THE EUTHANASIA DEBATE TODAY

Richard M. Doerflinger

"EU-THANASIA," FROM GREEK WORDS meaning a good or easy death, has taken on a very different meaning today: the killing of a patient by his or her doctor.

Some people draw a distinction between euthanasia (active killing by physicians) and physician-assisted suicide (prescribing or providing lethal drugs for the patient to self-administer). But the intent, that of causing the patient's premature death, is the same; the means, a lethal drug-overdose, is the same; and as Derek Humphry, founder of the Hemlock Society, has acknowledged, allowing assisted suicide inevitably forces us to consider allowing active euthanasia. Humphry says that suicide by oral overdose goes badly about 25% of the time, so a doctor should be standing by in every case "to administer the *coup de grace* if necessary."[i] Even recent court rulings favoring assisted suicide have found no real distinction between the two practices. So for all practical purposes, we can treat assisted suicide and active euthanasia together.

How are we faring in our struggle against legalized euthanasia? Until very recently, not too badly. Consider the following:

■ The voters of Washington (in 1991) and California (in 1992) defeated referenda designed to legalize euthanasia.

■ In November 1994, Oregon voters narrowly approved a measure to legalize assisted suicide, 51 to 49 percent; but it was enjoined by a federal court and has never gone into effect.

■ More importantly, despite predictions to the contrary, efforts to expand the Oregon agenda to other states have been a dismal failure. In 1995 and the first half of 1996 bills like Oregon's were introduced in at least 15 states but all were defeated. Some state legislatures allowed these bills to die without a hearing. Even states carefully chosen by euthanasia groups as ideal battlegrounds defeated such bills by lopsided margins: 6-to-1 in a committee of the New Mexico legislature (even though the state medical society refused to oppose the bill); 256-to-90 in the New Hampshire House of Representatives.

■ In fact the only new laws being enacted on this issue are laws that

absolutely *ban* assisted suicide. Iowa became the 34th state with a specific ban on assisted suicide on March 1, 1996; at this writing Rhode Island seems poised to become the 35th, differently worded bills having been overwhelmingly approved in both House and Senate.

■ Finally, until a few weeks ago, *no* jurisdiction in the country had a court ruling recognizing any "right" to assisted suicide. Indeed, three courts had recently ruled that there is no such right: a three-judge panel of the Ninth Circuit Court of Appeals (upholding Washington State's law against assisted suicide); a U. S. District Court in New York (upholding that state's similar ban); and the State Supreme Court of Michigan. And a federal judge had ruled that Oregon's new law selectively *allowing* assisted suicide for the terminally ill violated constitutional guarantees of equal protection under law.

THE APPELLATE RULINGS

Into this rather promising situation, two federal appellate court decisions this spring fell like hand grenades tossed into a hospital ward. Having failed almost universally to win the support of the American people and their elected representatives, euthanasia supporters stepped up their efforts in the federal courts and won two resounding victories. On March 6, an 11-judge panel of the Ninth Circuit Court of Appeals voted 8-to-3 to knock down Washington's ban on assisted suicide as it applies to terminally ill adults, arguing that the Due Process clause of the 14th Amendment guarantees the "right" of such patients to receive "life-ending medication" to hasten their deaths. (An odd choice of words: If lethal poison is "medication," the disease it "cures" must be life itself.) On April 2, the Second Circuit Court of Appeals denied the existence of such a fundamental right, but still knocked down New York's law against assisted suicide. Here the argument was that there is no "rational basis" for banning the prescribing of lethal drugs to terminally ill patients when the State already recognizes their right to hasten death by refusing unwanted medical treatment.

These two rulings are worth reviewing because, far from striking a blow in favor of assisted suicide, their logic shows very clearly why our society should *never* start down this path.

THE 9TH CIRCUIT RULING IN *COMPASSION IN DYING V. WASHINGTON*

The lethal inevitability of euthanasia's "slippery slope" is most glaringly evident in the Ninth Circuit decision. Knocking down traditional distinctions between withdrawal of medical treatment and killing, the court defines a new constitutional right to assisted suicide for all "terminally ill,

competent adults who wish to hasten their own deaths."[ii] At first there seem to be three limits on this right: it applies only to assisting a suicide, so the patient himself has to administer the drugs; it must be by a competent adult's own voluntary decision; and it applies only to the terminally ill. The court then proceeds to take each of these limits away, one by one.

