PHYSICIAN-ASSISTED SUICIDE: CHA AMICUS BRIEF

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THE U.S. SUPREME COURT IS ABOUT TO RULE ON THE CONSTITUTIONALITY OF PHYSICIAN-ASSISTED SUICIDE. LAST YEAR THE CATHOLIC HEALTH ASSOCIATION FILED AN AMICUS CURIAE BRIEF ARGUING THAT THE COURT SHOULD REJECT THE PRACTICE. THIS SPECIAL SECTION CONTAINS THE BRIEF, ACCOMPANIED BY A LETTER TO THE COURT BY THE LATE CARD. JOSEPH BERNARDIN AND AN ARTICLE BY CHARLES GILHAM, JD, LLM, AND PETER LEIBOLD, JD, PROVIDING CONTEXT FOR THE CARDINAL'S LETTER.

CHA Amicus Curiae Brief on Physician-Assisted Suicide

The Catholic Health Association of the United States submitted an amicus curiae brief to the U.S. Supreme Court last October in support of petitioners Dennis C. Vacco, attorney general of the state of New York (in the case of *Vacco v. Timothy E. Quill, MD, et al.*), and the state of Washington (in *State of Washington, et al. v. Harold Glucksberg, MD, et al.*). The brief was filed as the Court agreed to hear arguments on the issue of whether terminally ill people have a constitutionally protected right to physician-assisted suicide. In January 1997 the petitioners went before the Court to argue appeals to federal appellate rulings that struck down New York and Washington laws making physician-assisted suicide a crime. The Court is expected to rule in late June.

Questions Presented

(1) Is there a Fourteenth Amendment substantive due process right to obtain a physician's assistance in committing suicide?

(2) Are patients who refuse or withdraw consent to life-sustaining treatment similarly situated to patients who request that a physician prescribe or administer a lethal dose of medication?

(3) Does the state have a sufficiently important interest in prohibiting the consensual killing of patients by physicians to outweigh any purported right to assistance in suicide?

Interest of the Amicus Curiae

The Catholic Health Association of the United States ("CHA") represents over 1200 Catholic sponsored health care facilities and organizations that serve millions of people each year.

Catholic health care organizations understand their mission to be far more than simply the delivery of a social good. "Catholic sponsored health ministry, like the church itself, must not only proclaim the gospel but commit to transform the social order according to gospel norms" of love and justice. National Coalition on Catholic Health Care Ministry, *Catholic Health Ministry in Transition,* p. 4 (1995). This ministry is rooted in and informed by a deeply held commitment to promote and defend human life and human dignity.

CHA's interest in this case stems from its concern for the need to protect vulnerable persons; to insure appropriate care for dying persons; to preserve the integrity of the health care profession; to strengthen the bonds of community; and also to preserve the integrity of Catholic health ministry.

A body of moral principles developed over centuries informs Catholic teaching on health care matters. These moral principles likewise inform the National Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* (1995), which provide guidance to Catholic health professionals on a range of economic, technological, social and moral challenges. For instance, Catholic health care is required to support patients and their families who must face the reality of death (*Directives,* p. 21).

Furthermore, the *Directives* guide Catholic health ministry in its advocacy efforts:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination . . . the elderly; [and] those with incurable diseases. . . . In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons. Id., p. 7.

Assisted suicide offends the most basic moral precepts of our culture and, in particular, poses a grave danger to those "at the margins of our society." In fulfilment of its mission, the *amicus* urges this Court to reverse the Courts of Appeals.

Summary of Argument

The Ninth Circuit partial *en banc* opinion in *Compassion in Dying v. Washington* (Wash. Pet. App. A-1 to A-

117), positing a substantive due process right to physician-assisted suicide, is based on two fundamental misconceptions: first, that this Court's abortion jurisprudence stands for the proposition that any "private" or "intimate" decision by a citizen is entitled to protection under the Due Process Clause; and second, that an instruction to a physician to withdraw life-sustaining treatment, which this Court assumed to merit constitutional protection in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), is equivalent to a request for a physician's assistance in suicide.

