)¹ is, on its face, unconstitutional.”² The plaintiffs cited "the existence of a liberty interest protected by the Fourteenth Amendment³ which extends to a personal choice by a mentally competent, terminally ill adult to commit physician assisted suicide.”⁴ The District Court, “relying primarily on *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), and *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), ...agreed, 850 F. Supp., at 1459-1462, and concluded that Washington's assisted suicide ban is unconstitutional because it ‘places an undue burden on the exercise of [that] constitutionally protected liberty interest.’”⁵ Furthermore, the District Court found that the “Washington statute violated the Equal Protection Clause's requirement

¹ Wash Rev. Code 9A.36.060(1) (1994) states “A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.”

² *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459 (WD Wash. 1994) . Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997). See also note 4 of the Supreme Court’s opinion, in which Rehnquist writes, “John Doe, Jane Roe, and James Poe, plaintiffs in the District Court, were then in their terminal phases of serious and painful illnesses. They declared that they were mentally competent and desired assistance in ending their lives. Declaration of Jane Roe, *id.*, at 23-25; Declaration of John Doe, *id.*, at 27-28; Declaration of James Poe, *id.*, at 30-31; *Compassion in Dying* , 850 F. Supp. 1456-1457.”

³ Amendment XIV, Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

⁴ *Ibid.*, at 1459. Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

⁵ *Compassion in Dying v. Washington*, 850 F. Supp. 1465 (WD Wash. 1994). Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997). See also note 5 to the Supreme Court’s opinion, which states “The District Court determined that *Casey*’s ‘undue burden’ standard, 505 U.S., at (joint opinion), not the standard from *United States v. Salerno*, 481 U.S. 739, 745 (1987) (requiring a showing that "no set of circumstances exists under which the [law] would be valid"), governed the plaintiffs' facial challenge to the assisted suicide ban. 850 F. Supp., at 1462-1464.”

that "all persons similarly situated . . . be treated alike."⁶ In 1995, a Ninth Circuit Court of Appeals panel reversed the District Court's decision, "emphasizing that "[i]n the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction."⁷ In 1996, the Ninth Circuit reheard the case en banc⁸, thereby reversing the panel's earlier decision and affirming the decision of the District Court. The en banc Court of Appeals used similar reasoning as the District Court, as it emphasized the Supreme Court's *Casey* and *Cruzan* decisions.⁹ The Appellate Court "also discussed what it described as 'historical' and 'current societal attitudes' toward suicide and assisted suicide, *id.*, at 806-812, and concluded that 'the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death--that there is, in short, a constitutionally recognized 'right to die.'"¹⁰ The Appellate Court, "after '[w]eighing and then balancing' this interest against Washington's various interests, the Court held that the State's assisted suicide ban was unconstitutional 'as applied to terminally ill competent adults who wish to hasten their deaths with

⁶ *Compassion in Dying v. Washington*, 850 F. Supp. 1466 (WD Wash. 1994). In its opinion, the District Court quoted *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 439 (1985)). Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

⁷ *Compassion in Dying v. Washington*, 49 F. 3d 586, 591 (1995). Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

⁸ A Court of Appeals usually hears cases in panels consisting of three judges. When a case is reheard by the full court, it is called an "en banc" court. <http://www.citylegalguide.com/glossary.cfm> was used as a guide for this definition.

⁹ *Compassion in Dying v Washington*, 79F. 3d 813-816. Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

¹⁰ *Ibid.*, at 816. Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

medication prescribed by their physicians.”¹¹ However, the Appellate “Court did not reach the District Court's equal protection holding.”¹²

Chief Justice Rehnquist delivered the opinion of the Court. Rehnquist stated that because this case concerned the Due Process Clause, then it would first be necessary to examine this country’s history, legal traditions, and practices of physician-assisted suicide. Rehnquist found that both Anglo American tradition had long condemned physician-assisted suicide. This led to the early settlers of this country handing out harsh penalties for suicide and assisted suicide. The first state law to specifically prohibit assisted suicide was endorsed in 1828 in New York, and most new states soon followed by creating similar laws of their own.¹³ In 1980, the Model Penal Code was drafted and with the observation that “‘the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim.’

¹¹ *Ibid.*, at 836, 837. Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997). See also note 6 of the opinion of the Supreme Court where Rehnquist writes “Although, as Justice Stevens observes, *post*, at 2-3 (opinion concurring in judgment), “[the court's] analysis and eventual holding that the statute was unconstitutional was not limited to a particular set of plaintiffs before it,” the court did note that “[d]eclaring a statute unconstitutional as applied to members of a group is atypical but not uncommon.” 79 F. 3d, at 798, n. 9, and emphasized that it was ‘not deciding the facial validity of [the Washington statute],’ *id.*, at 797-798, and nn. 8-9. It is therefore the court’s holding that Washington’s physician assisted suicide statute is unconstitutional as applied to the ‘class of terminally ill, mentally competent patients,’ *post*, at 14 (Stevens, J., concurring in judgment), that is before us today.”

¹² *Ibid.*, at 838. Cited in *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

¹³ Rehnquist, William Hubbs, Opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

American Law Institute, Model Penal Code § 210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980).”¹⁴

Rehnquist goes on to observe that this modern opposition to physician-assisted suicide seems inconsistent when analyzed with respect to recent advances made in modern medicine. As a result of such advances, many infectious diseases such as tuberculosis, cholera, and polio have been eliminated. Therefore, while the average life expectancy has increased, the likelihood of dying in an institution, suffering from a terminal illness, has also increased. As a result, public concern has focused much recent attention on end of life issues. Many states now permit living wills, surrogate health care decision-making, and allow the withdrawal of life sustaining medical treatment.¹⁵ This, however, is an inconsistency because despite the number of deaths from terminal illness, the State bans on assisted suicide continue to be upheld.

Due Process and *Washington v. Glucksberg*

Rehnquist acknowledges that, in the past, the Court has held that in addition to the rights enumerated in the Bill of Rights, the Due Process Clause protects the right to marry, the right to have children, the right to direct the education and upbringing of one’s children, the right to marital privacy, the right to use contraception, the right to bodily integrity, the right to abortion, and the traditional right to refuse unwanted

¹⁴Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et .al.* 117 S.Ct.2293 (1997).

¹⁵ Rehnquist, William Hubbs. Opinion of the Court in *Washington, et.al. v. Glucksberg, et .al.* 117 S.Ct.2258 (1997).

lifesaving medical treatment.¹⁶ In this case, he reports that the Court of Appeals questioned whether or not there is a right to die, appealing to *Cruzan v Director, Mo. Dept. of Health*, which is often described as a “right to die” case. Rehnquist, however denies that *Cruzan* concerns this issue.¹⁷ Rather, he explains that the Court “assumed that the Constitution granted competent persons a ‘constitutionally protected right to refuse lifesaving hydration and nutrition.’”¹⁸

In *Washington v. Glucksberg*, however, the Supreme Court is concerned with whether or not the liberty protected by the Due Process Clause “includes a right to

¹⁶ For specific detail about these decisions regarding the Due Process Clause, Rehnquist referred to *Loving v. Virginia*, 388 U.S. 1 (1967); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942); *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Rochin v. California*, 342 U.S. 165 (1952), *Casey, supra*; *Cruzan*, 497 U.S., at 278-279. Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

¹⁷ In *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997), Rehnquist writes; “In *Cruzan*, we considered whether Nancy Beth Cruzan, who had been severely injured in an automobile accident and was in a persistive vegetative state, ‘ha[d] a right under the United States Constitution which would require the hospital to withdraw life sustaining treatment’ at her parents’ request. *Cruzan*, 497 U. S., at 269. We began with the observation that ‘[a]t common law, even the touching of one person by another without consent and without legal justification was a battery.’ *Ibid.* We then discussed the related rule that ‘informed consent is generally required for medical treatment.’ *Ibid.* After reviewing a long line of relevant state cases, we concluded that ‘the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.’ *Id.*, at 277. Next, we reviewed our own cases on the subject, and stated that ‘[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.’ *Id.*, at 278. Therefore, ‘for purposes of [that] case, we assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.’ *Id.*, at 279; see *id.*, at 287 (O’Connor, J., concurring). We concluded that, notwithstanding this right, the Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient’s wishes concerning the withdrawal of life sustaining treatment. *Id.*, at 280-281. Respondents contend that in *Cruzan* we ‘acknowledged that competent, dying persons have the right to direct the removal of life sustaining medical treatment and thus hasten death,’ Brief for Respondents 23, and that ‘the constitutional principle behind recognizing the patient’s liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication,’ *id.*, at 26. Similarly, the Court of Appeals concluded that ‘*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life sustaining food and water, necessarily recognize[d] a liberty interest in hastening one’s own death.’ 79 F. 3d, at 816.” William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

commit suicide which itself includes a right to assistance in doing so.”¹⁹ Upon examination of legal and social history, the Court found that assisted suicide has been rejected nearly every time an effort has been made to permit it. This being the case, the Court decided “that the asserted ‘right’ to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause.”²⁰ Furthermore, the Court found that Washington’s assisted suicide ban was indeed related to legitimate government interests (such as the interest in preservation of human life, the interest in protecting human life, and protecting persons in vulnerable groups such as the poor, the elderly, and the disabled).²¹ Furthermore, the Court suspects that allowing assisted suicide will eventually lead to the occurrence of voluntary and involuntary euthanasia.²²

Background Information of *Vacco v. Quill*

The respondents of *Vacco et al. v. Quill et al.* are three physicians who practice medicine in the state of New York. These physicians feel that “although it would be

¹⁸ *Cruzan*, 497 U.S., at 279. (O’Connor, J., concurring “[A] liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions”). Cited by William Hubbs Rehnquist in the opinion of the Court, *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2293 (1997).

¹⁹ Rehnquist, William Hubbs, opinion of the Court in *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2258 (1997). See also note 18 to Rehnquist’s opinion which states “ See, e.g., *Quill v. Vacco*, 80 F. 3d 716, 724 (CA2 1996) (‘right to assisted suicide finds no cognizable basis in the Constitution’s language or design’); *Compassion in Dying v. Washington*, 49 F. 3d 586, 591 (CA9 1995) (referring to alleged ‘right to suicide,’ ‘right to assistance in suicide,’ and ‘right to aid in killing oneself’); *People v. Kevorkian*, 447 Mich. 436, 476, n. 47, 527 N. W. 2d 714, 730, n. 47 (1994) (‘[T]he question that we must decide is whether the [C]onstitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance’).”

²⁰ Rehnquist, William Hubbs. Opinion of the Court in *Washington, et.al. v. Glucksberg, et.al.* 117 S.Ct.2258 (1997).

²¹ *Ibid.*

²² *Ibid.*

‘consistent with the standards of [their] medical practice[s]’ to prescribe lethal medication for ‘mentally competent, terminally ill patients’ who are suffering great pain and desire a doctor’s help in taking their own lives, they are deterred from doing so by New York’s ban on assisting suicide.’²³ The petitioners of this case are various New York public officials. The respondents and three terminally ill patients sued the New York State’s Attorney General in the US District Court on the basis that since “‘New York permits a competent person to refuse life sustaining medical treatment, and because the refusal of such treatment is ‘essentially the same thing’ as physician-assisted suicide, New York’s assisted suicide ban violates the Equal Protection Clause.’ *Quill v. Koppell*, 870 F. Supp. 78, 84-85 (SDNY 1994).”²⁴ However, the District Court disagreed with the petitioners. They found that “[I]t is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death producing device.’ *Id.*, at 84.”²⁵ The District Court cited the State of New York’s “‘obvious legitimate interests in preserving life, and in protecting vulnerable persons,’ and concluded that ‘[u]nder the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State.’ *Id.*, at 84-85.”²⁶ In 1996, the Second Circuit

²³ Rehnquist cites the Declaration of Timothy E. Quill, M. D., App. 42-49; Declaration of Samuel C. Klagsbrun, M. D., *id.*, at 68-74; Declaration of Howard A. Grossman, M. D., *id.*, at 84-89; 80 F. 3d 716, 719 (CA2 1996). Cited in the opinion of the Court, *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

²⁴ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

²⁵ *Ibid.*

²⁶ *Ibid.*

Court of Appeals reversed the District Court's decision.²⁷ The Appellate Court determined that, "despite the assisted suicide ban's apparent general applicability, 'New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths,' because 'those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life sustaining equipment, are not allowed to hasten death by self administering prescribed drugs.' *Id.* At 727, 729."²⁸ According to the Appellate Court, "[t]he ending of life by [the withdrawal of life support systems] is *nothing more nor less than assisted suicide.*' *Id.*, at 729 (emphasis added) (citation omitted)."²⁹ Furthermore, the Court of Appeals determined that this supposed unequal treatment was not rationally related to any legitimate state interest. "[t]o the extent that [New York's statutes] prohibit a physician from prescribing medications to be self administered by a mentally competent, terminally ill person in the final stages of his terminal illness," the Court stated, "they are not rationally related to any legitimate state interest.' *Id.*, at 731."³⁰ The Supreme Court granted certiorari and proceeded to reverse the decision of the Appellate Court.

²⁷ *Quill v. Koppell*, 80 F. 3d 716 (1996). Cited by William Hubbs Rehnquist in the opinion of the Court, *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

²⁸ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

²⁹ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

³⁰ *Ibid.*

***Vacco v. Quill* and the Equal Protection Clause**

Chief Justice Rehnquist delivered the opinion of the Supreme Court. According to Rehnquist, “The Equal Protection Clause commands that no State shall ‘deny to any person within its jurisdiction the equal protection of the laws.’ This provision creates no substantive rights.’ *San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1, 33 (1973); *Id.*, at 59 (Stewart, J., concurring).”³¹ Instead, Rehnquist stated that the Equal Protection Clause “embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly.’ *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (“[T]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same’”) (quoting *Tigner v. Texas*, 310 U.S. 141, 147 (1940)).”³² The Court found that, *prima facie*, the New York ban on assisted suicide does not treat patients any differently than what is allowed under the statute permitting patients to refuse medical treatment. The Court asserts that, under New York law, “everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide. Generally speaking, laws that apply evenhandedly to all ‘unquestionably comply’ with the Equal Protection Clause.’ *New York City Transit Authority v. Beazer*, 440 U.S. 568, 587 (1979); see *Personnel Administrator of Mass. v. Feeney*, 442 U.S. 256, 271-273 (1979) (“[M]any [laws] affect certain groups unevenly, even though the law itself treats them no differently from all other

³¹ *Ibid.*

³² *Ibid.*

members of the class described by the law").³³ However, the Appellate Court found that under such laws, those terminally ill patients dependent upon life support (such as a ventilator or feeding tube) are treated differently than terminally ill patients who are not dependent upon life support. This is because those terminally ill patients dependent on life support are able to hasten their deaths by ending treatment, but those terminally ill patients not dependent on life support cannot hasten their deaths by use of physician assisted suicide.³⁴ Furthermore, this distinction “depends on the submission that ending or refusing lifesaving medical treatment ‘is nothing more nor less than assisted suicide.’ *Ibid.*”³⁵ However, the Supreme Court did not agree with the Appellate Court.

The Supreme Court and Intent of the Physician

The Supreme Court feels that physician intent plays a tremendous role in the apparent distinction between withdrawing treatment and assisted suicide. According to Rehnquist, “we think the distinction between assisting suicide and withdrawing life sustaining treatment, a distinction widely recognized and endorsed in the medical profession³⁶ and in our legal traditions, is both important and logical; it is certainly

³³ *Ibid.*

³⁴ *Quill v. Koppell*, 80 F. 3d 716 (1996). Cited by William Hubbs Rehnquist in the opinion of the Court, *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

³⁵ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

³⁶ See note 6 of Rehnquist’s opinion, where he writes “The American Medical Association emphasizes the “fundamental difference between refusing life sustaining treatment and demanding a life ending treatment.” American Medical Association, Council on Ethical and Judicial Affairs, Physician Assisted Suicide, 10 Issues in Law & Medicine 91, 93 (1994); see also American Medical Association, Council

rational.’ See *Feeney, supra*, at 272 (“When the basic classification is rationally based, uneven effects upon particular groups within a class are ordinarily of no constitutional concern”).³⁷ The Court feels that the distinction between withdrawal of treatment and assisted suicide is consistent with the principles of causation and intent. Rehnquist stated that “‘when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.’ See, e.g., *People v. Kevorkian*, 447 Mich. 436, 470-472, 527 N. W. 2d 714, 728 (1994), cert. denied, 514 U.S. 1083 (1995); *Matter of Conroy*, 98 N. J. 321, 355, 486 A. 2d 1209, 1226 (1985) (when feeding tube is removed, death ‘result[s] . . . from [the patient’s] underlying medical condition”); *In re Colyer*, 99 Wash. 2d 114, 123, 660 P. 2d 738, 743 (1983) (“[D]eath which occurs after the removal of life sustaining systems is from natural causes”); American Medical Association, Council on Ethical and Judicial Affairs, Physician Assisted Suicide, 10 *Issues in Law & Medicine* 91, 92 (1994) (“When a life sustaining treatment is declined, the patient dies primarily because of an underlying disease”).³⁸ The Court makes a distinction, based on physician intent, between this type of death and the death that results from physician-

on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 *JAMA* 2229, 2230-2231, 2233 (1992) (“The withdrawing or withholding of life sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence,” but assisted suicide “is contrary to the prohibition against using the tools of medicine to cause a patient’s death”); New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 108 (1994) (“[Professional organizations] consistently distinguish assisted suicide and euthanasia from the withdrawing or withholding of treatment, and from the provision of palliative treatments or other medical care that risk fatal side effects”); Brief for the American Medical Association et al. as *Amici Curiae* 18-25. Of course, as respondents’ lawsuit demonstrates, there are differences of opinion within the medical profession on this question. See New York Task Force, *When Death is Sought, supra*, at 104-109.” Cited in *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

³⁷ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

assisted suicide. Rehnquist writes that “a physician who withdraws, or honors a patient's refusal to begin, life sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and ‘to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them.’ Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass).”³⁹ The Court finds that the physician’s intent is the same when he “provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or maybe, only to ease his patient's pain.”⁴⁰