First, the Court admits that "it may be difficult to make a principled distinction" between assisting a patient's suicide and simply injecting that patient with lethal drugs. "We would be less than candid," says the court, "if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life.... *We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end.*"[iii] So ends any firm barrier against lethal injections by physicians; instead we are to rely on the voluntariness of the patient's own decision. That is the next limit to disappear.

Second, the court notes approvingly that life-sustaining treatment is withdrawn from incompetent patients by surrogate decision makers all the time. These surrogates may be family members, proxies appointed by the patient, or even guardians appointed by the State. The court transfers all this delegated decision making over to the euthanasia context: "Finally, we should make it clear that a decision of a duly appointed surrogate decision maker *is for all legal purposes the decision of the patient himself.*"[iv] So the "voluntary decision" safeguard is gone as well: "Substituted judgment" and other doctrines will be used to decide that incompetent patients should be killed, and those decisions will be treated as though they came from the patients themselves. The court notes that some surrogates may make decisions based on unworthy motives, or even for economic reasons—but it says this also happens in decisions to withdraw treatment, so it should not slow us down in approving this new "right." In any case, the court says, the risk of abuse here is greatly reduced because these patients are terminally ill and "will die shortly in any event."[v] So the final barrier to widespread killing is the restriction to patients who are truly terminally ill.

Third, this final limitation drops away when the court defines what it means by "terminally ill." It notes that there are many different definitions in over 40 state laws, and that some of these laws define the term "without reference to a fixed time period." For example, some laws define it to include people in a coma or "persistent vegetative state" even if they could survive for many years with continued feeding and nursing care. Of special interest to the court is the Uniform Rights of the Terminally Ill Act, which defines a condition as "terminal" if it will lead to death in a relatively short time

"*without* administering life-sustaining treatment." Anyone who needs medical assistance to continue living—a diabetic who needs insulin, or a physically disabled person who needs a ventilator to assist breathing—could be seen as "terminal" under such definitions. The court decides that "*all* of the persons described in the various statutes would appear to fall within an appropriate definition of the term."[vi]

So much for any meaningful restriction to cases of "terminal" illness. Combined with the other expansions of the "right" outlined above, this new definition of "terminal" lays the groundwork for giving lethal injections to patients who are helpless and incompetent (therefore "terminal" in this new sense) who never asked for death, based on the wishes of proxies or state-appointed guardians.

THE 2ND CIRCUIT RULING IN *QUILL V. VACCO*

The Second Circuit Court of Appeals does not draw out these same consequences so openly. Yet its analysis clearly sets the groundwork for the same expansions of the right to kill. It does so by constructing an "equal protection" argument: Terminally ill patients who are on life support now have a right to hasten their deaths by refusing that support; but terminally ill patients who are not sick enough to need such artificial support cannot presently enjoy that same right, because there is nothing for them to refuse so they can die. Therefore the State must allow them to exercise their right to hasten death by receiving lethal drugs from their doctors.[vii]

There are many flaws in this analysis, to say the least. Among other things it seems to imply that your right to receive lethal drugs is stronger the *healthier* you are—for only the completely strong and healthy person can be sure that he will need lethal drugs (and not a mere refusal of outside support) in order to exercise the coveted "right to hasten death."

But the central confusion in this ruling is the denial of any "rational" difference between refusing unwanted or burdensome treatment and committing suicide. To be sure, there are borderline cases where a patient or family may refuse some easily provided form of care precisely in order to hasten death; but such motives are generally hidden from the eyes of the law.

Most often, life-extending treatment is refused because it will have little benefit in curing or ameliorating the disease, or because it would impose unnecessary suffering and other burdens on a patient who is already weak and vulnerable. As Dr. Leon Kass said at a congressional hearing on assisted suicide on April 29, 1996, these decisions are generally not about seeking death but about "how we choose to *live*, even while we are dying."

In fact, from a doctor's legal viewpoint the two situations are opposites.

The patient's refusal of treatment gives a doctor no new legal power or authority, but places a firm *limit* on that power and authority: he *may not* provide or continue such treatment without the patient's consent, or he will be performing a battery. By contrast, giving legal validity to a request for lethal drugs gives the physician a new power to take life that has never existed since the advent of the Hippocratic oath.