The Second Circuit's opinion in *Quill v. Vacco* (N.Y. Pet. App. 1a-62a) likewise erroneously equates a person's negative right to refuse unwanted treatment with a positive right to be assisted in suicide, holding that New York's permission of the former and prohibition of the latter violates the Equal Protection Clause. The court could see no rational basis for making such a distinction.

Nothing in the Constitution or this Court's jurisprudence entitles citizens to request that a physician prescribe or administer the means to kill. The States of Washington and New York have the duty to protect the lives of their citizens from the consequences of legalized assisted suicide. Similarly, these states have the obligation to protect the fiduciary relationship between doctor and patient, upon which the integrity of the medical profession depends. Once health care professionals are permitted to "assist" people in killing themselves, our society's rationally constructed bright line prohibiting private killing will be obliterated.

ARGUMENT

The courts below seek to create a new constitutional right to assisted suicide based primarily on their fallacious equating of assisted suicide with the withdrawal of treatment. This fundamental error is at odds with our legal and cultural tradition.

As a starting point, we look to the example of Joseph Cardinal Bernardin, Archbishop of Chicago, who announced in October 1996 that he had decided not to continue chemotherapy for his cancer. S. Kloehn, "Bernardin Ends Cancer Care/Chemotherapy Hasn't Reduced Tumor Size," *Chicago Tribune,* Oct. 18, 1996, p. 1. In his letter to this Court, Cardinal Bernardin states, "I know from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention." App., infra, 1a. Where life-sustaining interventions are deemed ineffective or disproportionately burdensome, even in the case of a person on a ventilator, the intervention may be removed. Whether deciding to discontinue chemotherapy or to remove a ventilator, the absence of an intent to kill distinguishes these acts from one in which a person intends to take his own life. Such an act is suicide. Facilitating such an act is assisted suicide.

I. THE DUE PROCESS CLAUSE DOES NOT GUARANTEE A RIGHT TO OBTAIN A PHYSICIAN'S ASSISTANCE IN COMMITTING SUICIDE

In a sweeping act of positive lawmaking, the Ninth Circuit attempts to create a new substantive due process right to assisted suicide. This Court should not endorse such a dramatic departure from its precedent and from the Nation's legal and moral traditions.

A. THE WASHINGTON STATUTE BANS HOMICIDE, NOT "HASTENING ONE'S DEATH"

Suicide is "[t]he act of killing oneself intentionally." *Webster's II: New Riverside Dictionary* (1984). Catholic teaching has consistently recognized the difference between killing oneself (suicide) and withholding or withdrawing disproportionate means to sustain life.[1]

However, the Ninth Circuit asks not whether there is a right to be assisted in "killing oneself intentionally," but whether there is a liberty interest in "determining the time and manner of" or "hastening one's death." Wash. Pet. App. A-29. The court's oblique declaration of the constitutional "right" it creates allows it to sweep into the discussion "a whole range of acts that are generally not considered to constitute 'suicide' [including] . . . the act of refusing or terminating unwanted medical treatment." Id. Indeed, in a total subversion of the English language, the court states that it has "serious doubts that the terms 'suicide' and 'assisted suicide' are appropriate legal descriptions of the specific conduct at issue here." Id.

The court's use of words is more than mere semantics. The newly proposed right is quite broad. There is no coherent way to limit a purported right to "assisted suicide" to terminally ill people or to competent people who can communicate. Once the Court affords terminally ill citizens the "right" to have a physician assist them in suicide, it will have to afford such a right at least to all competent adults for, according to the Ninth Circuit, the right is grounded not in the terminal illness, but in the right to determine the time and manner of one's death. Moreover, there is nothing to limit this right to patient-administered medication; the lower courts' reasoning would appear to apply just as readily to those seeking euthanasia (i.e., physician-administered lethal medication). Of course, the Ninth Circuit dismisses this fundamental concern, "consider[ing] it less important who administers the medication than who determines whether the terminally ill person's life shall end." Wash. Pet. App. A-100 to A-101.