However, the Court finds a tremendous difference in intent when a doctor assists with a terminally ill patient’s suicide. Rehnquist asserts that a physician assisting a suicide “‘must, necessarily and indubitably, intend primarily that the patient be made dead.’ *Id.*, at 367.”⁴¹ Furthermore, the Court also asserted that “‘a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not.’ See, *e.g.*, *Matter of Conroy, supra*, at 351, 486 A. 2d, at 1224 (patients who refuse life sustaining treatment “may not harbor a specific intent to die” and may instead “fervently wish to live, but to do so free of unwanted medical technology, surgery, or

³⁸ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

³⁹ *Ibid.*

⁴⁰ *Ibid.*

⁴¹ *Ibid.*

drugs"); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 743, n. 11, 370 N. E. 2d 417, 426, n. 11 (1977) ("[I]n refusing treatment the patient may not have the specific intent to die").⁴² The Court cites many past cases in which the actor's intent was used to distinguish between two seemingly similar acts. Such cases include "*United States v. Bailey*, 444 U.S. 394, 403-406 (1980) [in which] [t]he . . . common law of homicide often distinguishes . . . between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life"); *Morissette v. United States*, 342 U.S. 246, 250 (1952) [where the] distinctions based on intent are 'universal and persistent in mature systems of law'; *M. Hale*, 1 Pleas of the Crown 412 (1847) [where it is stated that, if an actor], 'with an intent to prevent gangrene beginning in his hand doth without any advice cut off his hand, by which he dies, he is not thereby *felo de se* for tho[sic] it was a voluntary act, yet it was not with an intent to kill himself.'⁴³ In essence, "'the law distinguishes actions taken 'because of' a given end from actions taken 'in spite of' their unintended but foreseen consequences.'" *Feeney*, 442 U. S., at 279; *Compassion in Dying v. Washington*, 79 F. 3d 790, 858 (CA9 1996) (Kleinfeld, J., dissenting) ("When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death . . . His purpose, though, was to . . . liberate Europe from the Nazis").⁴⁴ Given this precedent Rehnquist asserts that it is easy to see why so many

⁴² *Ibid.*

⁴³ *Ibid.*

⁴⁴ *Ibid.*

state courts draw a distinction based upon a physician's intent.⁴⁵ Moreover, the first state court decision to permit the withdrawal of lifesaving treatment stated that the "real distinction between the self infliction of deadly harm and a self determination against artificial life support." In *re Quinlan*, 70 N. J. 10, 43, 52, and n. 9, 355 A. 2d 647, 665, 670, and n. 9, cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).⁴⁶ This sentiment was echoed in 1997 when the Michigan Supreme Court "also rejected the argument that the distinction 'between acts that artificially sustain life and acts that artificially curtail life' is merely a 'distinction without constitutional significance--a meaningless exercise in semantic gymnastics,' insisting that 'the *Cruzan* majority disagreed and so do we.' *Kevorkian*, 447 Mich., at 471, 527 N. W. 2d, at 728."⁴⁷

⁴⁵ Rehnquist says to "See, e.g., *Fosmire v. Nicoleau*, 75 N. Y. 2d 218, 227, and n. 2, 551 N. E. 2d 77, 82, and n. 2 (1990) ("[M]erely declining medical . . . care is not considered a suicidal act"). Note 7 to Rehnquist's opinion occurs at the end of this sentence. Note 7 states: "Thus, the Second Circuit erred in reading New York law as creating a "right to hasten death"; instead, the authorities cited by the court recognize a right to refuse treatment, and nowhere equate the exercise of this right with suicide. *Schloendorff v. Society of New York Hospital*, 211 N. Y. 125, 129-130, 105 N. E. 92, 93 (1914), which contains Justice Cardozo's famous statement that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body," was simply an informed consent case. See also *Rivers v. Katz*, 67 N. Y. 2d 485, 495, 495 N. E. 2d 337, 343 (1986) (right to refuse antipsychotic medication is not absolute, and may be limited when "the patient presents a danger to himself"); *Matter of Storar*, 52 N. Y. 2d 363, 377, n. 6, 420 N. E. 2d 64, 71, n. 6, cert. denied, 454 U.S. 858 (1981)." *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁴⁶ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁴⁷ Note 8 to Rehnquist's opinion occurs at the end of this sentence. Note 8 states: "Many courts have recognized this distinction. See, e.g., *Kevorkian v. Thompson*, 947 F. Supp. 1152, 1178, and nn. 20-21 (ED Mich. 1997); *In re Fiori*, 543 Pa. 592, 602, 673 A. 2d 905, 910 (1996); *Singletary v. Costello*, 665 So. 2d 1099, 1106 (Fla. App. 1996); *Laurie v. Senecal*, 666 A. 2d 806, 808-809 (R. I. 1995); *State ex rel. Schuetzle v. Vogel*, 537 N. W. 2d 358, 360 (N. D. 1995); *Thor v. Superior Court*, 5 Cal. 4th 725, 741-742, 855 P. 2d 375, 385-386 (1993); *DeGrella v. Elston*, 858 S. W. 2d 698, 707 (Ky. 1993); *People v. Adams*, 216 Cal. App. 3d 1431, 1440, 265 Cal. Rptr. 568, 573-574 (1990); *Guardianship of Jane Doe*, 411 Mass. 512, 522-523, 583 N. E. 2d 1263, 1270, cert. denied *sub nom. Doe v. Gross*, 503 U.S. 950 (1992); *In re L. W.*, 167 Wis. 2d 53, 83, 482 N. W. 2d 60, 71 (1992); *In re Rosebush*, 195 Mich. App. 675, 681, n. 2, 491 N. W. 2d 633, 636, n. 2 (1992); *Donaldson v. Van de Kamp*, 2 Cal. App. 4th 1614, 1619-1625, 4 Cal. Rptr. 2d 59, 61-64 (1992); *In re Lawrance*, 579 N. E. 2d 32, 40, n. 4 (Ind. 1991); *McKay v. Bergstedt*, 106 Nev. 808, 822-823, 801 P. 2d 617, 626-627 (1990); *In re Browning*, 568 So. 2d 4, 14 (Fla. 1990); *McConnell v. Beverly Enterprises Connecticut, Inc.*, 209

State legislatures assert they are respecting end-of-life issues even while they continue to distinguish between the withdrawal of treatment and assisted suicide by keeping assisted suicide illegal and permitting the withdrawal of treatment. This is apparent as "nearly all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health care situations, or in 'living will' statutes." *Kevorkian*, 447 Mich., at 478-479, and nn. 53-54, 527 N. W. 2d, at 731-732, and nn. 53-54.⁴⁸ New York is a prime example as a type of state that

Conn. 692, 710, 553 A. 2d 596, 605 (1989); *State v. McAfee*, 259 Ga. 579, 581, 385 S. E. 2d 651, 652 (1989); *In re Grant*, 109 Wash. 2d 545, 563, 747 P. 2d 445, 454-455 (1987); *In re Gardner*, 534 A. 2d 947, 955-956 (Me. 1987); *Matter of Farrell*, 108 N. J. 335, 349-350, 529 A. 2d 404, 411 (1987); *Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P. 2d 674, 685 (1987); *Bowvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144-1145, 225 Cal. Rptr. 297, 306 (1986); *Von Holden v. Chapman*, 87 App. Div. 2d 66, 70, 450 N. Y. S. 2d 623, 627 (1982); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 196-197, 209 Cal. Rptr. 220, 225-226 (1984); *Foody v. Manchester Memorial Hospital*, 40 Conn. Sup. 127, 137, 482 A. 2d 713, 720 (1984); *In re P. V. W.*, 424 So. 2d 1015, 1022 (La. 1982); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 10, 426 N. E. 2d 809, 815 (Ohio Comm. Pleas 1980); *In re Severns*, 425 A. 2d 156, 161 (Del. Ch. 1980); *Satz v. Perlmutter*, 362 So. 2d 160, 162-163 (Fla. App. 1978); *Application of the President and Directors of Georgetown College*, 331 F. 2d 1000, 1009 (CA DC), cert. denied, 377 U.S. 978 (1964); *Brophy v. New England Sinai Hospital*, 398 Mass. 417, 439, 497 N. E. 2d 626, 638 (1986). The British House of Lords has also recognized the distinction. *Airedale N. H. S. Trust v. Bland*, 2 W. L. R. 316, 368 (1993).” *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁴⁸ Note 9 to Rehnquist’s opinion occurs at the end of this sentence. Note 9 states: “See Ala. Code §22-8A--10 (1990); Alaska Stat. Ann. §§18.12.080(a), (f) (1996); Ariz. Rev. Stat. Ann. §36-3210 (Supp. 1996); Ark. Code Ann. §§20-13-905(a), (f), 20-17-210(a),(g) (1991 and Supp. 1995); Cal. Health & Safety Code Ann. §7191.5(a), (g) (West Supp. 1997); Cal. Prob. Code Ann. §4723 (West. Supp. 1997); Colo. Rev. Stat. §§15-14-504(4), 15-18-112(1), 15-18.5-101(3), 15-18.6-108 (1987 and Supp. 1996); Conn. Gen. Stat. §19a--575 (Supp. 1996); Del. Code Ann., Tit. 16, §2512 (Supp. 1996); D. C. Code Ann. §§6-2430, 21-2212 (1995 and Supp. 1996); Fla. Stat. §§765.309(1), (2) (Supp. 1997); Ga. Code Ann. §§31-32-11(b), 31-36-2(b) (1996); Haw. Rev. Stat. §327D--13 (1996); Idaho Code §39-152 (Supp. 1996); Ill. Comp. Stat., ch. 755, §§35/9(f), 40/5, 40/50, 45/2-1 (1992); Ind. Code §§16-36-1-13, 16-36-4-19, 30-5-5-17 (1994 and Supp. 1996); Iowa Code §§144A.11.1-144A.11.6, 144B.12.2 (1989 and West Supp. 1997); Kan. Stat. Ann. §65-28,109 (1985); Ky. Rev. Stat. Ann. §311.638 (Baldwin Supp. 1992); La. Rev. Stat. Ann. 40: §§1299.58.10(A), (B) (West 1992); Me. Rev. Stat. Ann., Tit. 18-A, §§5-813(b), (c) (West Supp. 1996); Mass. Gen. Laws 201D, §12 (Supp. 1997); Md. Health Code Ann. §5-611(c) (1994); Mich. Comp. Laws Ann. §700.496(20) (West 1995); Minn. Stat. §§145B.14, 145C.14 (Supp. 1997); Miss. Code Ann. §§41-41-117(2),41-41-119(1) (Supp. 1992); Mo. Rev. Stat. §§459.015.3, 459.055(5) (1992); Mont. Code Ann. §§50-9-205(1), (7), 50-10-104(1), (6) (1995); Neb. Rev. Stat. §§20-412(1), (7), 30-3401(3) (1995); N. H. Rev. Stat. Ann. §§137-H:10, 137-H:13, 137 J:1 (1996); N. J. Stat. Ann. §§26:2H--54(d), (e), 26:2H--77 (West 1996); N. M. Stat. Ann. §§24-7A--13(B)(1), (C) (Supp. 1995); N. Y. Pub. Health Law §2989(3) (1993); Nev. Rev. Stat. §449.670(2) (1996); N. C. Gen. Stat. §§90-320(b), 90-321(f) (1993); N. D. Cent. Code §§23-06.4-01, 23-06.5-01 (1991); Ohio Rev. Code Ann. §2133.12(A), (D) (Supp. 1996); Okla. Stat. Ann., Tit. 63,

allows the withdrawal of treatment but does not permit assisted suicide. The first statute prohibiting assisted suicide was passed in 1965.⁴⁹ Since this statute, the state of New York has passed many laws with the intention of protecting “‘a patients’ common law right to refuse treatment.’ Act of Aug. 7, 1987, ch. 818, §1, 1987 N. Y. Laws 3140 (“Do Not Resuscitate Orders”) (codified as amended at N. Y. Pub. Health Law §§2960-2979 (McKinney 1994 and Supp. 1997)); Act of July 22, 1990, ch. 752, §2, 1990 N. Y. Laws 3547 (“Health Care Agents and Proxies”) (codified as amended at N. Y. Pub. Health Law §§2980-2994 (McKinney 1994 and Supp. 1997)).”⁵⁰

However, the State has “‘neither endorsed a general right to ‘hasten death’ nor approved physician assisted suicide. Quite the opposite: The State has reaffirmed the line between ‘killing’ and ‘letting die.’” N. Y. Pub. Health Law §2989(3) (McKinney 1994) (“This article is not intended to permit or promote suicide, assisted suicide, or euthanasia”); New York State Task Force on Life and the Law, *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* 36-42 (July 1987); *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New*

§§3101.2(C),3101.12(A),(G) (1996); 20 Pa. Cons. Stat. §5402(b) (Supp. 1996); R. I. Gen. Laws §§23-4.10-9(a), (f), 23-4.11-10(a), (f) (1996); S. C. Code Ann. §§44-77-130, 44-78-50(A), (C), 62-5-504(O) (Supp. 1996); S. D. Codified Laws §§34-12D--14, 34-12D--20 (1994); Tenn. Code Ann. §§32-11-110(a), 39-13-216 (Supp. 1996); Tex. Health & Safety Code Ann. §§672.017, 672.020, 672.021 (1992); Utah Code Ann. §§75-2-1116,75-2-1118 (1993); Va. Code Ann. §54.1-2990 (1994); Vt. Stat. Ann., Tit. 18, §5260 (1987); V. I. Code Ann.,Tit. 19, §§198(a), (g) (1995); Wash. Rev. Code §§70.122.070(1), 70.122.100 (Supp. 1997); W. Va. Code §§16-30-10, 16-30A--16(a), 16-30B--2(b), 16-30B--13, 16-30C--14 (1995); Wis. Stat. §§154.11(1), (6), 154.25(7), 155.70(7) (Supp. 1996); Wyo. Stat. §§3-5-211, 35-22-109, 35-22-208 (1994 & Supp. 1996). See also, [42 U.S.C. § 14402\(b\)\(1\), \(2\), \(4\)](#) (“Assisted Suicide Funding Restriction Act of 1997”).” *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁴⁹ Note 10 to Rehnquist’s opinion occurs at the end of this sentence. Note 10 states: “It has always been a crime, either by statute or under the common law, to assist a suicide in New York. See Marzen, O’Dowd, Crone, & Balch, *Suicide: A Constitutional Right?*, 24 *Duquesne L. Rev.* 1, 205-210 (1985) (Appendix).” *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁵⁰ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

York State Task Force on Life and the Law 15 (Apr. 1986).”⁵¹ Recently, the New York State Task Force on Life and the Law, after studying euthanasia and assisted suicide, unanimously recommended against legalization, stating that “‘allowing decisions to forego life sustaining treatment and allowing assisted suicide or euthanasia have radically different consequences and meanings for public policy.’” *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* vii (1994). In the Task Force's view, ‘allowing decisions to forego life sustaining treatment and allowing assisted suicide or euthanasia have radically different consequences and meanings for public policy.’” *Id.*, at 146. ⁵²

Furthermore, the Supreme Court has also recognized this same distinction. In *Cruzan v. Director, Mo. Dept. of Health* the Supreme Court stated that “[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.”⁵³ The Court of Appeals assumed that a person’s right to refuse treatment was based on the proposition that “patients have a general and abstract ‘right to hasten death.’”⁵⁴ However, the Supreme Court instead assumed this right to be based “‘on well established, traditional rights to bodily integrity and freedom from unwanted touching.’” *Cruzan*, 497 U. S., at 278-279; *id.*, at 287-288 (O'Connor, J.,

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278 (1990), Cited by William Hubbs Rehnquist in *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁵⁴ *Quill v. Koppell*, 80 F. 3d, at 727-728 (1990), Cited by William Hubbs Rehnquist in the opinion of the Court, *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

concurring).”⁵⁵ In fact, the Supreme Court noted “the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.” *Id.*, at 280.”⁵⁶ The Court thus feels that the *Cruzan* decision does not provide a basis to for the Appellate Court to claim that withdrawal of treatment is equal to suicide.

It is for these above reasons that the Court “disagree[s] with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is ‘arbitrary’ and ‘irrational.’” Brief for Respondents 44”⁵⁷ The Court maintains that “logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently.”⁵⁸ The Court feels that the state of New York follows a longstanding rational tradition when they permit withdrawal of treatment and ban assisted suicide.

⁵⁵ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁵⁶ *Ibid.*

⁵⁷ Note 11 to Rehnquist's opinion occurs at the end of this sentence. Note 11 states: “Respondents also argue that the State irrationally distinguishes between physician assisted suicide and “terminal sedation,” a process respondents characterize as “induc[ing] barbiturate coma and then starv[ing] the person to death.” Brief for Respondents 48-50; see 80 F. 3d, at 729. Petitioners insist, however, that “[a]lthough proponents of physician assisted suicide and euthanasia contend that terminal sedation is covert physician assisted suicide or euthanasia, the concept of sedating pharmacotherapy is based on informed consent and the principle of double effect.” Reply Brief for Petitioners 12 (quoting P. Rousseau, Terminal Sedation in the Care of Dying Patients, 156 Archives Internal Med. 1785, 1785-1786 (1996)). Just as a State may prohibit assisting suicide while permitting patients to refuse unwanted lifesaving treatment, it may permit palliative care related to that refusal, which may have the foreseen but unintended “double effect” of hastening the patient's death. See New York Task Force, When Death is Sought, *supra*, n. 6, at 163 (“It is widely recognized that the provision of pain medication is ethically and professionally acceptable even when the treatment may hasten the patient's death, if the medication is intended to alleviate pain and severe discomfort, not to cause death”).” *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

⁵⁸ *Vacco et al. v. Quill et al.*, 117 S.Ct.2293 (1997).

CHAPTER III

TERMINAL SEDATION

Introduction

In this country, the Supreme Court draws a firm distinction between the withdrawal of life sustaining treatment and physician-assisted suicide. They claim that withdrawal of treatment is fundamentally different from physician-assisted suicide, the latter of which can be likened to euthanasia. The Court wishes to maintain a distinction between active and passive causes of death. They assert that withdrawal of life-sustaining treatment (such as a ventilator) is considered to be a “passive” cause of death – a case in which treatment is merely withdrawn and the patient succumbs to their underlying illness.⁵⁹ The court contrasts this with active euthanasia, which is considered to be an “active” case of death because the patient dies not from his or her illness, but rather from life-ending drugs administered by a physician. The Court permits withdrawal of treatment because the Court recognizes that treatment is an intrusion on one’s body. Such intrusions, without the consent of the patient, comprise battery of the patient. Therefore, it is up to the patient to determine whether or not he or she will accept or reject treatment. As a result, the

⁵⁹ Orentlicher, David. “The Supreme Court and Terminal Sedation: An Ethically Inferior Alternative to Physician Assisted Suicide”. Reprinted in *Physician Assisted Suicide: Expanding the Debate*. Eds: Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York: Routledge, 1998. pp. 300.

