

## Reading SAL: Assisted Suicide

### Dworkin: Introduction to the Philosopher's Brief (1997)

The laws of all but one state now forbid doctors to prescribe lethal pills for patients who want to kill themselves.

Two states have argued before their federal appeals courts that this prohibition should be declared unconstitutional by the US Supreme Court, and the circuit courts agreed.

If the Supreme Court reverses their decision, it might be on the basis of two versions of a "slippery slope" argument: one theoretical, one practical.

- A. The theoretical slippery slope: That right once granted could not be limited by any principled line that would restrict it to all and only the appropriate cases
  - a. But: Every competent person has a right to make momentous personal decisions about life's value for himself.
  - b. It is true that people may make such decisions impulsively; but states may be allowed to prevent assisted suicide who plausibly might later regret it.
    - i. Dealing with such cases will be a pain in the neck to the courts—but it is better that they be inconvenienced than that so many suffer.
- B. The practical slippery slope: States will adopt regulations to assure that any decision for AS will be informed, competent and free—but such regulations cannot be adequately enforced, and the most vulnerable patients will be hustled into unwanted decisions.
  - a. But under the present system, the more privileged can already get around the prohibition, leading to a 'two-tier system'
  - b. —and if regulations are adopted, the result might actually be more equitably distributed, better end-of-life care for everyone, including the more vulnerable.

If the court closes the door to a constitutional right to PAS, it will have to do so by EITHER  
 --denying that people do not have, even in principle, the right to control their own deaths—

calling into question the long-standing right of people to demand  
 the withdrawal of life-sustaining tx,

OR

--allowing individual states to get out of supporting constitutional rights because it's just too hard, either in terms of will or resources.

### The Philosopher's Brief

#### *Introduction*

There is an important liberty interest at stake in these cases.

Those who argue against that point do so either by denying there is such a liberty interest, or claiming that it would be too difficult to recognize it if there were one.

#### *Argument*

1. The liberty interest at stake is supported by 'due process' clause of the 14<sup>th</sup> amendment.:  
 ["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."]
- 2.—and previous court cases have cited it in support of similar liberty interests.  
 Cf. *Planned Parenthood v. Casey* and *Cruzan*  
 Some people claim that the liberty interest upheld by *Cruzan* —the right to refuse or have withdrawn treatment—is different than the right to receive an active intervention to end life; the former is merely an omission—not a commission. (p. 491) We maintain that there is no important moral difference between the two.

*The difference between acts of omission and acts of commission has a long history, and is discussed at some length in an article on active and passive euthanasia by James Rachels. (See "Killing and Letting Die" on the website, from The End of Life , 1986)*

There is one important distinction between the two kinds of case: Patients have in principle the right to compel the removal of life support machinery from their body. But they do not have the right to compel a physician to assist in their death.

“The right is only to the help of a willing doctor.” (492)

3--State interests do not justify a categorical prohibition

The Cruzan precedent says the risk of death is not sufficient to override the liberty interest, and states have not proved incapable of addressing that interest.

Protocols even for withdrawing tx require the patient to be competent, informed and free—and so will these. Those have been deemed sufficient for withdrawal.

The two risks are that the information on which his consent for PAS might be wrong, and that a request for PAS may be subject to coercion; and neither of those are sufficient to override the strong liberty interest this case represents.

*Conclusion*

Affirming (rather than overriding) the decisions of the courts of appeals establishes nothing more than that there is a constitutionally protected liberty right in principle to request the assistance of a physician in achieving a free and informed death.

### **Battin: Euthanasia: The Way We Do It, the Way They Do It**

Battin discusses legal options in three countries: the US, where (with the exception of Oregon) only withholding and withdrawing LST is allowed; the Netherlands, where voluntary active euthanasia and physician assistance in suicide are legal; and Germany, where assistance in suicide (from non-physicians) has not been illegal since 1742.

Problems with the three models: For the Germans, forbidding physicians to participate increases the risks of false diagnosis and of undiagnosed impaired judgment.

There are concerns that the Dutch practice reduces incentives for good terminal care (although there seems no evidence of that); and some fear that the Dutch will gradually abandon their strong emphasis on the voluntariness of the decision (cf. Battin on the ‘slippery slope,’ p. 503)

The US model is the most dangerous of the three, since (a) non-treatment is less conspicuous so invites less protections; (b) relying on withholding and withdrawing tx invites rationing—“a particular problem where health care financing is decentralized, profit oriented and non-universal” (p. 504); and (c) it may be the cruelest of the options available. The ways diseases kill people can be far more cruel than the ways physicians kill patients in euthanasia or assisting suicide.

The three models each have advantages and disadvantages. Which should we adopt? The Dutch have much closer and consistent contact with a physician who knows them (and pays house visits) than we do. Their model for us would often lead to death at the hands of strangers. The US has a more confrontational culture, and a more volatile (and litigious) legal climate than either the Netherlands or Germany. And the biggest difference: both the other countries have national health care, removing financial considerations from decisions about how to die.