Until this spring, almost every state or federal judge to address the issue had found that refusal of medical treatment was qualitatively different from suicide or euthanasia. Courts have consistently ruled that a seriously ill patient's decision to refuse treatment does not cause death, but allows the patient to die of natural causes; death is really caused by his or her underlying illness.

Most courts establishing the legal right to refuse treatment have insisted so firmly on the distinction between refusing treatment and committing suicide, that if they are no longer allowed to draw that distinction they might well reconsider whether the right to refuse treatment exists either. But the Second Circuit judges assume that the opposite course is correct: Having rejected the grounds on which most courts have defended the right to refuse treatment, the judges nonetheless assume that it exists and then piggyback onto it a right to receive assistance in suicide.

If the two rights really are the same under the Constitution, what follows? Well, what follows is the same set of consequences that we have already seen in the Ninth Circuit decision. The right to refuse treatment, after all, belongs to everyone and not just to the terminally ill; so the right to assisted suicide can hardly be restricted to the terminally ill in any narrow sense of the term. (Unlike the Ninth Circuit, the Second Circuit judges do not try to define terminal illness but proclaim that everyone knows what it is; "everyone" presumably includes the legislators who wrote those 41 different laws cited by the Ninth Circuit.) The right to refuse treatment is often exercised on behalf of incompetent patients by family members, appointed proxies, and even state-appointed guardians. And once the obvious and traditional distinction between allowing nature to take its course and actively intervening to provide lethal means for suicide is destroyed, does anyone really think the court will find a new and convincing basis for the far more precarious distinction between assisted suicide and active euthanasia? In short, while the Second Circuit decision is not so explicit in drawing out the consequences of its legal reasoning, it takes us to the same place as the Ninth Circuit decision.

THE SLIPPERY SLOPE

Clearly the "slippery slope" of euthanasia already has its illustrations in our history. No society—I repeat, no society—that has officially endorsed voluntary suicide or euthanasia has ever failed to move on to killing people without their consent. Greek and Roman society are sometimes cited as honoring an idea of "noble" suicide—yet this practice also became a means of execution by the State, as in Socrates' forced "suicide" by hemlock. Nazi Germany's experiment with euthanasia of the retarded and mentally ill was never based on the voluntary request of the victim, though it began with a request from the parents of a handicapped child and was often publicly defended in terms of the victims' "right to die." And according to the Dutch government's own 1991 study, the Netherlands' experiment in "voluntary" euthanasia produces more killing of patients without their request every year than with their request.

Physicians in the Netherlands have moved fairly quickly from ending the lives of the terminally ill to doing so to the physically disabled and to people who have no physical illness but are elderly or depressed. Now we know that doctors give lethal injections to handicapped newborn infants at least 10 times a year—infants with disabilities like Down's Syndrome or spina bifida, who certainly never asked to be killed.

In one recent case reported by American psychiatrist Herbert Hendin, a Dutch physician gave a lethal injection to a Catholic nun who was in considerable pain while dying. She never asked for euthanasia, but he felt that was because her religion wouldn't let her—so he simply gave it to her without asking.

These cases are frightening enough. But by "constitutionalizing" the issue, our American courts have managed to do in days what it took the Dutch twenty years to do. In our legal system the slippery slope is more like a leap from the edge of a cliff. But perhaps this is a good thing if it demonstrates to Americans all at once where this agenda leads. In our country there will be no gradual raising of the temperature, so that we are heated up to boiling without knowing exactly when to cry out. We should be crying out right now—especially to the Supreme Court, which is about to take up the Second and Ninth Circuit cases. (In this context, of course, we will have to cry out very articulately and with all the appropriate footnotes.)

EQUAL DIGNITY UNDER LAW

What should we say to the Court, at the level of principled legal argument? I think we would do well to study U. S. District Judge Michael Hogan's ruling in *Lee v. Oregon*, which found Oregon's law *allowing* assisted suicide for the terminally ill to be unconstitutional.

Hogan's ruling is a mirror image of the Second Circuit decision now on its way to the Supreme Court. He argues that laws allowing assisted suicide for certain classes of citizens violate constitutional guarantees of equal protection under law, by depriving a class of citizens of the protections against killing that all other citizens continue to enjoy.