Supreme Court allows states to prohibit physician-assisted suicide, but maintains that states must permit withdrawal of treatment.

Terminal Sedation

How, then, does the Court respond to dying patients who endure extreme suffering? Within the category of “withdrawal of treatment” exists a procedure known as terminal sedation. This occurs when patients are “deeply sedated to eliminate their awareness of pain or other suffering. Once sedated, the patient’s food and water is typically withheld, and the patient dies, either from the underlying disease or the withholding of food and water.”⁶⁰

One may wonder why terminal sedation is necessary; why must a person be sedated to the point of coma until death? During advanced stages of terminal illnesses, patients may experience symptoms such as: excruciating pain, shortness of breath, agitated delirium, or persistent vomiting; such symptoms are not responsive to traditional pain management treatments.⁶¹ These symptoms occur as a result of terminal illnesses such as “cancer metastatic to the spine with collapse of the vertebral bodies, intestinal obstruction, headache due to massive intra-cerebral edema (i.e., massive build-up of fluid in the brain). Intolerable shortness of breath also may be caused by a number of conditions, including emphysema, lung and other cancers, and congestive heart failure.”⁶² In such cases, narcotics and/or tranquilizing drugs are

⁶⁰ *Ibid.*, p. 303.

⁶¹ *Ibid.*

⁶² *Ibid.* Orentlicher states that we should see “Nathan I. Cherny and Russell K. Portenoy, ‘Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment,’ *Journal of*

used to sedate the patient into unconsciousness, as this is the only way to relieve the patient of his suffering.⁶³ This unconscious state is maintained until the patient dies either from his illness or from the withholding of nutrition and hydration. This decision about food and water is additional to the decision to terminally sedate. Although it is not required, the withdrawal of nutrition and hydration often accompanies the administration of coma-inducing drugs “[s]ince the sedation leaves the patient with a depressed level of consciousness and stopping the sedation would only result in the patient re-experiencing the suffering, the patient frequently agrees to have food and water withheld rather than having life prolonged for a short time. In cases that terminal sedation shortens the patient’s life it usually does so by hours to days. For some patients, life is shortened by as much as several weeks.”⁶⁴

The Court indicates that the practice of terminal sedation is an acceptable solution for dying patients who are experiencing pain and suffering. However, upon closer examination, terminal sedation not only weakens the Court’s morally asymmetrical distinctions, but it is a substandard solution to the alternative of recognizing physician assisted suicide as an individual right.

Causation and Intent

In *Vacco v. Quill*, the Supreme Court justified its decision to uphold the state of New York’s ban on physician-assisted suicide by considering differences between

Palliative Care 10 (2) (1994): 31-38. Also, David B. Reuben and Vincent Mor, ‘Dyspnea in Terminally Ill Cancer Patients,’ *Chest* 89 (1986): 234-36.”

⁶³ *Ibid.*

⁶⁴ *Ibid.*

causation and intent. The Court finds that when a physician withdraws treatment, he does so with the intent of freeing that patient from any unwanted medical interference – the death of the patient is merely a foreseen consequence. In contrast, when a physician assists with a patient’s suicide, he does so with the intent of bringing about that patient’s death.⁶⁵ The Court relies heavily on this apparent distinction in its decision to hold that physician-assisted suicide bans are constitutional. However, even if we accept the Court’s distinction regarding intent and causation, the Court’s attitude towards terminal sedation involves supporting euthanasia and undermines the very distinction upon which their decision is based.

Court Support of Terminal Sedation

Along with its emphasis on physician intent, the Court also relies on the availability of pain management and terminal sedation. The Court finds that physician assisted suicide is not an individual right and should not be made available because adequate pain management and terminal sedation are already available to dying patients suffering from pain. In *Washington v. Glucksberg*, Justice O’Connor states that “the parties and amici agree that in these States [New York and Washington] a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness

⁶⁵ The apparent moral asymmetry between intending and foreseeing will be discussed in greater detail in a later section.

and hastening death.”⁶⁶ O’Connor adamantly asserts that dying patients can in fact obtain sedatives that would accelerate their death.

Justice Breyer echoed Justice O’Connor’s sentiment in his own concurring opinion. “As Justice O’Connor points out,” Breyer writes, “the laws before us do not force a dying person to undergo that kind of [severe physical] pain. Rather, the laws of New York and Washington do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill... Medical technology, we are repeatedly told, makes the administration of pain relieving drugs sufficient, except for a very few individuals for whom the ineffectiveness of pain control medicines can mean, not pain, but the need for sedation which can end in a coma.”⁶⁷ Justice Ginsburg concurred with Justices O’Connor and Breyer for the same reasons.⁶⁸ These three Justices reject the contention that terminally ill patients have the right to physician-assisted suicide since such patients have access to sufficient pain management, including terminal sedation.

⁶⁶ Justice O’Connor referenced Wash. Rev. Code §70.122.010 (1994); Brief for Petitioners in No. 95-1858, p. 15, n. 9; Brief for Respondents in No. 95-1858, p. 15. Justice O’Connor’s concurring opinion in *Washington, et.al. v. Glucksberg, et .al.*, 117 S.Ct.2258 (1997).

⁶⁷ Breyer, Stephen. See Cf. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 163, n. 29 (May 1994). Also, Brief for National Hospice Organization 8; Brief for the American Medical Association (AMA) et al. as *Amici Curiae* 6; see also Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 *J. Palliative Care* 25, 26 (1993); New York State Task Force, at 44, and n. 37. We are also told that there are many instances in which patients do not receive the palliative care that, in principle, is available, *id.*, at 43-47; Brief for AMA as *Amici Curiae* 6; Brief for Choice in Dying, Inc., as *Amici Curiae* 20, but that is so for institutional reasons or inadequacies or obstacles, which would seem possible to overcome, and which do *not* include a *prohibitive set of laws. Ante.*, at 2 (O’Connor, J., concurring). . *Washington, et.al. v. Glucksberg, et .al.*, 117 S.Ct.2258 (1997).

⁶⁸ Ginsburg, Ruth Bader. Concurring opinion in *Washington, et.al. v. Glucksberg, et .al.*, 117 S.Ct.2258 (1997).

Terminal Sedation – A Type of Euthanasia?

Prima facie, the distinction the Court makes between active and passive cases of death appears to include terminal sedation as a type of passive death. However, upon closer analysis, we are able to see how terminal sedation is in fact a type of active death.

First, we will examine David Orentlicher's argument regarding terminal sedation. Orentlicher separates terminal sedation into two steps – first, the introduction of coma-inducing drugs and second, the withdrawal of nutrition and hydration. As noted previously, the Supreme Court's own distinction between active and passive cases of death classifies a death as passive when treatment is withdrawn and the patient dies from the underlying illness. Orentlicher does not find the first step of terminal sedation to be problematic for the Court's distinction because the goal of administering coma-inducing drugs to the patient is to alleviate pain and suffering, not to cause death. It is the second step that Orentlicher feels is problematic for the Court and their active/passive distinction. Orentlicher claims that "[i]f the sedation step and the withholding of nutrition and hydration step are viewed as a total package, then we have a situation in which a patient's life is ended by the active intervention of a physician."⁶⁹

Orentlicher's has good intentions as he attempts to prove terminal sedation to be a morally inferior alternative to physician-assisted suicide. Ultimately, however, his argument is off-target. Orentlicher's argument confuses the pertinent issues in two

⁶⁹ Orentlicher, David. "The Supreme Court and Terminal Sedation: An Ethically Inferior Alternative to Physician Assisted Suicide". Reprinted in *Physician Assisted Suicide: Expanding the Debate*. Eds: Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York: Routledge, 1998. pp. 304.

important ways. First, Orentlicher does not use the term “active death” in the same way it is used by the Supreme Court. Orentlicher considers an active death to be a death caused by the active intervention of a physician. However, when the Supreme Court discusses an active death, they are referring to death that does not result from an underlying illness. Orentlicher’s argument is supposedly a response to *Washington* and *Vacco*, yet this confusion of terminology weakens his response.

Furthermore, Orentlicher incorrectly divides terminal sedation into two steps. There is only one “step” in terminal sedation: the administration of drugs that results in a patient’s terminal coma. Orentlicher’s “second step” is actually not part of terminal sedation itself. Rather, the withdrawal of nutrition and hydration is a decision that may accompany terminal sedation. A patient (or his proxy) may or may not decide to refuse nutrition and/or hydration during the sedation. This is how Orentlicher confuses the pertinent issues. It is the withdrawal of nutrition and/or hydration that is the issue at hand, not the actual terminal sedation of a patient.

According to the 1990 Patient Self Determination Act (PSDA), patients (or their appointed proxy) can lawfully refuse any type of medical treatment, even if this treatment is essential to sustaining life.⁷⁰ Therefore, a patient (or his proxy) can

⁷⁰ The Patient Self-Determination Act (PSDA), passed in 1990 and instituted on December 1, 1991, encourages all people to make choices and decisions now about the types and extent of medical care they want to accept or refuse should they become unable to make those decisions due to illness. The PSDA requires all health care agencies (hospitals, long-term care facilities, and home health agencies) receiving Medicare and Medicaid reimbursement to recognize the living will and power of attorney for health care as advance directives. The PSDA does not create new rights for patients but reaffirms the common-law right of self-determination as guaranteed by the Fourteenth Amendment. Under the PSDA, health care agencies must ask if patients have advance directives and must provide patients with educational materials about their rights under state law. This information is taken from “The American Cancer Society: Treatment Topics and Resources.” http://www.cancer.org/eprise/main/docroot/MIT/content/MIT_3_2X_The_Patient_Self-Determination_Act?sitearea=MIT. Copyright 2001 © American Cancer Society, Inc.

lawfully refuse nutrition, hydration, or both during his sedation. Although the Supreme Court must uphold this step as a result of the PSDA, doing so is inconsistent with their active/passive distinction. When patients refuse nutrition, hydration, or both during terminal sedation, their death does not result from the underlying disease. Their death comes from dehydration and starvation – a product of withholding nutrition and hydration. Thus, the Court runs into problems with their earlier distinction of active/passive because the withholding of nutrition and/or hydration during terminal sedation introduces a new cause of death – the patient dies from starvation/dehydration rather than from the underlying disease. This is inconsistent with the earlier classification of terminal sedation as a passive case of death. Thus, when the withdrawal of nutrition and/or hydration accompanies terminal sedation, it is considered an active case of death and is in the same category of euthanasia.

Terminal Sedation – A Morally Inferior Alternative To Physician-Assisted Suicide

Terminal sedation accompanied by the withdrawal of nutrition and/or hydration is both analogous to euthanasia and is a morally inferior alternative to physician-assisted suicide. Terminal sedation accompanied with the withdrawal of nutrition and/or hydration serves fewer purposes of patient rights addressed in the PSDA than either assisted suicide or euthanasia. Terminal sedation accompanied with the withdrawal of nutrition and/or hydration does respect the concerns addressed by the PSDA and is intended to provide relief from pain and suffering. However, what terminal sedation accompanied with the withdrawal of nutrition and/or hydration does

not respond to is the patient's concern that he will die without dignity; that the final memory left with his family will be one of a slow death. Terminal sedation accompanied with the withdrawal of nutrition and/or hydration does not respond to this concern, in fact, it imposes these very circumstances onto a dying patient by making their death drawn out over a period of days.⁷¹ Thus, terminal sedation accompanied with the withdrawal of nutrition and/or hydration is valuable to patients in terms of pain and suffering, but it does not take into consideration other aspects of dying that are considered by physician-assisted suicide.

Another concern of the Court when considering physician-assisted suicide is its apparent potential for abuse. When delivering the opinion of the Court in *Washington v. Glucksberg*, Justice Rehnquist voiced his concern over the potential abuse of physician-assisted suicide when he stated that

The State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as "ludicrous on its face." 79 F. 3d, at 825. We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations. *Cruzan*, 497 U. S., at 281. Similarly, the New York Task Force warned that "[l]egalizing physician assisted suicide would pose profound risks to many individuals who are ill and vulnerable... The 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." New York Task Force 120; see *Compassion in Dying*, 49 F. 3d, at 593 ("[A]n insidious bias against the handicapped--again coupled with a cost saving mentality--makes them especially in need of Washington's statutory protection"). If physician assisted

⁷¹ This is note 19 to Orentlicher's argument: "*Cruzan*, 497 U.S. at 310-12 (Brennan, J., dissenting). ("For many, the thought of an ignoble end, steeped in decay, is abhorrent... A long, drawn-out death can have a debilitating effect on family members... For some, the idea of being remembered in their persistent vegetative state rather than as they were before their illness or accident may be very disturbing). James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (1975): 78-80."

suicide were permitted, many might resort to it to spare their families the substantial financial burden of end of life health care costs.⁷²

However, what the Court fails to recognize is that terminal sedation potentially poses the same risk of abuse as those cited above concerning physician-assisted suicide. It seems absurd for the Court to believe that terminal sedation would not be vulnerable to the same risks associated with physician-assisted suicide. Using the same reasoning Rehnquist used above, we could assert that terminal sedation could be abused in the same way that physician-assisted suicide could be abused. Furthermore, terminal sedation imposes a risk that is not associated with physician-assisted suicide. It is not “possible to coerce an unconscious or severely demented person to commit suicide⁷³, it is a simple matter to terminally sedate, or perform euthanasia on, any incompetent person without that person’s consent or even the person’s knowledge. The death-causing act of suicide is much more under the control of the patient than are the death-causing acts of terminal sedation and euthanasia.”⁷⁴ Thus, the Supreme Court failed to recognize that not only does terminal sedation impose even greater risk of abuse than physician-assisted suicide, terminal sedation neglects to acknowledge the rights that are important to patients at the end of their lives.

⁷² Rehnquist, William Hubbs. Opinion of the Court in *Washington, et. al. v. Glucksberg, et. al.*, 117 S.Ct.2258 (1997).

⁷³This is note 24 in Orentlicher’s argument: “These persons are unable to take pills themselves. Marcia Angell, ‘The Supreme Court and Physician-Assisted Suicide – The Ultimate Right,’ *New England Journal of Medicine* 336 (January 2, 1997): 50-53.”

⁷⁴ Orentlicher, David. “The Supreme Court and Terminal Sedation: An Ethically Inferior Alternative to Physician Assisted Suicide”. Reprinted in *Physician Assisted Suicide: Expanding the Debate*. Eds: Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York: Routledge, 1998. pp. 307.

Conclusion

The Supreme Court unwittingly supports euthanasia when it advocates terminal sedation with the option of refusing nutrition and/or hydration in place of physician-assisted suicide. The Court's primary justifications for maintaining a distinction between withdrawal of treatment and euthanasia are a distinction between active and passive cases of death and a classification of physician intent. Both of these justifications fail to support terminal sedation accompanied by the withdrawal of nutrition and/or hydration and in fact, demonstrate how terminal sedation accompanied by the withdrawal of nutrition and/or hydration is a type of euthanasia. It is unfortunate that terminally ill patients cannot choose physician-assisted suicide and are instead forced to accept terminal sedation with the option of refusing nutrition and/or hydration at the end of their lives. Not only is terminal sedation accompanied by the withdrawal of nutrition and/or hydration an inadequate substitution for physician-assisted suicide, it is a morally inferior choice as well.

CHAPTER IV

“THE PHILOSOPHER’S BRIEF”

Introduction

“The Philosopher’s Brief”, authored by Ronald Dworkin, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson, is an *Amici Curiae* brief in support of the respondents of *Washington v. Glucksberg* and *Vacco v. Quill*. “The Philosopher’s Brief” was written before the Court made their decisions regarding *Washington* and *Vacco* and was meant to show the Court why they should decide in favor of the patient-plaintiffs. The authors of the brief are moral and political philosophers who have differing opinions regarding morality and public policy. Despite these differences in opinion, all six of these prominent philosophers agree that the decisions of the Appellate Courts (in *Washington* and *Vacco*) should be affirmed.⁷⁵

Summary of Amici’s Argument

“The Philosopher’s Brief” states that neither *Washington* nor *Vacco* are requiring the Supreme Court to make moral, ethical, or religious judgments about death. Instead, these cases are asking “the Court to recognize that individuals have a

⁷⁵ Dworkin, Ronald, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson. “The Philosopher’s Brief”. Reprinted in *Physician Assisted Suicide: Expanding the Debate*. Eds: Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York: Routledge, 1998. pp. 431.

constitutionally protected interest in making those grave judgments for themselves, free from the imposition of any religious or philosophical orthodoxy by court or legislature.”⁷⁶ These philosophers admit that states have a legitimate interest in suicide issues because states wish to protect their citizens from making irrational, uninformed, or hasty decisions regarding death, and concede that states have a right to regulate and control the assistance that physicians are able to provide to patients who request to hasten death.⁷⁷ However, this right does not include denying

people in the position of the patient-plaintiffs in these cases [*Washington* and *Vacco*] the opportunity to demonstrate, through whatever reasonable procedures the state might institute – even procedures that err on the side of caution – that their decision to die is indeed informed, stable, and fully free. Denying that opportunity to terminally ill patients who are in agonizing pain or otherwise doomed to an existence they regard as intolerable could only be justified on the basis of a religious or ethical conviction about the value or meaning of life itself.⁷⁸

The First Amendment to the United States Constitution prohibits government from placing such religious or ethical constraints on its citizens.