Once all competent adults have such a right, the right would have to be extended to incompetent adults, for incompetent persons do not lose their constitutional freedoms simply due to their incompetence. See Wash. Pet. App. A-159 (Beezer, J., dissenting). The only issue would be whether and how a surrogate can act for an incompetent person (e.g., *Cruzan,* supra). Once incompetent people have the right to assisted suicide (whether or not they are terminally ill), advocates for mature or emancipated minors, and for the legal representatives of minors, would urge the extension of the right to them as well. Cf. *Planned Parenthood v. Casey*, 505 U.S. 833, 970-71 (1992); *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983); *Bellotti v. Baird*, 443 U.S. 622, (1979).

In addition, once this Court recognizes a Substantive Due Process right of physician-assisted suicide, even for healthy adults, it will face the compelling argument of those who do not need a physician's help to commit suicide, but only wish the help of a friend or trusted family member. The purported right to assisted suicide is based on the belief that the law may not prevent a person from ending his own life, and thus that a state may not interfere with the efforts of those who would assist in such an endeavor. There is no implicit limitation in such a right to the assistance of physicians; in theory, a person entitled to "hasten their death" should be able to

accept the help of anyone. At this point, assisted suicide is no longer a clinical event occurring in a health care setting; it is nothing more than state-sanctioned killing by private agreement.

B. The Court Should Not Create a New "Right" to Assisted Suicide That Lacks Any Basis in the Text of the Constitution or the History and Tradition of Our Nation

The Ninth Circuit begins (Wash. Pet. App. A-31 to A-32) by dutifully reciting the standard expressed in what it calls this Court's "highly controversial" opinion in *Bowers v. Hardwick,* 478 U.S. 186, 191-92 , (1986) (citations omitted):

> Striving to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government, the Court has sought to identify the nature of the rights qualifying for heightened judicial protection. In *Palko v. Connecticut,* it was said that this category includes those fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." A different description of fundamental liberties appeared in *Moore v. East Cleveland,* where they are characterized as those liberties that are "deeply rooted in this Nation's history and tradition."

Unfortunately, the Court of Appeals ignores this standard, all but disregarding the long history and tradition in this country of prohibiting consensual killing. Indeed, the court proceeds to survey "current societal attitudes," citing polls showing public support for "the prerogative [of patients] to accelerate their death by refusing or terminating treatment" and for assisted suicide and euthanasia. Wash. Pet. App. A-48. Relying on its understanding of "our unwritten history" and its own knowledge, the court concludes that suicide and assisted suicide are actually accepted practices in society, justifying enshrining them in the pantheon of constitutionally protected activities which may not be proscribed by legislation. See id., A-51 to A-52.

An accurate reading of the American legal tradition reveals something much different. It demonstrates a consistency between our society's historical rejection of assisted suicide and Catholic teaching. Moreover, Church teaching has been influential in shaping the societal views and practices which inform this Court's due process analysis.[2]

From the earliest times, the Church has condemned suicide.[3] Two figures in the Church's history stand out in this regard. St. Augustine of Hippo (354-430) articulated the principles on which Christianity condemned suicide by arguing that the prohibition against killing applies to all persons, including oneself. St. Augustine, *City of God*, Book I, ch. 20. Building upon that foundation, St. Thomas Aquinas (c.1225-1273) further explained the reasoning behind the prohibition, arguing that suicide is contrary to the natural inclination that persons love themselves, that suicide injures the community, and that God alone has the power over life and death. St. Thomas Aquinas, *Summa Theologica II*, Q. 64, art. 5. Significantly, Aquinas also argued that suicide is an offense because it is an act of injustice against the community.

In this century, the Second Vatican Council reiterated the Church's powerful opposition to suicide:

> The varieties of crime [against the human person] are numerous: all offenses against life itself, such as murder, genocide, abortion, euthanasia and wilful *suicide* . . . all these and the like are criminal: they poison civilization; and they debase the perpetrators more than the victims and militate against the honor of the creator. "Pastoral Constitution on the Church in the Modern World" (*Gaudium et spes 27*), *Vatican Council II,* p. 928 (A. Flannery, ed., 1992) (emphasis added).