Surely there is no rational basis for treating terminally ill people and other people in completely opposite ways when they are tempted to commit suicide. Suicidal people are found in every demographic group—especially among the young, the very old and members of certain high-stress professions. From the viewpoint of suicidal persons in any such group, their pain and suffering is more real and more intolerable than any physical pain that could be relieved by morphine and other painkillers. Persistent suicidal desires among the terminally ill are not significantly more common, no more "free," and no less caused by treatable depression than such desires felt by people in these other groups. Yet an entire legal and political movement has dedicated itself to facilitating suicide for the seriously ill, even while the law continues to forbid such "assistance" for everyone else.

Why would the State continue to view assisting the suicide of anyone else as a homicide, but view assisting the suicide of certain seriously ill or disabled people as a decent and lawful act? The only possible answer is: Because the State has made its own supposedly "objective" judgment that these patients, unlike any other citizens, have lives not worth protecting. When these particular people think they have lives not worth living, government can think of no reason to disagree.

Imagine the scenario: two people come forward wanting to commit suicide. Both have made a suicidal decision that they see as free and rational; both say they find nothing but pain and suffering in continuing with life. But one is able-bodied, while the other has an illness or disability that two physicians say is "terminal." On this basis, a law like the one recently approved in Oregon says to the first person that his life is too valuable to throw away—that we will provide counseling and psychological assistance to relieve these suicidal feelings, and legally forbid anyone to provide "aid" in suicide. To the second person the State will say: "Go right ahead. In fact we've anticipated your request, by proclaiming in advance that we have no interest in preventing the suicide of someone with your condition. Officially the government doesn't care whether you live or die."

This is not a recipe for greater freedom. It gives to government a new power that no human being should have: the power to decide which citizens' lives will be protected by law, and which will not. As one columnist put it very succinctly during the debate on the California euthanasia referendum,

this is "Death With a Note from Big Brother."[viii]

Clearly, judges and others who support such legal developments do not think they are practicing invidious discrimination against people with serious illnesses and disabilities. They believe they are giving these people a new "right" to end their lives painlessly. Yet they say they are not interested in granting this right to able-bodied people like themselves. If a law gave such selective "freedom" for assisted suicide to other defined classes of people—solely to women, or to members of a particular ethnic or religious group—howls of protest would rise up from civil rights organizations, and rightly so. The fact that many people do not see such invidious discrimination in the assisted-suicide agenda is an indication of how deep some of our prejudices about frail or seriously ill people really are. Physically healthy people simply assume that in some objective sense these patients are indeed "better off dead," that their suicides are rational and legitimate when other people's suicides are not.

In fact this prejudice is directly contrary to the views of those with the most experience of serious illness or old age. Whatever opinion polls may show at any moment—and many of the polls have greatly exaggerated public support for assisted suicide by asking vague questions filled with euphemisms—every major poll shows that senior citizens are far more opposed to assisted suicide than younger voters.[ix] Low-income voters, black and Hispanic citizens, and others who are relatively powerless in our society are also more opposed to it than others—perhaps because they can well imagine assisted suicide becoming the "treatment of choice" for people like them when public health clinics are strapped for resources. Physicians who have treated many terminally ill patients also oppose assisted suicide more strongly than those without such experience.[x]

In my view, Judge Hogan was absolutely correct when he found that a law allowing assisted suicide for the terminally ill "withholds from terminally ill citizens the same protections from suicide the majority enjoys." After finding that the Ore-gon law provided "little assurance that only competent terminally ill persons will voluntarily die," he added: "The majority has not accepted this situation for themselves, and there is no rational basis for imposing it on the terminally ill."[xi]

"SAFEGUARDS" AND THE BOTTOM LINE

Some people think the exploitation of vulnerable patients under a regime of legalized assisted suicide can be prevented by incorporating various "safeguards" into the law. In fact, to some extent the Ninth Circuit's new ruling renders that question moot, by indicating that some widely supported

"safeguards" may well be found unconstitutional once the courts view assisted suicide as a fundamental right. For example, the Court says any waiting periods to think over the euthanasia decision must be "short."[xii] Further, it says that "constitutional concerns" would be raised by any requirement that family members be consulted and agree with the decision.[xiii] By noting that minor children have the same "right to die" as adults do, the Court invites all the battles about euthanasia for minors and parental consent that we have already fought for many years in the abortion context.[xiv]

In any event, calls for safeguards miss the point. Any law that singles out a class of citizens for disparate treatment under the law of homicide perpetrates the same basic injustice. Once that unjust decision has been made, efforts to "fix" the law by tightening its loopholes only have the effect of defining ever more clearly the isolated class of patients to be singled out for exclusion from the law's protection. Such an unfair law cannot be "fixed." Government will still be making a pre-emptive judgment that citizens of a certain description—the vast majority of whom have never expressed any desire to die—are good candidates for a premature death by lethal drugs.