“The Philosopher’s Brief” affirms that the states of Washington and New York offer two contradictory arguments in their cases. First, some state that the plaintiffs do not have a liberty to hasten their own deaths that is protected under the Fourteenth Amendment. Second, the Solicitor General, arguing on behalf of the petitioners, offers a contradictory argument that states that although the patient-plaintiffs do have a constitutional liberty interest, yet the states of Washington and New York “properly ignored this interest when they required the patient-plaintiffs to live on in

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ *Ibid.*

circumstances they found intolerable.”⁷⁹ The Solicitor General asserts that a state, unable to formulate a regulatory scheme that would protect patients from making thoughtless, irrational, or coerced decisions about wanting to die, may then depend on a blanket prohibition in order to protect its citizens. The Amici find this to be inconsistent with the Court’s prior opinions. Dworkin, et. al. feel that a liberty interest emerges from the Supreme “Court’s previous decisions... about matters ‘involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy.’”⁸⁰ The Amici point out that the Supreme Court has never accepted this type of rationale for denying protection completely “to a conceded constitutional interest...” doing so at this point would render this interest meaningless.⁸¹

The Fourteenth Amendment and the Liberty Interest in *Washington And Vacco*

The Amici assert that the Due Process Clause of the Fourteenth Amendment protects the liberty interest maintained by the plaintiffs in both cases. The Amici point out previous Supreme Court cases where the Court has emphasized the individual liberty protected by the Due Process Clause. These decisions include “religious faith, political and moral allegiance, marriage, procreation, and death... Such deeply personal decisions pose controversial questions about how and why

⁷⁹ *Ibid.*, p. 432.

⁸⁰ *Ibid.*, Amici cite *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) as an example of an opinion that involves just such a liberty interest.

⁸¹ *Ibid.*

human life has value. In a free society, individuals must be allowed to make those decisions for themselves, out of their own faith, conscience, and convictions. This Court has insisted, in a variety of contexts and circumstances, that this great freedom is among those protected by the Due Process Clause as essential to a community of ‘ordered liberty’.⁸² Furthermore, in the *Planned Parenthood v. Casey*, the Court asserted that “matters [sic] involving the most intimate and personal choices a person may make in a lifetime, choices central to a person’s dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.”⁸³ This statement was indicative of many of our basic constitutional rights.⁸⁴ Dworkin, et.al. quote the Court’s opinion in *West Virginia State Board of Education v. Barnette*, which states: “If there is any fixed star in our constitutional constellation, it is that no official... can

⁸² *Ibid.*, Amici cite *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) in support of this claim.

⁸³ *Ibid.*, Amici also cite *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

⁸⁴ *Ibid.*, Note 1 of *The Philosopher’s Brief* occurs here. In note 1, the Amici write “In *Cohen v. California*, 403 U.S. 15, 24 (1971), for example, this Court held that the First Amendment guarantee of free speech and expression derives from “the belief that no other approach would comport with the premise of individual dignity and choice upon which our political system rests.” Interpreting the religion clauses of the First Amendment, this Court has explained that “[t]he victory for freedom of thought recorded in our Bill of Rights recognizes that in the domain of conscience there is a moral power higher than the State.” *Girouard v. United States*, 328 U.S. 61, 68 (1946). And, in a number of Due Process cases, this Court has protected this conception of autonomy by carving out a sphere of personal family life that is immune from government intrusion. See, e.g., *Cleveland Bd. of Educ. v. LeFleur*, 414 U.S. 632, 639 (1974) (“This Court has long recognized that freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment.”); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1973) (recognizing right “to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear and beget a child”); *Skinners v. Oklahoma*, 316 U.S. 535, 541 (1942) (holding unconstitutional a state statute requiring the sterilization of individuals convicted of three offenses, in large part because the state’s actions unwarrantedly intruded on marriage and procreation, “one of the basic civil rights of man”); *Loving v. Virginia*, 388 U.S. 1, 12 (1967) (striking down the criminal prohibition of interracial marriages as an infringement of the right to marry and holding that “[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men”).”

prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by work or act their faith therein.”⁸⁵

The Amici find that death is among the most significant events that will occur in a person’s life. In *Cruzan v. Missouri*, Chief Justice Rehnquist stated that “[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality.”⁸⁶ Due to the personal nature of death, the Amici assert that the last act in the drama of life should reflect the characteristics of the life we lived, not the principles of others forced upon us in our final moments.⁸⁷ By nature, people will differ in their religious and ethical convictions. These convictions will carry over into how people view the end of their lives. This is why some people may want doctors to use every means possible to keep them alive while others refuse available life saving treatment. The plaintiffs in *Washington* and *Vacco*, motivated by their personal religious and ethical beliefs, “want to end their lives when they think that living on, in the only way they can, would disfigure rather than enhance the lives they had created.”⁸⁸ Sometimes pain is not even an issue to such patients – “Even if it were possible to eliminate all the pain for a dying patient, that would not end or even much alleviate the anguish some would feel at remaining alive, but intubated, helpless, and often sedated near oblivion.”⁸⁹ Due to the personal nature of death, it is not for the government to impose its own beliefs about death on those who do not feel

⁸⁵ *Ibid.*, Amici also cite *West Virginia State Board of Education v. Barnette*, 319 U.S. 624, 642 (1943).

⁸⁶ *Ibid.*, p. 433.

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*

⁸⁹ *Ibid.*

likewise. The Constitution claims that “people must be free to make these deeply personal decisions for themselves and must not be forced to end their lives in a way that appalls them, just because that is what some majority thinks proper.”⁹⁰

Precedent of a Liberty Interest: *Cruzan* and *Casey*

In *Planned Parenthood v. Casey*, the Supreme Court held that “a state cannot constitutionally proscribe abortion in all cases, [in its decision, the Court] reiterated that the Constitution protects a sphere of autonomy in which individuals must be permitted to make certain decisions for themselves.”⁹¹ The Court highlighted that “[a]t 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.”⁹² The Court went on to state that choices “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... Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.”⁹³ In *Casey*, the Court explained why decisions about abortion fell under this category of personal and intimate decisions. Decisions about abortion “‘originat[ing] within the zone of conscience and belief,’ involves conduct in which

⁹⁰ *Ibid.*

⁹¹ *Ibid.*, Amici citing *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

⁹² *Ibid.*, Amici citing *Casey* at 851.

⁹³ *Ibid.*

‘the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law.’”⁹⁴ The Court stated that the decision to get an abortion is based on a woman’s own concept of her spirituality and place in society and ultimately involves her destiny. Therefore, “‘the State is [not] entitled to proscribe [abortion] in all instances.’ Rather, to allow a total prohibition on abortion would be to permit a state to impose one conception of the meaning and value of human existence on all individuals. This the Constitution forbids.”⁹⁵ Dworkin, et. al. note the Solicitor General’s claim that the right to abortion could be supported on grounds other than autonomy; such as the burden an unwanted child imposes on the mother.⁹⁶ Amici argues, however, that the Court did not actually support the right to abortion on these alternative grounds. Rather, the Court chose to rely on autonomy in its decision in *Casey*. It follows from the *Casey* decision that the plaintiffs in *Washington* and *Vacco* do in fact have a liberty interest and that a state cannot institute a blanket prohibition against physician-assisted suicide. Amici find a woman’s decision to have an abortion analogous to a decision to die. “Like a woman's decision whether to have an abortion, a decision to die involves one's very ‘destiny’ and inevitably will be ‘shaped to a large extent on [one's] own conception of [one's] spiritual imperatives and [one's] place in society.’”⁹⁷ According to Amici, “just as a blanket prohibition on abortion would involve the improper imposition of one conception of the meaning and value of human existence on all individuals, so too would a blanket prohibition

⁹⁴ *Ibid.*, Amici citing *Casey* at 852.

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*, Amici refer to the Brief for the United States at 14-15.

⁹⁷ *Ibid.*, Amici also cite *Casey* at 852.

on assisted suicide.”⁹⁸ In essence, the Amici claim that the Court cannot reject the liberty interest of the plaintiffs without rejecting the rationale behind *Casey*. The Appellate Courts recognized the parallel between the liberty interest asserted in *Casey* and the liberty interest asserted by the plaintiffs in *Washington* and *Vacco*.⁹⁹ The Amici feel that the Supreme Court should recognize this precedent and support the decision of the lower courts.

Dworkin, et. al. assert that the Supreme Court’s decision in *Cruzan v. Director, Missouri Department of Health* also support a liberty interest with regard to the plaintiff-patients in *Washington* and *Vacco*. However, the states of Washington and New York disagree and assert that the *Cruzan* case was limited to the right to reject an invasion of one’s body.¹⁰⁰ However, in light of the fact that the Supreme Court has repeatedly allowed unwanted invasions of the body (in appropriate circumstances), it would indeed be a hasty decision to assert that this was the only right involved in *Cruzan*.¹⁰¹ The Amici believe that what the *Cruzan* case really

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*, Amici cite *Compassion in Dying v. Washington*, 79 F.3d 790, 801 (9th Cir. 1996) (en banc) (“In deciding right-to-die cases, we are guided by the Court’s approach to the abortion cases. *Casey* in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment.”), *aff’g*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994) (“[T]he reasoning in *Casey* [is] highly instructive and almost prescriptive…”).

¹⁰⁰ *Ibid.*, See also note 2 of *The Philosopher’s Brief* where the Amici write “In that case, the parents of Nancy Cruzan, a woman who was in a persistent vegetative state following an automobile accident, asked the Missouri courts to authorize doctors to end life support and therefore her life. The Supreme Court held that Missouri was entitled to demand explicit evidence that Ms. Cruzan had made a decision that she would not wish to be kept alive in those circumstances, and to reject the evidence the family had offered as inadequate. But a majority of justices assumed, for the sake of the argument, that a competent patient has a right to reject life-preserving treatment, and it is now widely assumed that the Court would so rule in an appropriate case.

¹⁰¹ *Ibid.*, Amici also write “See, e.g., *Schmerber v. California*, 384 U.S. 757 (1966) (extraction of blood sample from individual suspected of driving while intoxicated, notwithstanding defendant’s

concerned was the right to choose the manner and timing of one's death. The Amici feel that "If a competent patient has a constitutional right to refuse life-sustaining treatment, then, the Court implied [In *Cruzan*], the state could not override that right. The regulations upheld in *Cruzan* were designed only to ensure that the individual's wishes were ascertained correctly. Thus, if *Cruzan* implied a right of competent patients to refuse life-sustaining treatment, that implication must be understood as resting not simply on a right to refuse bodily invasions but on the more profound right to refuse medical intervention when what is at stake is a momentous personal decision, such as the timing and manner of one's death."¹⁰² In fact, Amici point out that in her concurring decision to *Cruzan*, Justice O'Connor "expressly recognized that the right at issue involved a 'deeply personal decision' that is 'inextricably intertwined' with our notion of 'self-determination.'"¹⁰³ Furthermore, the *Cruzan* decision supports the Amici's claim that a state may not thwart a patient's liberty interest in determining the time and manner of his death by barring doctors from removing unwanted life sustaining treatment. However, the states of New York and Washington "insist that a state may nevertheless burden that right in a different way by forbidding doctors to assist in the suicide of patients who are not on life-support machinery."¹⁰⁴ The petitioners argue "that doctors who remove life support are only

objection, does not violate privilege against self-incrimination or other constitutional rights); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (upholding compulsory vaccination for smallpox as reasonable regulation for protection of public health)."

¹⁰² *Ibid.*

¹⁰³ *Ibid.*, Amici quote Justice O'Connor from *Cruzan v. Director, Missouri Department of Health* 497 U.S. at 287-89.

¹⁰⁴ *Ibid.*, p. 435.

allowing a natural process to end in death whereas doctors who prescribe lethal drugs are intervening to cause death. So, according to this argument, a state has an independent justification for forbidding doctors to assist in suicide that it does not have for forbidding them to remove life support. In the former case though not the latter, it is said, the state forbids an act of killing that is morally much more problematic than merely letting a patient die.”¹⁰⁵

However, the Amici assert that the petitioner’s argument at this point is based on a misinterpretation of the moral principles significant to the cases. The Amici offer a clear explanation of the moral principles at hand:

It is certainly true that when a patient does not wish to die, different acts, each of which foreseeably results in his death, nevertheless have very different moral status. When several patients need organ transplants and organs are scarce, for example, it is morally permissible for a doctor to deny an organ to one patient, even though he will die without it, in order to give it to another. But it is certainly not permissible for a doctor to kill one patient in order to use his organs to save another. The morally significant difference between those two acts is not, however, that killing is a positive act and not providing an organ is a mere omission, or that killing someone is worse than merely allowing a "natural" process to result in death. It would be equally impermissible for a doctor to let an injured patient bleed to death, or to refuse antibiotics to a patient with pneumonia—in each case the doctor would have allowed death to result from a "natural" process—in order to make his organs available for transplant to others. A doctor violates his patient's rights whether the doctor acts or refrains from acting, against the patient's wishes, in a way that is designed to cause death.¹⁰⁶

However, when it is a competent patient requesting death, the moral situation obviously changes. It is counterintuitive to cite a patient’s right not to be killed as a reason why an act designed to cause death is morally impermissible.¹⁰⁷ When this

¹⁰⁵ *Ibid*

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

situation is examined from a patient's point of view, there is no morally significant difference between a doctor withdrawing life-sustaining treatment (according to the patient's wishes) and a doctor providing pills that will help the patient end his own life when he is ready.¹⁰⁸ Furthermore, there is not a significant moral difference in these two situations from a doctor's point of view; "if it is permissible for a doctor deliberately to withdraw medical treatment in order to allow death to result from a natural process, then it is equally permissible for him to help his patient hasten his own death more actively, if that is the patient's express wish."¹⁰⁹ Although some physicians are reluctant to terminate life support "and do so only in deference to a patient's right to compel them to remove unwanted invasions of his body. But other doctors, who believe that their most fundamental professional duty is to act in the patient's interests and that, in certain circumstances, it is in their patient's best interests to die, participate willingly in such decisions: they terminate life support to cause death because they know that is what their patient wants."¹¹⁰ The *Cruzan* decision implied that a state cannot prohibit a doctor from deliberately causing death at the patient's request "in that way and for that reason."¹¹¹ It thus follows from *Cruzan* that "a state may not prohibit doctors from deliberately using more direct and often more humane means to the same end when that is what a patient prefers."¹¹²

¹⁰⁸ *Ibid.*, In fact the only moral difference the Amici see on this point is that the assisted suicide situation "may be quicker and more humane."

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

¹¹¹ *Ibid.*

¹¹² *Ibid.*

Those persons, such as the petitioners, who claim that “failing to provide life-sustaining treatment may be regarded as ‘only letting nature take its course’ is no more morally significant in this context, when the patient wishes to die, than in the other, when he wishes to live. Whether a doctor turns off a respirator in accordance with the patient's request or prescribes pills that a patient may take when he is ready to kill himself, the doctor acts with the same intention: to help the patient die.”¹¹³

However, the Amici feel that the withdrawal of treatment and assisted suicide do in fact differ in one important aspect. The Amici state, “Since patients have a right not to have life-support machinery attached to their bodies, they have, in principle, a right to compel its removal. But that is not true in the case of assisted suicide: patients in certain circumstances have a right that the state not forbid doctors to assist in their deaths, but they have no right to compel a doctor to assist them. The right in question, that is, is only a right to the help of a willing doctor.”¹¹⁴

State Interest Does Not Justify A Blanket Prohibition on Physician-Assisted Suicide

The Solicitor General argues that “‘a competent, terminally ill adult has a constitutionally cognizable liberty interest in avoiding the kind of suffering experienced by the plaintiffs in this case,’” and agrees that “this interest extends not only to avoiding pain, but to avoiding an existence the patient believes to be one of

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

intolerable indignity or incapacity as well.”¹¹⁵ Despite this concession, however, the Solicitor General goes on to argue that states have the right to “override” this liberty interest completely “because a state could reasonably conclude that allowing doctors to assist in suicide, even under the most stringent regulations and procedures that could be devised, would unreasonably endanger the lives of a number of patients who might ask for death in circumstances when it is plainly not in their interests to die or when their consent has been improperly obtained.”¹¹⁶ However, the Amici object to the Solicitor General’s argument for three reasons.

First, the Supreme Court “noted that its various decisions supported the recognition of a general liberty interest in refusing medical treatment, even when such refusal could result in death.”¹¹⁷ The risks listed by the Solicitor General are also applicable to the situations described in *Cruzan*. For example, “a patient kept alive only by an elaborate and disabling life-support system might well become depressed, and doctors might be equally uncertain whether the depression is curable: such a patient might decide for death only because he has been advised that he will die soon anyway or that he will never live free of the burdensome apparatus, and either diagnosis might conceivably be mistaken. Relatives or doctors might subtly or crudely influence that decision, and state provision for the decision may (to the same degree in this case as if it allowed assisted suicide) be thought to

¹¹⁵ Amici quote the Brief for the United States at 8, 12.

¹¹⁶ Dworkin, Ronald, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson. “The Philosopher’s Brief”. Reprinted in *Physician Assisted Suicide: Expanding the Debate*. Eds: Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York: Routledge, 1998. pp. 436.

¹¹⁷ *Ibid.*, Amici also note *Cruzan v. Director, Missouri Department of Health* 497 U.S. at 278-279.

encourage it.”¹¹⁸ However, what the Solicitor General seems to ignore completely is that states could in fact address such risks of abuse through stringent regulation. The Amici note *McKay v. Bergstedt*, 106 Nev. 808, 801 P.2d 617 (1990) where the “Nevada Supreme Court held that ‘competent adult patients desiring to refuse or discontinue medical treatment’ must be examined by two non-attending physicians to determine whether the patient is mentally competent, understands his prognosis and treatment options, and appears free of coercion or pressure in making his decision.”¹¹⁹ It is therefore obvious that safeguards are already in place to protect against the very dangers concerning the Solicitor General.

The Amici find no case law that suggests such safeguards to be “inevitably insufficient to prevent deaths that should have been prevented.”¹²⁰ In fact, the Amici find the risk of abuse greater in cases where life support must be terminated. The *Cruzan* decision “implied that a state must allow individuals to make such decisions through an advance directive stipulating either that life support be terminated (or not initiated) in described circumstances when the individual was no longer competent to make such a decision himself, or that a designated proxy be

¹¹⁸ *Ibid.*

¹¹⁹ *Ibid.*, Amici quote *McKay v. Bergstedt*, 106 Nev. 808, 801 P.2d 617 (1990). The Amici go on to say “See also: *Id.* at 827-28, 801 P.2d at 630. See also: *id.* (in the case of terminally-ill patients with natural life expectancy of less than six months, [a] patient’s right of self-determination shall be deemed to prevail over state interests, whereas [a] non-terminal patient’s decision to terminate life-support systems must first be weighed against relevant state interests by trial judge); [and] *In re Farrell*, 108 N.J. 335, 354, 529 A.2d 404, 413 (1987) ([which held that a] terminally-ill patient requesting termination of life-support must be determined to be competent and properly informed about [his] prognosis, available treatment options and risks, and to have made decision voluntarily and without coercion).