More recently, the Vatican reiterated the Church's opposition to suicide:

> Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and loving plan. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia,* p.7 (1980). See also *Directives,* p. 21 ("Suicide and euthanasia are never morally acceptable options").

Most recently, the *Catechism of the Catholic Church* emphasizes the broad social consequences of killing oneself. Suicide "offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations." United States Catholic Conference, *Catechism of the Catholic Church*, section 2281, p. 550 (1994). In sum, the Catholic tradition's aversion to suicide is so strong that the American Bishops insist that those associated with the Catholic health care ministry neither condone nor participate in assisted suicide. *Directives,* p. 23.

Our own legal tradition has also consistently condemned suicide, and thus assisted suicide. Henry de Bracton's 1220 treatise and Sir Edward Coke's 1644 treatise, *Third Institute of the Law of England*, identified the common law crime of suicide and its severe property penalties. See T. Marzen, M. O'Dowd, D. Crone & T. Balch, "Suicide: A Constitutional Right?" p. 24, Duquesne L. Rev. 1, 57, 60 (1985). In *Hales v. Petit*, 75 Eng. Rep. 387 (1561-62), the English Court applied sanctions against suicide. In the United States, *Massachusetts Commonwealth v. Bowen*, 13 Mass. 356 (1816), illustrates the early American common law prohibition against assisted suicide. The fact that states later abolished criminal penalties for unilateral suicide does not reflect societal approval of these acts. "These changes occurred, rather, because punishment was seen as unfair to innocent relatives of the suicide and because those who committed or who attempted to commit the act were thought to be prompted by mental illness." Y. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" 23 *Hastings Center Report* 32, 41 (1993). Indeed, the common law, and in many instances state statutes, prohibited suicide and assisted suicide both at the time of the Revolution and at the time the Fourteenth Amendment was ratified. See Wash. Pet. App. A-44 to A-46; *Cruzan*, 497 U.S., p. 294 (Scalia, J., concurring), citing Marzen, et al., supra. In fact, notwithstanding the Ninth Circuit's research into popular opinion, all but one state today prohibit assisted suicide. See Wash. Pet. App. A-48 to A-49.

Because our moral tradition and our law have so uniformly condemned these practices, it is simply inaccurate to say that the right to assist in committing a suicide is a "liberty" that is "deeply rooted in this Nation's history and tradition," or that is "implicit in the concept of ordered liberty." Indeed, it is our proud history to have prohibited such dangerous conduct.

C. This Court's Decisions in Casey And Cruzan Do Not Protect Consensual Killing or Assisted Suicide

The Ninth Circuit relies on *Casey* and *Cruzan* for the unsupportable proposition that there is a liberty interest in "hastening death" which the state may not burden. Neither *Casey* nor *Cruzan*, however, can support the creation of this expansive right. Although in both cases this Court applied a balancing test to state restrictions on actual or assumed liberty interests (the same test the Ninth Circuit purports to apply), the finding of liberty interests in *Casey* and *Cruzan* was itself subject to the larger principles enunciated in *Bowers* and prior cases.

1. Casey

According to the Ninth Circuit, *Planned Parenthood v. Casey* requires the conclusion that there is a liberty interest in assisted suicide because "the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy'" (Wash. Pet. App. A-57 [quoting *Casey*]).

The language in *Casey* about highly personal and intimate decisions cannot be taken out of context to support the awesome breadth of the Ninth Circuit's pronouncement.[4] The Court did not say that *any* intimate decision of importance to the individual ought to be treated as a liberty interest. Many such decisions not only lack constitutional protection, but are in fact proscribed by law:

> Those adjectives might be applied, for example, to homosexual sodomy, polygamy, adult incest, *and suicide,* all of which are equally 'intimate' and 'deep[ly] personal' decisions involving 'personal autonomy and bodily integrity,' and all of which can constitutionally be proscribed because it is our unquestionable constitutional tradition that they are proscribable. *Casey,* 505 U.S. at 984 (Scalia, J.) (emphasis added).