It defies belief to claim that insurance companies, health maintenance organizations and state governments struggling to save money will not also act on such judgments. Even before it legalized assisted suicide, Oregon instituted a Medicaid rationing plan under which terminally ill patients who are poor will simply not be able to receive various life-supporting treatments for their conditions. Once the assisted suicide measure passed, the state Medicaid director announced that assisted suicide *will* be covered for *every* patient—it will be very high on the priority list, under the title "comfort care." (One wonders whether the state treasury really receives the greatest "comfort" from this policy.) So the State will take away all the *other* treatments patients might have wanted to *support* life, and give them assisted suicide free of charge. This idea of essentially offering patients an economic *incentive* to assisted suicide by giving it public funds has been endorsed by that bastion of individual freedom in our society, the American Civil Liberties Union.

WHAT TO DO?

What is being done to oppose this, and what can we do?

We can tell others what this issue really entails—through articles, opinion pieces, letters to the editor, call-in shows and private conversation. We can write to our state and federal legislators, urging them to oppose legalization of assisted suicide and to pass new laws against it where necessary. We can

promote compassionate care of the dying by supporting, and volunteering at, local hospices and respite care programs. And we can pray that our society will come to a full recognition of the dignity of each and every human life.

In Washington, D.C., some groups are working together to advance a federal policy on this problem. Both President Clinton and Senate Majority Leader Dole recently announced their opposition to assisted suicide. A bill will soon be introduced in Congress to prevent all funding and support for assisted suicide in federal health programs. Recently 40 members of Congress wrote to the U. S. Solicitor General, urging the Clinton Administration to file a brief urging the Supreme Court to review and reverse the Second Circuit decision. And the U. S. Catholic Conference has joined with Lutheran, Southern Baptist and Evangelical Christian groups to file its own brief urging the Supreme Court to take these cases.

In short, the current situation has many alarming features, and there is much work to be done. But if I have to offer one assessment of where we stand in the national debate on assisted suicide, it is this: We're not dead yet.

NOTES

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i. Derek Humphry, Letter to the Editors, *The New York Times* (12/3/94) 22.

ii. *Compassion in Dying v. Washington*, No. 94-35534, slip op. at 3117 (9th Cir. March 6, 1996).

iii. *Ibid.* at 3201-2.

iv. *Ibid.* at 3201 n. 120.

v. *Ibid.* at 3189.

vi. *Ibid.* at 3200.

vii. *Quill v. Vacco*, No. 95-7028, slip op. at 29-31 (2d Cir. April 2, 1996).

viii. D. Saunders, in *The San Francisco Chronicle* (8/31/92) A18.

ix. Even polls by the Hemlock Society show that "the younger the person, the more likely he or she is to favor this legislation" allowing assisted suicide (Hemlock *TimeLines* [Jan.-Feb. 1994] 9). A recent national survey by the *Washington Post* showed 50% support for making physician-assisted suicide legal (*Washington Post* [4/4/96] A18); but support dropped to 38% among those aged 65 or over. A July 1995 poll by The Tarrance Group found that "voters aged 18 to 34 years old support assisted suicide, 56% to 40%. But those aged 65 and over—whom some would see as the primary beneficiaries of a legal 'right to die'—oppose the practice 55% to 37%, with 48% strongly opposed" ("Poll: Americans Divided on Euthanasia" in *Life at Risk: A Chronicle of Euthanasia Trends in America* [June/July 1995] 1).

x. In a recent survey of Michigan physicians, legalization was favored by 73% of those

who "never" treat terminally ill patients but by only 44% of those who treat them "very often" (J. Bachman *et al.*, "Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia" in *New England Journal of Medicine* (2/1/96) 306. The same correlation is found among Washington physicians: see J. Cohen *et al.*, "Attitudes toward assisted suicide and euthanasia among physicians in Washington State" in *New England Journal of Medicine* (7/14/94) 93.

xi. *Lee v. Oregon*, 891 F. Supp. 1429, 1438 (D. Or. 1995).

xii. *Compassion in Dying* at 3204.

xiii. *Ibid.* at 3192 n. 100.

xiv. *Ibid.* at 3164.