¹²⁰ *Ibid.*, at p. 437.

allowed to make that decision.”¹²¹ The risks described by the Solicitor General occur “when the decision is made through or pursuant to such an advance directive, and a grave further risk is added: that the directive, though still in force, no longer represents the wishes of the patient. The patient might have changed his mind before he became incompetent, though he did not change the directive, or his proxy may make a decision that the patient would not have made himself if still competent.”¹²² In the *Cruzan* decision, the Supreme Court “held that a state may limit these risks through reasonable regulation. It did not hold—or even suggest—that a state may avoid them through a blanket prohibition that, in effect, denies the liberty interest altogether.”¹²³

Secondly, the Amici refute the Solicitor General’s argument because there is no evidentiary support for his conclusion that “no system of rules and regulations could adequately reduce the risk of mistake.”¹²⁴ As previously mentioned, the “experience of states in adjudicating requests to have life-sustaining treatment removed indicates the opposite.”¹²⁵ The Solicitor General does not supply evidence

¹²¹ *Ibid.*

¹²² *Ibid.*

¹²³ *Ibid.*

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*, see also note 3 to the Amici brief which states “When state protocols are observed, sometimes the patient is permitted to die and sometimes not. *See, e.g., In re Tavel*, 661 A.2d 1061 (Del. 1995) (affirming finding that petitioner-daughter had proven by clear and convincing evidence that incompetent patient would want life-support systems removed); *In re Martin*, 450 Mich. 204, 538 N.W.2d 399 (1995) (holding that wife's testimony and affidavit did not constitute clear and convincing evidence of incompetent patient's pre-injury decision to decline life-sustaining medical treatment in patient's present circumstances); *DiGrellav. Elston*, 858 S.W.2d 698, 710 (Ky. 1993) (“If the attending physician, the hospital or nursing home ethics committee where the patient resides, and the legal guardian or next of kin all agree and document the patient's wishes and condition, and if no one

why the procedures already in place would not be applicable to cases of physician-assisted suicide. In fact, many detailed plans regarding regulation of physician-assisted suicide have been presented to the voters of some states.¹²⁶ In fact, the voters of one state have passed such plans.¹²⁷ Furthermore, a group of distinguished professors of law and other professions drafted and defended such schemes.¹²⁸ The Amici note that neither the petitioners in *Washington, Vacco*, nor the Solicitor General attempted to show that these proposed statutes were based on fallacious arguments or that they would be ineffective at guarding against abuses in physician-assisted suicide cases.¹²⁹

disputes their decision, no court order is required to proceed to carry out [an incompetent] patient's wishes"); *Mack v. Mack*, 329 Md. 188, 618 A.2d 744 (1993) (holding that wife failed to provide clear and convincing evidence that incompetent husband would want life support removed); *In re Doe*, 411 Mass. 512, 583 N.E.2d 1263 (applying doctrine of substituted judgment and holding that evidence supported finding that, if incompetent patient were capable of making a choice, she would remove life support)."

¹²⁶ *Ibid.* See also note 4 of the Amici brief which states "For example, 46 percent of California voters supported Proposition 161, which would have legalized physician-assisted suicide, in November 1992. The measure was a proposed amendment to Cal. Penal Code § 401 (1992) which currently makes assisted suicide a felony. Those who did not vote for the measure cited mainly religious reasons or concerns that the proposed law was flawed because it lacked safeguards against abuse and needed more restrictions that might be easily added, such as a waiting period and a psychological examination. Alison C. Hall, *To Die With Dignity: Comparing Physician-Assisted Suicide in the United States, Japan, and the Netherlands*, 74 Wash. U.L.Q. 803, 817 n.84 (1996)."

¹²⁷ *Ibid.*, See also note 5 of the Amici brief which states "In November 1994, Oregon voters approved the Oregon Death With Dignity Act through voter initiative, legalizing physician-assisted suicide under limited circumstances. Oregon Death With Dignity Act, Or. Rev. Stat. §§ 127.800-.827 (1995). Under the Oregon Act, a capable adult resident of the state, who has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his life in a humane and dignified manner in accordance with [the provisions of the Act]. Or. Rev. Stat. § 127.805 (1995). The Act provides specific definitions of essential terms such as "incapable" and "terminal disease." The Act also provides numerous other regulations designed to safeguard the integrity of the process.

¹²⁸ The Amici cite *Charles H. Baron, et. al., A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. Legis. 1 (1996).

¹²⁹ Dworkin, Ronald, Thomas Nagel, Robert Nozick, John Rawls, Thomas Scanlon, and Judith Jarvis Thomson. "The Philosopher's Brief". Reprinted in *Physician Assisted Suicide: Expanding the Debate*. Eds: Margaret P. Battin, Rosamond Rhodes, and Anita Silvers. New York: Routledge, 1998. pp. 437.

Furthermore, the Solicitor General's argument depends heavily on "flat and conclusory statements. It cites New York Task Force reports, written before the proposals just described were drafted, whose findings have been widely disputed and were implicitly rejected in the opinion of the Second Circuit below.¹³⁰ The weakness of the Solicitor General's argument is signaled by his strong reliance on the experience in the Netherlands which, in effect, allows assisted suicide pursuant to published guidelines.¹³¹ The Dutch guidelines are more permissive than the proposed and model American statutes, however. The Solicitor General deems the Dutch practice of ending the lives of people like neo-nates who cannot consent particularly noteworthy, for example, but that practice could easily and effectively be made illegal by any state regulatory scheme without violating the Constitution."¹³² The Amici state that if the issue at hand was simply whether or not states have any rational basis for an absolute prohibition on assisted suicide, then the Solicitor General's argument might have more force because it might call attention to risks that states would not be willing to take.¹³³ However, the Solicitor General himself concedes that this is not the issue at hand.

The issue, rather, is "whether a state has interests sufficiently compelling to allow it to take the extraordinary step of altogether refusing the exercise of a liberty

¹³⁰ *Ibid.*, In this portion of the brief, Amici cite generally *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

¹³¹ *Ibid.*, In this portion of the brief, Amici cite Brief for the United States at 23-24.

¹³² *Ibid.*

¹³³ *Ibid.*

interest of constitutional dimension.”¹³⁴ The Amici finds that in such circumstances, the burden of proof rests clearly on the state to “demonstrate that the risk of mistakes is very high, and that no alternative to complete prohibition would adequately and effectively reduce those risks. Neither of the petitioners has made such a showing.”¹³⁵ Furthermore, it would be nearly impossible for any state to prove such a burden. For example, “the burden a state would have to meet to show that it was entitled altogether to ban public speeches in favor of unpopular causes because it could not guarantee, either by regulations short of an outright ban or by increased police protection, that such speeches would not provoke a riot that would result in serious injury or death to an innocent party. Or that it was entitled to deny those accused of crime the procedural rights that the Constitution guarantees, such as the right to a jury trial, because the security risk those rights would impose on the community would be too great. One can posit extreme circumstances in which some such argument would succeed.”¹³⁶

Third, the Amici are dubious “whether the risks the Solicitor General cites are even of the right character to serve as justification for an absolute prohibition on the exercise of an important liberty interest.”¹³⁷ The Amici feel that there are two distinct types of risks: the risk of medical mistake and the risk that a patient will be

¹³⁴ *Ibid.*

¹³⁵ *Ibid.*

¹³⁶ *Ibid.*, p. 438. The Amici also state “See, e.g., *Korematsu v. United States*, 323 U.S. 214 (1944) (permitting United States to detain individuals of Japanese ancestry during wartime). But these circumstances would be extreme indeed, and the *Korematsu* ruling has been widely and severely criticized.”

¹³⁷ *Ibid.*

excessively influenced by considerations not deemed to be in his best interest. The first type of risk includes that of misdiagnosis of patient competence or of terminal illness. The Amici believe that no amount of regulation can guarantee that medical mistakes will not occur. However, just because the information upon which the consent is based may be incorrect, the Constitution does not permit states to deny patients the right to decide many important issues.¹³⁸ The Amici assert that although the very same risks exist in decisions to withdraw life support, they are not successful in validating a blanket prohibition of its exercise.¹³⁹

The second type of risk is that a patient “will be unduly influenced by considerations that the state might deem it not in his best interest to be swayed by, for example, the feelings and views of close family members.”¹⁴⁰ However, the Amici note that what a patient regards as the normative foundation for such a decision reflects

exactly the judgments of personal ethics – of why his life is important and what affects its value – that patients have a crucial liberty interest in deciding for themselves. Even people who are dying have a right to hear and, if they wish, act on what others might wish to tell or suggest or even hint to them, and it would be dangerous to suppose that a state may prevent this on the ground that it knows better than its citizens when they should be moved by or yield to particular advice or suggestion in the exercise of their right to make fateful personal decisions for themselves. It is not a good reply that some people may not decide as they really wish—as they would decide, for example, if free from the ‘pressure’ of others. That possibility could hardly justify the most serious pressure of all—the criminal law which tells them that they may not decide for death if they need the help of a doctor in dying, no matter how firmly they wish it.”¹⁴¹

Furthermore, the Amici find another weakness in the Solicitor General’s argument. The Solicitor General affirms that “a state may reasonably judge that the

¹³⁸ *Ibid.*

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, The Amici also cite the Brief for the United States at 20.

¹⁴¹ *Ibid.*

risk of ‘mistake’ to some persons justifies a prohibition that not only risks but insures and even aims at what would undoubtedly be a vastly greater number of ‘mistakes’ of the opposite kind—preventing many thousands of competent people who think that it disfigures their lives to continue living, in the only way left to them, from escaping that—to them—terrible injury.”¹⁴² The Amici rightly point out that a state irreparably harms its citizens when it prohibits their escape. Although the Solicitor General’s argument may seem reasonable to those who believe that forcing a person to continue their life while enduring great pain, suffering, and living in an undignified manner is not harming the patient.¹⁴³ However, it remains clear that there are others who do not agree with the Solicitor General’s argument and feel that those patients are indeed harmed. As a result, the state cannot take “one side in that essentially ethical or religious controversy as its justification for denying a crucial liberty.”¹⁴⁴

Moreover, the Amici point out “that neither Petitioners nor the Solicitor General does claim—that any such prohibition [blanket prohibition on assisted suicide] could serve the interests of any significant number of terminally ill patients.”¹⁴⁵ The Amici note that such a prohibition acts towards the contrary by appealing to widely contested religious and ethical convictions many patients,

¹⁴² *Ibid.*

¹⁴³ *Ibid.*

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*, p. 439.

including those concerned in *Washington* and *Vacco*, do not accept.¹⁴⁶ The Amici assert that allowing the latter justification to succeed would indeed violate the liberty interest of the patient-plaintiffs.¹⁴⁷

Conclusion

The Amici affirm that a state cannot deny the liberty interest claimed by the patient-plaintiffs in *Washington* and *Vacco* “without providing them an opportunity to demonstrate, in whatever way the state might reasonably think wise and necessary, that the conviction they expressed for an early death is competent, rational, informed, stable, and uncoerced.”¹⁴⁸ The Amici feel that if the Supreme Court affirms the decisions of the Appellate Court, they would be establishing that “some individuals, whose decisions for suicide plainly cannot be dismissed as irrational or foolish or premature, must be accorded a reasonable opportunity to show that their decision for death is informed and free.”¹⁴⁹ By reversing the decisions of the lower courts, the Amici claim that the Supreme Court’s decision would be justified only by the suggestion that “an American citizen does not, after all, have the right, even in principle, to live and die in the light of his own religious and ethical beliefs, his own convictions about why his life is valuable and where its

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*

¹⁴⁸ *Ibid.*, p. 440.

¹⁴⁹ *Ibid.*

value lies.”¹⁵⁰ It is clear that such a decision would directly conflict with past decisions of the Court such as *Cruzan* and *Casey*. It is for these reasons that the Amici urge the Court to affirm the decisions of the Appellate Courts in *Washington* and *Vacco*.

¹⁵⁰ *Ibid.*

CHAPTER V

THE DOCTRINE OF DOUBLE EFFECT

Introduction

As moral beings, we have intuitions about how we should act in certain situations. We believe that it is not morally permissible to send poisoned food to starving children in Somalia, yet we believe it is permissible to not send anything at all. We believe that we should try to save a group of swimmers from a shark, but not all means are morally equal. It is not, for example, morally permissible to throw a bystander in the water as a means of diverting the shark's attention away from the group of swimmers. Similarly, we feel morally compelled to stop a crowded trolley from rolling down a steep hill, yet we do not feel that it is morally permissible to push a passerby in the path of the trolley in order to stop it from rolling. Are such intuitions defensible, and is there a moral basis behind them?

There are several moral asymmetry views that could be used to explain why we have such intuitions. One such view concerns an agent's acts and omissions. Proponents of this view claim that there is a moral difference between an agent's actions and omissions and the outcomes that result. Another moral asymmetry view involves an agent's doing and allowing. Proponents of this view claim there is a moral difference between an agent's doing and the resulting outcome, and an agent's

allowing and the resulting outcome. Another moral asymmetry view concerns harming and failing to benefit. Defenders of this view believe that we have more stringent negative duties (duty not to harm) than positive duties (duty to benefit). Perhaps the most widely known moral asymmetry view concerns intended means and side effects. This view is called the Doctrine of Double Effect.

I will be concentrating on the Doctrine of Double Effect because the Supreme Court's reasoning in both *Washington v. Glucksberg* and *Vacco v. Quill* relies heavily on the morally asymmetrical distinction between intending and foreseeing. The Court cites this very distinction as a primary reason why terminal sedation is morally and legally permissible. It is true that many philosophers support the concept of the DDE and its implications on how we ought to make our moral decisions. However, I find the DDE to be extremely unsatisfying. As a result, I plan to explore and analyze other theories in hopes of finding a more suitable method of explaining why and how we ought to make our moral decisions.

The Doctrine of Double Effect

In her article, "The Doctrine of Double Effect: Problems of Interpretation," Ann Davis gives a detailed account of what the DDE entails. Davis states that the moral asymmetry view that distinguishes between intending and foreseeing has been defended through the DDE since the time of Thomas Aquinas.¹⁵¹ Davis states that "the DDE allows that it may be permissible for agents to pursue a course of action

¹⁵¹ Davis, Ann. "The Doctrine of Double Effect: Problems of Interpretation." Reprinted in *Ethics: Problems and Principles*. Eds John Martin Fischer and Mark Ravizza. New York: Harcourt Brace Jovanovich College Publishers, 1992. p. 201. It is at this point where note 7 to Davis' article occurs. Note 7 states: "Thomas Aquinas, *Summa Theologica*, II-II, Q. 64, art. 7."

that they foresee will produce a bad consequence as a side effect (or ‘second effect’) even though it would not be permissible for agents to pursue that course of action with the intention of producing that consequence.” Davis lists four qualifications of the DDE, and concedes that the third qualification is most important to us at this point. These four qualifications are as follows: “(1) the agent acts with a good intention and seeks to realize a good end (or, at least, one that is morally permissible); (2) The agent does not seek or will the bad consequence that he or she foresees will come about, and when this is feasible, tries to mitigate it, or prevent its coming about; (3) The bad consequence is not pursued either as an end in itself or as a means to the realization of the agent’s good end; (4) The good end that the agent seeks to realize is not morally disproportionate to the bad consequences that the agent’s pursuing that end will foreseeably bring about.”¹⁵²

Let us consider two cases cited by Fischer and Ravizza in the introduction to *Ethics: Problems and Principles*. These two cases are normally considered to be morally asymmetrical by the DDE.¹⁵³ In case (1), suppose you are a surgeon, Dr. X,

¹⁵² *Ibid.* It is at this point where note 8 to Davis’ article occurs. Note 8 states: “Different commentators offer subtly (but essentially similar) formulations of the four traditional qualifications of the DDE. Mine is a somewhat modified version of that given in *The Catholic Encyclopedia* (1907 edition) in the entry on abortion. Compare the formulations given in “The Principle of Double Effect” in *The New Catholic Encyclopedia* (1967), and in Joseph Mangan, S.J., “An Historical Analysis of the Principle of Double Effect,” *Theological Studies* 10 (1949), 60-61. It is important to recognize the DDE functions merely as a test of whether a proposed course of action is impermissible, and not as a recipe for right action: if a proposed action fails to satisfy any of the four qualifications, then it is wrong to undertake it; but if it satisfies the four conditions, it does not follow that the action is permissible, let alone good. (From a deontological standpoint, good actions are a subset of permissible ones). Failure to recognize that the DDE is not meant to be sufficient for the determination of an action’s moral acceptability has, I believe, misled a number of commentators, for example, R.G. Frey. “Some Aspects to the Doctrine of Double Effect,” *Canadian Journal of Philosophy* 5 (1975), 259-283, esp. 260, and Michael Walzer, *Just and Unjust Wars* (New York: Basic Books, 1977), pp. 152-157.

¹⁵³ These two cases are called *Transplant* (case 1) and *Hospital* (case 2) in the introduction to John Fischer and Mark Ravizza’s *Ethics: Problems and Principles*. New York: Harcourt Brace Jovanovich College Publishers, 1992. p. 2 and 7. In note 3 to their introduction, Fischer and Ravizza cite *Hospital*

and five of your patients need organ transplants or else they will die. Now suppose a man unrelated to any of the five comes to visit another patient in your hospital. As luck would have it, this visitor's organs are compatible with your five patients.

Would it be morally permissible for you to carve up this one visitor in order to save your five patients? Let us examine case (2). In this example, you are a doctor, Dr. Y, in the same hospital, and five of your patients desperately need a dose of a life-saving drug. Unfortunately, the hospital supply room is out of this drug, and the only way to ensure your patients will live is to manufacture the drug in the hospital laboratory. However, the manufacture of this drug will release a poisonous gas that will kill one innocent, but dying, patient in the hospital (not one of your patients). Is it morally permissible for you to manufacture the drug (knowing that one innocent person will die) in order for your five patients to live? The DDE states that case (1) is not morally permissible while case (2) is morally permissible.

The DDE does not justify the moral permissibility of (2) over (1) based solely on numbers, because in each case, five lives would be saved at the cost of one life. The DDE implies that there is a moral distinction between the two cases based on the distinction between intended ends and foreseen side effects. According to Fischer and Ravizza, the DDE

Exploits this distinction to claim that whereas it is sometimes permissible to bring about a bad result as a merely foreseen side-effect of what you do, it is in general not permissible to bring about such an effect as in intended end or a necessary means to some intended end. In particular, the doctrine claims that it is sometimes permissible to kill an innocent person as a foreseen (but unintended) side-effect of something you do, but it is in general impermissible to kill an innocent person as an

and state "Thomson introduces and discusses this case in "Killing, Letting Die, and the Trolley Problem" (p. 67) and "The Trolley Problem" (p. 279). In note 9 to their introduction, Fischer and Ravizza cite *Transplant* and state "This example comes from Phillipa Foot, "The Problem of Abortion and the Doctrine of Double Effect, (p. 59)."

intended end or necessary means of an intended end.¹⁵⁴

When this definition of the DDE is taken with the earlier definition given by Davis, we can see that case (1) is not morally permissible according to the DDE because Dr. X intends to kill the visitor and the visitor is a necessary means to the intended end of providing organs to the five patients. However, case (2) is morally permissible in accordance with the DDE because the death of the innocent patient is merely a foreseen side effect of manufacturing the life-saving drug, and this patient's death is not an intended end or necessary means to produce the drug that will save five lives. As a result, it seems as though the basis of the asymmetrical judgment, the distinction between intending and foreseeing, is intuitively unsatisfactory. This intuition-based objection to the DDE is admittedly weak. Some might argue that the DDE does in fact fit their intuitions regarding these two cases. What makes our intuitions in this case a reliable test? In order to formulate stronger objections to the DDE, we will discuss our cases in terms of responsibility and duty; this way, our discussion will not depend on a moral asymmetry view.

Responsibility and Duty

We will now turn to a discussion of responsibility and duty. H.L.A. Hart documents four senses of the word "responsibility" in his article entitled "Varieties of Responsibility." These four senses are: role responsibility, causal responsibility, liability responsibility, and capacity responsibility.

¹⁵⁴ Fischer, John and Mark Ravizza. "Ethics: Problems and Principles." Fort Worth: Harcourt Brace Jovanovich College Publishers, 1992. pp. 6.

Role responsibility occurs when a person occupies “a distinctive place or office in a social organization, to which specific duties are attached to provide for the welfare of others or to advance in some specific way the aims or purposes of the organization.”¹⁵⁵ Examples of persons in this situation include both professional roles (such as a doctor or a police officer) and private roles (such as a member of a family). Hart states that “a ‘responsible person,’ ‘behaving responsibly’ require for their elucidation a reference to role-responsibility. A responsible person is one who is disposed to take his duties seriously; to think about them, and to make serious efforts to fulfill them. To behave responsibly is to behave as a man would who took his duties in this serious way.”¹⁵⁶

Causal responsibility occurs when “it is possible to substitute for the expression ‘was responsible for’ the words ‘caused’ or ‘produced’ or some other causal expression referring to consequences, results, or outcomes.”¹⁵⁷ Hart goes on to say that examples of causal responsibility include such situations as: ‘His neglect was responsible for her distress.’ ‘The Prime Minister’s speech was responsible for the panic.’ ‘Disraeli was responsible for the defeat of the Government.’ ‘The icy condition of the road was responsible for the accident.’¹⁵⁸

Hart separates liability responsibility into two categories: legal liability responsibility and moral liability responsibility. Hart asserts that when “a man is legally responsible for some act or harm is to state that his connection with the act or

¹⁵⁵ Hart, H.L.A. “Varieties of Responsibility.” Law Quarterly Review. Vol. 83, 1967. p. 347.

¹⁵⁶ *Ibid.*, p. 348.

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid.*

harm is sufficient according to law for liability.”¹⁵⁹ Hart states that differences “between legal liability responsibility are due to substantive differences between the content of legal and moral rules and principles rather than to any variation in meaning of responsibility when conjoined with the word ‘moral’ rather than ‘legal’”.¹⁶⁰

Capacity responsibility is used to affirm that a person possesses certain mental/physical qualities that enable him to be responsible. Hart finds that “the capacities in question are those of understanding, reasoning, and control of conduct: The ability to understand what conduct legal rules or morality require, to deliberate and reach decision concerning these requirements, and to conform to a decision when made.”¹⁶¹ Capacity responsibility has implications for other forms of responsibility – if a person were found to be lacking capacity responsibility, then it would follow that they would not be held legally or morally responsible, and probably should not hold a position that would imply role responsibility.

Now we must consider how these four senses apply to our two cases. Let us first examine role responsibility. In both cases, Dr. X and Dr. Y have role responsibility. Both doctors are responsible in this sense for the lives of their patients, however, this role responsibility does not entail that another innocent patient should die in order to secure the health of the doctor’s patients. This is because the visitor has more of a claim on his body parts than does Dr. X’s five patients. Likewise, the innocent

¹⁵⁹ *Ibid.*, p. 355.

¹⁶⁰ *Ibid.*, p. 358.

¹⁶¹ *Ibid.*, p. 360.

patient has more of a claim on his own life than does Dr. Y's five patients.¹⁶² Both doctors are also causally responsible. Dr. X is causally responsible because he carved up the visitor thereby causing the visitor's death. However, Dr. Y is also causally responsible because he manufactured the drug in the hospital knowing that an innocent patient would die in the process. Hart states that "not only human beings but also their actions or omissions, and things, conditions, and events, may be said to be responsible for outcomes."¹⁶³ Therefore, Dr. X and Dr. Y can both be held causally responsible – Dr. X for an action, and Dr. Y for an omission.¹⁶⁴ With respect to liability responsibility, Dr. X and Dr. Y would be held both legally responsible for the deaths of the visitor and the innocent patient. They would be held legally responsible because Dr. X and Dr. Y's connections with the deaths of the visitor and the patient would be adequate according to the law for liability.¹⁶⁵ Furthermore, Dr. X and Dr. Y would both be morally responsible. This is because "to say that a person is morally responsible for something he has done or some harmful outcome of his own or others' conduct is to say that he is morally blameworthy or morally obliged to make amends

¹⁶² For more information on such claims, see the later chapter regarding introduction and redirection of harm.

¹⁶³ Hart, H.L.A. "Varieties of Responsibility." Law Quarterly Review. Vol. 83, 1967. p. 349.

¹⁶⁴ To be causally responsible for an omission means that a person's omission set about a chain of events that this person is responsible for. For example, suppose I oversleep tomorrow morning and, as a result, do not put the garbage bin by the curb for pickup. As a consequence of my omission, the bin will be overflowing for another week, etc. I am causally responsible for my omission of not placing the bin by the curb and the results that follow.

¹⁶⁵ Hart claims that "[i]n certain general contexts legal responsibility and legal liability have the same meaning... it will [thus] make sense to say that because a person is legally responsible for some action he is liable to be punished for it.", H.L.A. "Varieties of Responsibility." Law Quarterly Review. Vol. 83, 1967. p. 355- 356. Therefore, both Dr. X and Dr. Y would be held legally responsible because they are liable to be legally punished for their actions through either the criminal justice system and/or the civil justice system.

for his conduct so far as this depends on certain conditions: these relate to the character or extent of his control over his own conduct, or to the causal or other connection between his action and harmful occurrences or to his relationship with the person who actually did the harm.”¹⁶⁶ On this basis, both Dr. X and Dr. Y can be considered morally responsible because they each had control over their own conduct and their actions directly brought about the deaths of the visitor and the innocent patient. For our purposes, we presuppose that both Dr. X and Dr. Y have ability to reason, understand implications of their decisions, and understand what is required by legal and moral rules. As a result, both Dr. X and Dr. Y are capacity responsible because they understand the implications of their decisions.

I have shown that Dr. X and Dr. Y are responsible in all senses of the word, and I will now determine if any duties arise from these responsibilities. In this case, I believe the most stringent duty arises from their role. Dr. X and Dr. Y both have a duty not to harm their dying patients. However, they also have a duty to try to preserve the life of their patients. Does this duty mean that the visitor and the innocent patient can be used to preserve the life of Dr. X and Dr. Y’s patients? No, because both Dr. X and Dr. Y have a duty not to harm the visitor and the innocent patient. The duty not to harm and the duty to preserve life go hand in hand – the doctors cannot harm another person in order to save the life of a patient. These duties not to harm and to preserve life do not arise from Dr. X and Dr. Y’s role as physicians, because neither the visitor nor the innocent patient are under Dr. X or Dr.

¹⁶⁶ Hart, H.L.A. “Varieties of Responsibility.” Law Quarterly Review. Vol. 83, 1967. pp. 358

Y's care. Instead, it appears as though Dr. X and Dr. Y have a duty not to inflict harms that are also wrongs.¹⁶⁷

Analyzing The Doctrine of Double Effect: The “Closeness” Principle

Although our discussion of responsibility did not depend on the distinction imposed by DDE, it did not offer a better or clearer solution to our cases of Dr. X and Dr. Y. Perhaps we should re-examine the DDE and determine how it fails to show why physician-assisted suicide is morally impermissible. One interpretation of the DDE states that the visitor's death is not merely a means to saving the lives of Dr. X's five patients. Rather, the death of the visitor should be treated as an unwanted but foreseen consequence.¹⁶⁸ However, as Foot points out in her article “The Problem of Abortion and the DDE,” even if it is argued that there are two distinct events here (the taking of the visitor's organs and his death), “the two are obviously much too close for an application of the DDE.”¹⁶⁹ Foot applies this “closeness principle” to a different scenario in order to clarify the argument.

We may consider the story, well known to philosophers, of the fat man stuck in the mouth of the cave. A party of pot-holers have imprudently allowed the fat man to lead them as they make their way out of the cave, and he gets stuck, trapping the others behind him. Obviously the right thing to do is to sit down and wait until the fat man grows thin; but philosophers have arranged that flood waters should be rising within the cave. Luckily (luckily?) the trapped party have with them a stick of dynamite with which they can blast the fat man out of the mouth of the cave. Either they use the dynamite or they drown. In one version the fat man, whose head is *in* the cave, will drown with them; in the other he will be rescued in due course. Problem: may they use the dynamite or not? [The example is introduced in

¹⁶⁷ Permissible harms and the distinction between harm and wrong will be discussed in a later section.

¹⁶⁸ Foot, Philippa. “The Problem of Abortion and the Doctrine of Double Effect.” Reprinted in *Killing and Letting Die: Second Edition*. Eds Bonnie Steinbock and Alastair Norcross. New York: Fordham, 1994. p. 268.

¹⁶⁹ *Ibid.*

part] because it will serve to show how ridiculous one version of the doctrine of the double effect would be. For suppose that the trapped explorers were to argue that the death of the fat man might be taken as a merely foreseen consequence of the act of blowing him up. (“We didn’t want to kill him... only to blow him into small pieces” or even “...only to blast him out of the cave.”) In that those who use the doctrine of double effect would rightly reject such a suggestion, although they will, of course, have considerable difficulty in explaining where the line is to be drawn. What is to be the criterion of “closeness” if we say that anything very close to what we are literally aiming at counts as if part of our aim?¹⁷⁰

Thus, according to Foot’s argument, the defender of the DDE must now “defend herself against the objection that her principle permits actions that she wants it to prohibit: in the case of the fat man in the cave, it might be objected that the DDE allows blowing the fat man to bits, because this (and not his death) is what is intended.”¹⁷¹

Ann Davis and Problems With The Doctrine of Double Effect

In her article “The Doctrine of Double Effect: Problems of Interpretation,” Ann Davis explains why the DDE does not give a clear defense of a morally important difference between physician-assisted suicide and terminal sedation accompanied by withdrawal of nutrition and hydration. Davis suggests four cases normally viewed to be morally asymmetric under the DDE. In case 1, a “woman’s life is endangered by uterine cancer. She will die unless a hysterectomy is performed. The woman is pregnant, hence – on the assumption that the fetus is a person (an assumption that I shall make for the purpose of this discussion) – the surgical removal of the woman’s

¹⁷⁰ *Ibid.*, p. 268-269. This last sentence is note 5 in Foot’s article. It states “J. Salmond, *Jurisprudence*, ed. G. Williams (London, 1957), p. 283.

¹⁷¹ Fischer, John and Mark Ravizza. “Quinn on Double Effect: The Problem of Closeness.” Reprinted in *Ethics*, Volume 103, Issue 4 (Jul., 1993), p. 709.

uterus will result in the death of an innocent person, the fetus.”¹⁷² In case 2, Davis states that a “woman will die in childbirth unless the skull of the fetus is crushed. The fetus will die if its skull is crushed, hence the performance of the craniotomy upon the fetus will result in the death of an innocent person, the fetus.”¹⁷³ The third case, which Davis calls case 5, states that “a doctor administers what she knows will be a lethal dose of an analgesic drug (*d*) to a patient who is in terrible pain. Any smaller dose will not be effective in relieving the pain. The doctor administers *d* intending thereby to ease the patient’s pain, knowing (though regretting) that administering the drug will bring about the death of the patient.”¹⁷⁴ The fourth case, which Davis calls case 5, states that “a doctor administers what she knows will be a lethal dose of an analgesic drug *d* to a patient who is in terrible pain. The patient’s pain cannot be relieved without his dying: only if the patient dies will his pain cease. The doctor regrets the death of the patient, but she administers the lethal dose of *d* to the patient to bring about his death, and thereby relieve his pain.”¹⁷⁵

Davis rightly claims that defenders of the DDE will find cases 1 and 5 to be morally permissible, while finding cases 2 and 6 to be morally impermissible. Davis suggests that this is because, in cases 1 and 5, the defenders of the DDE believe that the deaths of the fetus and the patient are foreseen but unwanted consequences of performing the hysterectomy and administering the drug. In these cases, Davis points

¹⁷² Davis, Ann. “The Doctrine of Double Effect: Problems of Interpretation.” Reprinted in *Ethics: Problems and Principles*. Eds John Martin Fischer and Mark Ravizza. New York: Harcourt Brace Jovanovich College Publishers, 1992. p. 202.

¹⁷³ *Ibid.*

¹⁷⁴ *Ibid.*, p. 209.

¹⁷⁵ *Ibid.*

out that defenders of the DDE do not believe the deaths of the fetus and the patient to be a means to an end – but rather a “second effect.”¹⁷⁶ In case 2 and 6, however, Davis states that defenders of the DDE view the deaths of the fetus and patient as a means to an end – saving the mother’s life and relieving the patient’s pain, respectively.¹⁷⁷

Davis tries to find a foundation for the alleged moral asymmetry in these cases. She finds that “only if something like the occurrent intention or (actual) mental inventory of the doctors is allowed to be the determinant (of whether a course of action is *intended* or whether a certain course of action is to count as the agent’s *means*) can there be the required difference between the two cases.”¹⁷⁸ At this point, Davis states that supporters of the DDE face a difficult choice.

If they [defenders of the DDE] refuse to allow that the agent’s occurrent intention or mental state is the determinant of whether something is a means, then they can perhaps sustain the claim that there is a significant difference between cases 1 and 2. But then they cannot happily maintain that there is a significant difference between cases 5 and 6. If they allow that an occurrent intention may determine whether something is a means, then they can perhaps sustain then claim that there is a significant difference between cases 5 and 6. But then they cannot happily maintain that there is a significant difference between cases 1 and 2.”¹⁷⁹

As a result, Davis has shown that the DDE cannot be used as a laudable defense of the position that there is a morally significant difference between both cases 1 and 2

¹⁷⁶ *Ibid.*

¹⁷⁷ *Ibid.*

¹⁷⁸ *Ibid.* At this point, note 28 occurs in Davis’ article. Note 28 states “There are other alternatives. We could adopt a constructive and defeasible test, according to which certain intentions are to be attributed to agents unless specific presuppositions can be shown not to apply. (Compare the ‘rational man’ test from law). This strategy is hardly unproblematic, however, and it (too) requires a substantive account of intention before it can be got off the ground.”

¹⁷⁹ *Ibid.*

and cases 5 and 6.¹⁸⁰ This leaves supporters of the DDE with another choice. “If their intuitions are that there is a morally significant asymmetry between case 1 and case 2 *and* case 5 and case 6, they would do well to give up on the DDE and seek some other casuistical principle. For the DDE cannot accomplish their purpose.”¹⁸¹ Thus, Davis has shown that the DDE is not a credible way of cashing out the apparent distinction between intention and foreseee.

Conclusion

In this chapter, I have focused on the DDE in response to the Supreme Court’s reasoning in *Washington v. Glucksberg* and *Vacco v. Quill*. I defined the DDE and stated how its defenders use it to endorse the apparent moral asymmetry between an agent’s intending and foreseeing. I then discussed H.L.A. Hart’s four senses of responsibility in order to find a solution to our cases that was not based on the DDE. The discussion of duty and responsibility did not offer a better or more understandable solution to moral asymmetry cases. I then examined criticisms of the DDE offered by Phillipa Foot and Ann Davis. Foot’s criticism of the DDE was based on the closeness principle between the act and the consequence. Davis’ criticism was based on the inconsistency in the interpretation of the meanings of intention, means, and end. Davis showed that supporters of the DDE were inconsistent with their interpretation of intention, means, and end. The supporters of the DDE interpreted these meanings differently when explaining the distinctions between abortion cases and the distinctions between which cases dealing with the treatment of terminally ill

¹⁸⁰ *Ibid.*

patients. The implications of this chapter support the argument that the Supreme Court was erroneous when it used the DDE to justify the moral and legal permissibility of terminal sedation accompanied by the withdrawal of nutrition and hydration and the moral and legal impermissibility of physician-assisted suicide.

¹⁸¹ *Ibid.*

CHAPTER VI

INTRODUCING VS. REDIRECTING HARM

Introducing and Redirecting Harm

Looking at our cases in terms of duty and responsibility has done some work for us, but it has not taken us all the way. We have already determined that the Doctrine of Double Effect is not a credible method of defending these cases. Therefore, we need a way to examine our cases that considers whether it is morally permissible to harm both the visitor and the innocent patient. At this point, we will examine Thomson's distinction between introducing and redirecting a harm.

Thomson's approach does not depend on any sort of moral asymmetry view or numbers solution. Her explanation of the moral difference between superficially similar cases is that

Whereas it may be permissible to redirect an already extant threat in order to minimize the incidence of a bad result, it is in general impermissible either to redirect an extant by acts that themselves violate someone's stringent rights or to introduce a new threat in order to minimize the incidence of a bad result.¹⁸²

Thomson's strategy is most clearly understood if we consider a trolley problem.

Suppose that you see a runaway trolley racing down a track. The brakes of the trolley have failed, and you are standing near the track. On the track ahead of the trolley are

five persons. However, ahead you see that the track branches off. On this branching portion of the track stands one person. You are in a position where you may flip a switch that will send the trolley down the branching portion, thus saving the five people but killing one, or you may do nothing, thus allowing the five to be killed. You are not an employee of the trolley company, nor do you know any of the six people standing on the track. Therefore, you have no duty to any of the six people. As a result, it seems permissible for you to flip the switch and send the trolley down the branching portion of the track, and you could make this decision based solely on numbers.

However, according to Thomson, the decision to switch the trolley to the branching track containing one person would be made based on redirecting an existing harm. You would be deflecting an already existing harm from five people to one person. By flipping the switch, “you would be doing something to the threat to minimize the incidence of a bad result; you would not be doing something bad to a person to minimize the incidence of a bad result, nor would you be introducing a new threat.”¹⁸³

Thomson points out a difference here between doing something to the threat (i.e. the trolley) and doing something bad to a person – each of which is done to minimize the occurrence of a bad result. In the case of the trolley, if the one person has no more claim¹⁸⁴ against the trolley than any of the five people, the one person cannot

¹⁸² Thomson, Judith Jarvis, cited from the introduction of John Fischer and Mark Ravizza’s *Ethics: Problems and Principles*. Fort Worth: Harcourt Brace Jovanovich College Publishers, 1992. pp. 9.

¹⁸³ Thomson, Judith Jarvis, cited in the Introduction to John Fischer and Mark Ravizza’s *Ethics: Problems and Principles*. Fort Worth: Harcourt Brace Jovanovich College Publishers, 1992. pp. 9.

¹⁸⁴ The phrase “claim against the trolley” seems strange verbiage in this argument. However, Thomson clarifies her meaning. She states: “[t]here are examples in which it is clear enough that the one has

complain if you do something to the trolley itself in order to minimize a bad result.

However, the one person can indeed complain if you do something to him in order to minimize a bad result. Thomson illustrates her point through an example:

If there is a pretty shell on the beach and it is unowned, I cannot complain if you pocket it to give to another person who would get more pleasure from it than I would. But I can complain if you shove me aside so as to be able to pocket it to give to another person who would get more pleasure from it than I would. It's unowned; so you can do to it whatever would be necessary to bring about a better distribution of it. But a *person* is not something unowned, to be knocked about in order to bring about a better distribution of something else.¹⁸⁵

Thus, if the one person does not have any more claim against the trolley than the five people, the one person cannot object if we do something to the trolley (such as switching its direction) in order to minimize a bad result. However, even if the one person does not have any more claim against the trolley than the five people, he can indeed object if we do something to him (such as throw him in front of the trolley) in order to minimize the bad result.

As a result, in case (1) Dr. X would be killing the visitor for his organs in order to minimize a bad result, i.e. the death of 5 patients. According to Thomson, this is morally impermissible because Dr. X, in cutting up the visitor, would be introducing a new threat, and not simply redirecting an already existing one (as in the trolley

more of a claim against the trolley than any of the five does. Suppose that: The five on the track ahead are regular track workmen, repairing the track – they have been warned of the dangers of their job, and are paid specially high salaries to compensate. The right-hand track is a dead end, unused in ten years. The Mayor, representing the City, has set out picnic tables on it, and invited the convalescents at the nearby City Hospital to have lunch there, guaranteeing them safety from trolleys. The one [person] on the right-hand track is a convalescent having his lunch there; it would never have occurred to him to have his lunch there but for the Mayor's invitation and the guarantee of safety." Judy Jarvis Thomson, "Killing, Letting Die, and the Trolley Problem." Reprinted in John Fischer and Mark Ravizza's *Ethics: Problems and Principles*. Fort Worth: Harcourt Brace Jovanovich College Publishers, 1992. pp. 73.

¹⁸⁵ Judy Jarvis Thomson, "Killing, Letting Die, and the Trolley Problem." Reprinted in John Fischer and Mark Ravizza's *Ethics: Problems and Principles*. Fort Worth: Harcourt Brace Jovanovich College Publishers, 1992. pp. 76.

case). On Thomson's account, case (2) would also be impermissible because Dr. Y, in manufacturing the drug, would be introducing a new threat to the innocent patient, and not merely redirecting an already existing one. Thomson's approach is much different from the Doctrine of Double effect, which morally distinguishes between case (1) and case (2). On Thomson's account, both case (1) and case (2) are viewed as morally equivalent. Both case (1) and case (2) involve introducing a new harm (cutting up the visitor for his organs and causing the innocent patient to die through the production of poisonous gas) rather than the redirection of an already existing harm. Furthermore, both cases violate the stringent rights of the visitor and the innocent patient. Just because Dr. X's five dying patients need organs does not mean they have the right to an innocent visitor's organs. Similarly, just because Dr. Y's patients need a life-saving drug does not mean that they have the right to obtain the drug by the death of an innocent patient.

The Moral Difference Between Introducing and Redirecting Harm

Thomson's strategy seems intuitively right. But why does a moral distinction exist between introducing and redirecting harm? The reason for the moral difference has to do with rights. These rights specifically regard bodily intrusion. Thomson examines claims against bodily intrusion in *The Realm of Rights*. She states that we own a great number of material objects such as a sofa, a computer, a photograph, a lamp, etc. Because ownership is a "cluster of claims, privileges, and powers in respect of the thing owned,"¹⁸⁶ anyone who uses your material properties (your sofa,

¹⁸⁶ Thomson, Judith Jarvis. *The Realm of Rights*. Cambridge: Harvard University Press, 1990. p. 225.

your computer, and photographs) without your consent is violating a property claim of yours. Thomson feels that there are similar rights associated with our bodies – when our bodies are used without consent, our property rights are infringed.¹⁸⁷ Thomson admits there are some differences between owning a computer and owning your body. However, she finds that “ownership is really no more than a cluster of claims, privileges, and powers; and if the cluster of rights that a person X has in respect of his or her body is sufficiently like the clusters of rights people have in respect of their houses, typewriters, and shoes, then there is no objection, in theory, to saying that X does own his or her body – however odd it may sound to say so, however unaccustomed we may be to saying so.”¹⁸⁸

However, this line of thought seems to entail that we have a claim against anything that may cause us harm. But Thomson reveals that this is not the case. Thomson explains a scenario that makes this assertion very clear – the case of the famous violinist.¹⁸⁹ Suppose you wake up tomorrow morning to find that the Society of Music Lovers has kidnapped you, and plugged the unconscious violinist’s circulatory system into your own. The violinist has a rare kidney ailment and he needs your kidneys to filter his blood for nine years, after which he will be recovered from his ailment. You alone have the right blood type and, without the use of your kidneys, the violinist will die. Does the violinist have a right to use your kidneys? Thomson says no.

¹⁸⁷ *Ibid*

¹⁸⁸ *Ibid.*

¹⁸⁹ The case of the violinist is paraphrased from Judith Jarvis Thomson’s “A Defense of Abortion” *Philosophy and Public Affairs*, Volume 1, Issue 1 (Autumn, 1971), p. 47-66.

For nobody has any right to use your kidneys unless you give him such a right; and nobody has the right against you that you shall give him this right – if you do allow him to go on using your kidneys, this is a kindness on our part, and not something he can claim from you as his due. Nor has he any right against anybody else that *they* should give him continued use of your kidneys. Certainly he had no right against the Society of Music Lovers that they should plug him into you in the first place. And if you now start to unplug yourself, having learned that you will otherwise have to spend nine years in bed with him, there is nobody in the world who must try to prevent you, in order to see to it that he is given something he has a right to be given.¹⁹⁰

Thus, while it is true that I have property rights to my own body and subsequent rights against bodily intrusion, such rights do not entail that I can make claims against everyone and everything in order to ensure my safety, health, and well being. If this were the case, the world would be a much different place because we could make claims against everything we needed to sustain life. But this is not the case – just as the violinist did not have a right to use our kidneys, we do not have a right to be provided with anything that is necessary to sustain life. We are not entitled to things that keep us from harm – rather, we are only entitled to things that would keep us from being both harmed and wronged.

Harming vs. Wronging

Throughout this discussion, it is important to realize that a harm does not equal a wrong. Certain types of situations involve harms that are also wrongs and some situations involve a harm but not a wrong. Harming involves acting contrary to a person's interests, while wronging involves violating a person's rights.¹⁹¹ Certain

¹⁹⁰ *Ibid.*, p. 55.

¹⁹¹ Thomson, Judith Jarvis. *The Realm of Rights*. Cambridge: Harvard University Press, 1990. p. 112. On this page, Thomson writes: "I said in Chapter 3 that 'wrong' as adjective or adverb seems to me to be cognate with 'ought': thus I take 'It would be wrong for Y to not do alpha' and 'Y would be acting

kinds of harms are also wrongs. This happens when both a person's interests and rights are violated. An example of a harm that is also a wrong is our former example of Dr. X. When Dr. X cuts up the visitor to use his organs for the other patients, the visitor is both harmed and wronged by the doctor. The visitor is harmed because he is dead, and thus his interests are violated.¹⁹² He is wronged because his rights have been violated – his body has been intruded without his consent.¹⁹³

However, certain harms do not involve a wronging. Let's look at my example about your neighbor's choice of house color. Suppose your next-door neighbors decide to paint their house an unsightly shade of purple and replace all of their landscape with dirt. Now, this is a harm to you because your interests in having a beautiful neighborhood cannot be realized and you must see this house every time you look out of your windows. However, you are not wronged by this situation as you do not have a right to live in a beautiful neighborhood, nor do you have the right to look at something beautiful every time you look out of your windows.

Killing, Harming, and Wronging

Killing involves situations of harming and wronging. Just as before, there are cases of killing that involve both a harm and a wrong, and there are cases of killing

wrongly if he or she did not do alpha' to be equivalent to 'Y out to do alpha.' But 'wrong' as verb or noun is different. I will use 'Y wronged X' and 'Y did X a wrong' only where Y violated a claim of X's. So on my use of the locutions, they entail that Y acted wrongly; but they entail more than just that Y acted wrongly – they entail that Y wrongly infringed a claim of X's."

¹⁹² In our scenario about Dr. X, we presuppose the visitor to be a person whose death would be a loss for both him and those around him.

¹⁹³ Thomson, Judith Jarvis. *The Realm of Rights*. Cambridge: Harvard University Press, 1990. p. 225

that only involves a harm. However, what is most striking about killing is that some cases of killing involve neither a harm nor a wrong.

Situations where killing both harms and wrongs the victim are cases where the victim's rights are violated and interests are set back. If I were to shove you onto the tracks of an oncoming train, I have both harmed and wronged you. You were harmed in this case is by the resulting injury or death you received from the train. You were also wronged in this case because I violated your personal property rights when I shoved you onto the train tracks.¹⁹⁴

Situations also exist when killing harms but does not wrong the victim. An example of such a situation is the killing of combatants during wartime. Suppose it is wartime, and I am a combatant fighting on the side of country A, while you are a combatant fighting on the side of country B. If, during battle, I shoot and kill you, I have harmed you but I have not wronged you. This is because I have not violated any of your rights. As a combatant of country B, you waived your right to be protected during wartime when you joined (or were drafted¹⁹⁵) into country B's military. The same applies to myself, I waived my right to be protected during wartime when I joined country A's military. When I shot you, it was obvious to me that you were a combatant of country B – you had country B's military uniform on, and you were firing a weapon at the soldiers of country A. Therefore, I harmed you by shooting

¹⁹⁴ Thomson, Judith Jarvis. *The Realm of Rights*. Cambridge: Harvard University Press, 1990. p. 225

¹⁹⁵ Even if you are an unwilling or reluctant draftee, your rights would not be violated. This goes back to Thomson's violinist example. Being protected during times of war could possibly save your life, but this does not mean you have a right to it. No rights violation occurs here because the unwilling or reluctant draftee may need protected by the state during a time of war in order to save their lives, but they do not have a right to such protection.

you because you are now dead and this is not in your best interest. But I did not wrong you when I shot you because there was no violation of rights.

What is most interesting about killing, harming, and wronging is that it involves cases where killing is neither a harm nor a wrong. The best example of this type of situation is physician-assisted suicide. In physician-assisted suicide, the physician supplies a lethal dose of medication to a terminally ill patient, but does not administer the lethal dose himself. The patient is responsible for taking the lethal medication under his own power. Physician-assisted suicide is voluntary on the part of both the patient and the physician. When the patient dies from the lethal dose of medication, he has been neither harmed nor wronged by the physician. The patient is not being harmed because he autonomously chose to end his own life. The patient's death does not wrong him because his rights were not violated – his request for the suicide was voluntary and his personal property rights were not intruded upon because he took the lethal dose himself. When looked at in terms of harm and wrong, it is easy to see how physician-assisted suicide is much different from any other type of death. The patient is neither harmed nor wronged as a result of the suicide, and is in fact benefited because he no longer has to endure the pain and suffering associated with his terminal illness.

Conclusion – What This Means For Our Earlier Cases and Physician-Assisted Suicide

Therefore, Thomson's strategy of morally differentiating introduction and redirection of harm is grounded in rights. The reason why Dr. X cannot cut up the

visitor is due to the fact that this is introducing a harm to the visitor. The visitor has property rights over his body, and cannot be cut up without his consent or else a property rights violation occurs. Likewise, Dr. X's five patients do not have a right to the visitor's organs just because they need them in order to sustain life. The implications are similar for Dr. Y. He cannot manufacture the drug that would kill the innocent patient without the patient's consent. A property violation would also occur in this case because the patient cannot inhale toxic fumes without his consent. Furthermore, Dr. Y's five patients do not have a right to have the drug manufactured just because this drug is life-sustaining. In both the case of Dr. X and Dr. Y, a harm is introduced to both the patient and the visitor, not redirected. In the case of our trolley problem, an existing harm is redirected. In our case, none of the six people have a claim against the trolley, thus they cannot complain if we do something to the trolley in order to minimize a bad result. Not being hit by the trolley would be life sustaining to the six people on the tracks. However, this does not mean that any of the six have a right to not be hit by the trolley. Therefore, in this case, it is morally permissible to minimize a bad result a redirect the harm in question. Furthermore, I have shown that a harm does not always equal a wrong. Especially in the cases of physician-assisted suicide, it is clear that the patient is not harmed or wronged. Thus, physician-assisted suicide is morally permissible because it does not introduce a new harm, and it neither harms nor wrongs the patient.

CHAPTER VII

WHAT WE VALUE ABOUT LIFE

Introduction

In his book, *Causing Death and Saving Lives*, Jonathan Glover attempts to answer the question why killing is wrong. He begins by noting that there is a clear difference between those who believe that killing is always morally wrong in every circumstance, and those who believe that killing is morally justified in some special circumstances. In order to understand what makes killing wrong, Glover suggests it is helpful to start by examining a prevalent view that life is sacred. He examines the principle of the Sanctity of Life to ascertain its meaning, to evaluate its plausibility, and to get clearer about what exactly we value about human life.

The Sanctity of Life -- Determining What Is Valuable About Life

Glover examines the meaning principle of the Sanctity of Life because this principle is frequently cited as a way of describing why we value human life. At the heart of the principle of the Sanctity of Life is the view that killing is always directly wrong. Glover explains that there are two types of views of the principle held by those who believe that killing is wrong. The first view is that the principle of the

Sanctity of Life entails that killing is directly wrong. The second is that the principle of the Sanctity of Life entails that killing is indirectly wrong. However, the principle fails under the first view because it does not follow that everyone who believes killing to be directly wrong must also uphold the sacredness of life.¹⁹⁶ Glover suggests the best formulation of the principle of the Sanctity of Life is that “taking life is intrinsically wrong.”¹⁹⁷

Glover understands that those who hold the principle of the Sanctity of Life may feel that being alive, regardless of whether or not such life is in an unconscious state, is nonetheless intrinsically valuable. However, this view becomes problematic when considered in cases of people who are suffering from painful terminal illnesses. Glover concedes that even those who hold the principle of the Sanctity of Life could admit that people suffering from painful terminal illnesses might be better off dead. Such a statement would not conflict with the principle of the Sanctity of Life because it would not be inconsistent to admit that, although life itself is valuable, not suffering miserably is even more valuable.¹⁹⁸ Glover goes on to admit that he cannot refute the argument of “someone who holds that being alive, even though unconscious, is intrinsically valuable.”¹⁹⁹ However, he claims that it is not an attractive view given that a “permanently comatose existence is subjectively indistinguishable from death,

¹⁹⁶ Glover, Jonathan. *Causing Death and Saving Lives*. London: Penguin, 1990. p. 41.

¹⁹⁷ *Ibid.*, p. 42.

¹⁹⁸ *Ibid.*, p. 45.

¹⁹⁹ *Ibid.*

and unlikely often to be thought intrinsically preferable to it by people thinking of their own future.”²⁰⁰

With this in mind, Glover now considers a case of a person who holds the principle of the Sanctity of Life but regards being alive as only of instrumental value, and it is consciousness that has intrinsic value. Glover divides consciousness into two categories: mere consciousness and a high level of consciousness. Mere consciousness is the state of being aware or having experiences, i.e. a stream of consciousness.²⁰¹ However, the argument runs into problems with respect to the killing of animals and the priority of human life. Glover concedes that there “seems no reason to regard the ‘higher’ animals as less aware of the environment than ourselves. If the whole basis of the ban on killing were the intrinsic value of mere consciousness, killing higher animals would be as bad as killing humans.”²⁰² Thus, Glover points out that if one holds that mere consciousness has intrinsic value one would have to discard the priority now given to human life under the principle of the Sanctity of Life.

Thus, Glover goes on to consider another possibility – the possibility that human life is intrinsically valuable simply because it is human. Glover says that it is impossible for the objection to taking human life to rest on such a claim. Glover finds that an analogy to such a situation is racism. He states that racism is “objectionable partly because of its moral arbitrariness: unless some relevant

²⁰⁰ *Ibid.*, p. 46.

²⁰¹ *Ibid.*

²⁰² *Ibid.* p. 50.

empirical characteristics can be cited, there can be no argument for such discrimination.”²⁰³ Glover feels that an objection to taking human life based on a sentiment that humans are intrinsically valuable does not cite appropriate differences between humans and other species. Therefore, we are still faced with the question of what about life we find intrinsically valuable.

A Life Worth Living

In his criticism of the principle of the Sanctity of Life, Glover indicates that destroying life or mere consciousness does not constitute destruction of anything intrinsically valuable. Determining exactly what is intrinsically valuable has been, thus far, an elusive task. Glover does not find mere consciousness, being human, or being alive to be indicative of anything intrinsically valuable. Earlier, we determined that maximizing a good outcome, quantity, or numbers are not what we value about life. Rather, what we do value about life is quality – having a life worth living.

However, a life worth living is not a clear-cut concept. As Glover points out, determining what would constitute a life worth living is a difficult task. It is nearly impossible to establish what constitutes a life worth living; personal preferences make every situation different. Glover states that if someone’s life were, in fact, worth living, it would indeed be directly wrong to kill him.²⁰⁴ However, this is not inconsistent with the principle of the Sanctity of Life. Those who feel that “life is worth preserving only because it is the vehicle for consciousness, and consciousness is of value only because it is necessary for something else, then that ‘something else’

²⁰³ *Ibid.*

²⁰⁴ *Ibid.*, p. 52.

is the heart of this particular objection to killing. It is what is meant by a ‘life worth living’ or a ‘worth-while life’.”²⁰⁵ Glover adds that we cannot kill someone just because we think his life is not worth living. Rather, having a life worth living is one reason why it is directly wrong to kill that person.²⁰⁶

Glover believes the question why it is wrong to kill can be answered in two ways. The first way has to do with the direct wrongness of killing, the second has to do with the harmful side effects killing has on other people. Glover goes on to state three conclusions about the direct wrongness of killing. First, Glover states that it is wrong to shorten the length of a worthwhile life.²⁰⁷ Secondly, Glover adds that it is wrong to kill someone where the process of killing will be either frightening or painful. However, Glover admits that this reason is less central to the wrongness of direct killing and he in fact mentions it for the sake of completeness.²⁰⁸ Thirdly, Glover affirms that it is wrong to kill someone who wants to go on living even if you think this desire is not in the person’s own interests.²⁰⁹ Glover feels this reason will normally exclude involuntary euthanasia because a person’s “autonomy should almost always in practice be given priority over reasons for killing him that appeal to

²⁰⁵ *Ibid.*

²⁰⁶ *Ibid.*, p. 53.

²⁰⁷ *Ibid.*, p. 113.

²⁰⁸ *Ibid*

²⁰⁹ *Ibid.*

his own interests.”²¹⁰ Glover thus questions whether or not similar arguments justify killing a person in order to benefit others.

This question leads into Glover’s discussion of the harmful side effects killing has on others. First Glover lists the negative side effects associated with killing. These negative side effects include effects on family and friends, economic and social effects on the community of the deceased, provocation of feelings of hatred and resentment, a decreased sense of security, and an encouragement to take killing less seriously.²¹¹

However, although Glover admits that the direct objections to killing are generally strong reasons not to kill, they can in fact be overridden. Glover presents cases where killing can also produce favorable side effects. Glover asks us to consider the case of Adolph Hitler. Hitler probably did not want to die, and almost certainly considered his own life to be worth living. However Glover proposes that even if you still hold the side effects just mentioned regarding the direct wrongness of killing, you would still most likely think that it would have been right to assassinate Hitler.²¹² However, Glover finds the Hitler case to be extreme and proposes more plausible and morally debatable cases concerning the elderly or deformed children. When examining such cases strictly in terms of side effects, Glover argues that caring for the elderly or deformed children places such an emotional burden on their families that it would be better off if these people were dead.²¹³ However, in cases such as

²¹⁰ *Ibid.*

²¹¹ *Ibid.*, p. 114-115.

²¹² *Ibid.*

²¹³ *Ibid.*, p. 115.

these, Glover admits that the side effects of killing cannot always carry more weight than the direct objections to killing mentioned earlier. Therefore, neither the direct objections to killing nor the side effects of killing take priority over one another when trying to answer the question why killing is wrong. As a result, we will examine Glover's discussion of paternalism and autonomy in order to better answer this question.

Paternalism and A Life Worth Living

Glover states that, to this point, the main argument supporting the direct wrongness of killing rests on the premise that it is morally wrong to shorten a worthwhile life.²¹⁴ However, Glover feels that the argument is incomplete because we considered cases of killing people against their own wishes because we expected that their life was not worth living and they would be better off dead. Glover finds that this “[a]rgument will not seem incomplete to those who are willing to support such ‘paternalist killing. Nor will it seem incomplete to those who wish to rule out such acts of killing, but who are convinced that these acts can adequately be guarded against by appeals to side-effects, or to the uncertainty both of predictions about people’s future states and of the evaluation of lives as worth living or not.”²¹⁵ Glover believes the incompleteness of this line of argument results from a person’s autonomy being ignored when considering decisions about his or her own life and death.²¹⁶ We

²¹⁴ *Ibid.*, p. 75.

²¹⁵ *Ibid.*, p. 74.

²¹⁶ *Ibid.*

will now examine the relationship between autonomy, paternalism, and the concept of a life worth living.

Because the concept of a life worth living differs from person to person, it can become especially complex when considering case of physician-assisted suicide. This is because two different concepts of a life worth living may exist – the patient’s and the physician’s. How one decides whose view is determinative depends on one’s concept of the physician’s role. Some people feel that a physician should play a paternalistic role, exerting full power over the patient’s healthcare. Others feel that a physician should be there to serve patient needs in a non-paternalistic manner, giving patients more choice and power over their own healthcare. In order to determine when one of these views is preferable we must look to the concept of autonomy and the question of how much autonomy a patient should have over his own healthcare.

Glover states that when all things are considered, it is normally thought that people should have as much autonomy as possible.²¹⁷ As a result, Glover suggests that if a person wishes to go on living, autonomy is a reason why it would be directly wrong to kill him even if there is a strong basis for believing that his life would not be worth living.²¹⁸ Glover states that giving priority to autonomy is a rejection of one form of paternalism.²¹⁹ However, Glover is dubious of always giving absolute priority to autonomy. Glover supposes a case where a person wishes to start taking heroin, and we think it is right to stop him or her if we can.²²⁰ Glover states that we

²¹⁷ *Ibid.*, p. 74.

²¹⁸ *Ibid.*

²¹⁹ *Ibid.*

²²⁰ *Ibid.*

think it is right to stop a person from taking heroin because we give less weight to this person's autonomy and more weight is given to sparing the person the suffering involved in being a heroin addict.²²¹ Glover concedes that there are several non-paternalistic reasons for stopping heroin addiction, such as the side effects on the community and the family. However, Glover states that the special consideration given to paternalism in this case is "the admission that prevention would be right even in the absence of these reasons involving other people."²²²

Glover lists three central arguments for a paternalistic override of a person's autonomy in the case of preventing a person from becoming addicted to heroin. The first argument states that the suffering is very great, but we are confident that the person not being addicted to heroin is far better off than the addict.²²³ Second, there is little doubt that suffering will occur if the person becomes a heroin addict.²²⁴ Thirdly, Glover maintains that the process is not easily reversible, thus the person who begins to take heroin will restrict his future choices due to his addiction.²²⁵ Glover finds that the first two reasons might apply to some certain circumstances where killing a person would be against his or her will but in his or her best interests. Glover imagines a situation where a doctor, who lives on a plague-ridden island, knows that medical supplies are running low. The doctor decides that killing his

²²¹ *Ibid.*, p. 75

²²² *Ibid.*

²²³ *Ibid.*

²²⁴ *Ibid.*

²²⁵ *Ibid.*, p. 76.

patient now is the only means of avoiding the patient's pain and suffering later.²²⁶ However, Glover admits, "the decision about how bad a life must be for the person to be better off dead has to be taken before reason (i) applies."²²⁷ Glover points out that reflection on the third reason demonstrates the central difference between paternalistic killing and the paternalistic prevention of suicide. Glover suggests that the main difference between paternalistic killing and the paternalistic prevention of suicide lies in the finality of death. Glover states that he "feels justified in stopping you from killing yourself because I expect you will be glad later that I did. If I am mistaken, you will have opportunities for other attempts. Similarly, there will be other opportunities to start on heroin. But, if I kill you, this is final. You will not have second thoughts, and mine will come too late."²²⁸

Questions of Autonomy

One might wonder how autonomy fits into this discussion of paternalism and a life worth living. Glover states that there are three assumptions made by a person who believes that someone's autonomy should be given weight in a situation. First, Glover says that there is an existence condition – you must already exist, because it is impossible to override the autonomy of a potential person.²²⁹ Second, Glover states that there is a developmental condition – you must be at a state of development where

²²⁶ *Ibid.*

²²⁷ *Ibid.*

²²⁸ *Ibid.*

²²⁹ *Ibid.*, p. 76-77.

you are able to have appropriate wishes.²³⁰ Thirdly, Glover states that there is a possession condition – you must possess the desire that is in question.²³¹ Your autonomy can only be overridden where the decision goes against how you actually feel, not how you would feel if you had more information or more intelligence.²³² Glover clarifies this point by stating that this is to look at desires in a dispositional sense; “[y]ou do not have to be conscious of your desire at the moment it is overridden. Such a condition as that would license any decision I take on your behalf the moment you are asleep. And to think of desires in this disposition sense should also allow us to respect desires that have a stable role in a person’s outlook even when they are temporarily eclipsed by conditions such as hypnosis or being drugged.”²³³

Glover goes on to explore why we have a preference for autonomy. He states that we have a preference for making our own decisions because of the probability that we will be satisfied with the outcome.²³⁴ However, Glover also concedes that, when considering the major decisions of our life, we would not usually forfeit our autonomy even if by doing so we were guaranteed that our satisfactions would be increased.²³⁵ Glover suggests that having autonomy in important decisions, such as choosing our own jobs and marriages, is essential to our sense of living our own lives.

²³⁰ *Ibid.*, p. 77.

²³¹ *Ibid.*

²³² *Ibid.*

²³³ *Ibid.*

²³⁴ *Ibid.*, p. 80.

²³⁵ *Ibid.*

Glover foresees situations, such as being tortured, “[w]hich we might if necessary sacrifice all autonomy to avoid, but perhaps for *some* of us there is no degree of additional pleasure for which we would surrender control of the central decisions in our lives.”²³⁶ Thus, when it comes to the direct wrongness of killing, the strength of the unattractiveness of overriding someone’s autonomy lies in the fact that in some situations, no additional contentment would be produced if a person lost control over the main decisions of his or her life.

So far, Glover has considered two legitimate reasons that are direct objections to killing – the unattractiveness of shortening a worthwhile life, and the unattractiveness of overriding a person’s autonomy. Glover wishes to find an understandable moral importance between these two objections in order to determine what should be done when the two objections come into conflict.²³⁷ However, he states that he has not yet found a satisfying solution. Glover states that he is particularly “dissatisfied with any general claim about autonomy always taking priority, and have already conceded support to utilitarian paternalism in cases such as that of heroin addiction.”²³⁸ However, in cases where killing someone against his wishes is in his best interest, Glover suggests that there is no clear-cut method of determining what should be done in all possible situations.²³⁹ Glover considers an extreme circumstance of a Jew in Nazi Germany killing himself and his family against their wishes to avoid terrible

²³⁶ *Ibid.*, p. 81.

²³⁷ *Ibid.*, p. 82.

²³⁸ *Ibid.*

²³⁹ *Ibid.*

suffering in a death camp. In this situation, Glover states that he does not feel this decision would be morally wrong.²⁴⁰ However, in other situations, the priority given to autonomy and the arguments for its preference, generally discount paternalistic killing.²⁴¹ Glover suggests the following (admittedly ambiguous) principle regarding autonomy, paternalism, and the direct wrongness of killing: “Except in the most extreme circumstances, it is directly wrong to kill someone who wants to go on living, even if there is reason to think this desire not in his own interests.”²⁴²

What This Means For Physician-Assisted Suicide

Autonomy and paternalism become most important in cases where one’s choices are different from the mainstream. Such a case is that of physician-assisted suicide, where the patient’s preference for suicide is against the mainstream, but the decision is in fact in the patient’s best interest.

Suppose that a physician has a patient who is dying of advanced-stage cancer and feels that his life is no longer worth living. The patient expresses to the physician that he wishes to end his suffering through physician-assisted suicide. The physician and the patient then have various conversations about the patient’s motivation, explanation of alternatives, and physician recommendations. After such conversations, and perhaps a second opinion by another independent physician, the patient still continues to request physician-assisted suicide. When the physician feels that the patient has been well informed about the decision and alternate treatments,

²⁴⁰ *Ibid.*

²⁴¹ *Ibid.*, p. 83.

the physician decides to respect the patient's autonomy. In cases of physician-assisted suicide, the patient's autonomy is not overridden because the physician does not have to make a paternalistic decision for the patient. Furthermore, by committing assisted suicide, neither the patient nor the physician are shortening a worth while life because the patient has already determined that, for him, his life is no longer worth living and the physician has concurred with this decision.

One might object to this by saying that a physician preventing a patient's suicide (or refusal to assist in a suicide) is similar to Glover's heroin case. However, the assisted suicide of a terminally ill patient is very different from the paternalistic prevention of heroin addiction. In the case of preventing heroin addiction, the person will endure great suffering and experience a slow, painful death should he choose to start taking heroin. If he does not take the heroin, he will greatly increase his future choices and will not experience the slow, painful death associated with heroin addiction. This is why Glover feels justified in paternalistically stopping the person from taking heroin. In the case of assisted suicide, the patient would be relieved of his or her pain and suffering. Because the person is dying of a terminal illness, the suicide does not restrict his or her future choices, because the person's life is greatly shortened as a result of the illness. Furthermore, decisions of physician-assisted suicide originate with the patient and thus do not override the patient's autonomy. Thus, there is no reason to paternalistically prevent assisted suicide because it does not shorten the length of a worthwhile life and it does not override the patient's autonomy.

²⁴² *Ibid.*

CHAPTER VIII

THE MORAL PERMISSIBILITY OF PHYSICIAN-ASSISTED SUICIDE

Conclusion

In this paper, I examined two controversial Supreme Court cases, *Washington, et. al. vs. Glucksberg, et. al.* and *Vacco, et. al. vs. Quill, et. al.*. These cases dealt with the constitutionality of the states of New York and Washington's ban on physician-assisted suicide. I then discussed the Supreme Court's reasoning for upholding the state's ban on assisted suicide. Next, I explored the procedure of terminal sedation, accompanied by withdrawal of nutrition and hydration, and explained why the Court allows this procedure to take place while upholding the ban on assisted suicide. In order to further understand why the Court found terminal sedation accompanied by withdrawal of nutrition and hydration to be morally and legally acceptable, I discussed "The Philosopher's Brief." This brief helped us to understand exactly why the Court's should uphold the Appellate Court decisions in both cases.

Next I suggested ways of solving the physician-assisted suicide problem. First, I listed several moral asymmetry views in order to determine which would be best for our purposes here. I then decided to focus on the Doctrine of Double Effect and the apparent moral asymmetry between intending and foreseen. Through the criticisms of Phillipa Foot and Ann Davis, I was able to determine that the DDE was convincing method of defending the asymmetry between intend and foresee. As a result, such criticisms supported the argument that the Supreme Court was wrong in using the DDE to justify the moral and legal permissibility of terminal sedation accompanied by the withdrawal of nutrition and hydration and the moral and legal impermissibility of physician-assisted suicide.

Since the DDE was not useful in solving the physician-assisted suicide problem, the then turned to Judith Jarvis Thomson's strategy of distinguishing between introducing and redirecting a harm. This lead into a discussion of rights, harming, and wronging. Through this chapter, we were able to see that in some cases, it is morally permissible to minimize a bad result a redirect the harm in question. Furthermore, we were able to see the difference between harming and wronging and that a harm does not always equal a wrong. This chapter made it clear that, in cases of physician-assisted suicide, the patient is not harmed or wronged. Thus, physician-assisted suicide is morally permissible because it does not introduce a new harm, and it neither harms nor wrongs the patient.

I then discussed Jonathan Glover and the principle of the Sanctity of Life in order to determine why we consider killing to be wrong and establish exactly what we value about human life. This lead into a discussion of autonomy, paternalism, and a

life worth living. We determined that Glover feels justified in paternalistically stopping a person from taking heroin because it greatly restricts this person's future choices and the addiction would cause this person pain and suffering. However, we were able to see that in cases of physician-assisted suicide, the patient would be relieved of his or her pain and suffering. Because the person is dying of a terminal illness, the suicide does not restrict his or her future choices, because the person's life is greatly shortened as a result of the illness. Furthermore, decisions of assisted suicide originate with the patient and thus do not override the patient's autonomy. Thus, there is no reason to paternalistically prevent assisted suicide because it does not shorten the length of a worthwhile life and it does not override the patient's autonomy.

Consequently, I was able to prove that physician-assisted suicide is in fact morally permissible. The DDE, which is the traditional argument against physician-assisted suicide, was shown to be a weak argument because of problems interpreting the concepts of means, intention, and ends. I instead outlined methods of discussing physician-assisted suicide that did not depend on the DDE, but instead depended on harm and rights. As you can see, physician-assisted suicide does not harm the patient, nor does it violate the patient's autonomy or personal property rights. As a result, physician-assisted suicide is not morally impermissible, nor should it continue to remain illegal in 49 states until the issues presented here are better understood.

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