Suicide—and *a fortiori*, assisted suicide—have long been proscribed, and are not entitled to constitutional protection regardless of their "intimate" or "personal" nature. Cf. Bernardin, infra, 1a-2a (assisted suicide not merely a personal matter because it harms society).

2. Cruzan

The Ninth Circuit next cites this Court's decision in *Cruzan* to support its creation of a constitutional right to "hasten death." Wash. Pet. App. A-62. In *Cruzan*, the Court assumed that a patient would have the right to refuse or terminate life-sustaining medical treatment, but held that the state had the right to insist on strict safeguards in cases involving incompetent persons. Accordingly, the Court upheld Missouri's "clear and convincing" standard for proof of an incompetent individual's wishes. 497 U.S., p. 284.

Cruzan did not recognize any generalized "right to die," let alone a right to assisted suicide. On the contrary, the Court explicitly noted with approval the fact that assisted suicide was *illegal* under state law:

> States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, *the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.* 497 U.S., p. 280 (emphasis added).

Despite this clear language and the expressly narrow grounds of this Court's decision, the Ninth Circuit used *Cruzan* as a springboard to an expansive "right" heretofore unknown to the law:

> *Cruzan,* by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, *necessarily* recognizes a liberty interest in hastening one's own death. Wash. Pet. App. A-62 (emphasis added).

To appreciate the magnitude of the lower court's illogical leap from the actual *Cruzan* holding, the Court need look no further than at how the *Cruzan* Court reached its decision.

The Court began with a discussion of the doctrine of informed consent at common law. 497 U.S. at 269 ("[the] notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment"). As the Court noted, "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." Id., p. 270. See also id., p. 277 ("As these [state law] cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment"). This was not anything so broad as a right to "privacy,"[5] but rather the right to be free of compelled surgical intrusions. E.g., *Cruzan*, 497 U.S., p. 287-289 (O'Connor, J., concurring):

> Requiring a competent adult to endure [forced medical treatment] against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

The right assumed to exist in *Cruzan* is thus firmly rooted in the jurisprudence of battery, not some inchoate right to control human destiny in all respects. *Cruzan* does not govern this case.

II. The Equal Protection Clause Does Not Guarantee the Right to Assistance in Suicide

As the Second Circuit observes, the Equal Protection Clause "simply requires the states to treat in a similar manner all individuals who are similarly situated" (N.Y. Pet. App. 20a.). "The general rule, then, is that state legislation carries a presumption of validity if the statutory classification is 'rationally related to a legitimate state interest.'" Id., p.21a, quoting *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985).

The Second Circuit struck New York's statutes criminalizing assisted suicide under the Equal Protection Clause on the ground that:

> 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 [and] the distinctions made by New York law with regard to such persons do not further any legitimate state purpose. N.Y. Pet. App. 24a.

The court acknowledged that the statute fell "within the category of social welfare legislation and [was] therefore subject to rational basis scrutiny upon judicial review" but could see no "legitimate state purpose" to distinguish between persons who withhold or withdraw their consent for life-sustaining treatment and persons who wish to have physicians assist them in killing themselves. Id., p. 24a-25a.

A. The Law Regarding Assisted Suicide and Discontinuation of Treatment Applies Equally to All

The Second Circuit errs in subjecting New York's legislation to judicial review because New York does not discriminate between "similarly situated" individuals at all. In New York, as almost everywhere, a patient has the right to refuse or discontinue unwanted medical treatment. See N.Y. Pub. Health Law, section 2892. As noted in Section I, supra, this right derives from the doctrine of informed consent, and is grounded in the Constitution's protection of bodily integrity. See *Cruzan*, 497 U.S., p. 277. Arguably, a physician who does not respect this right is guilty of at least a civil battery. Id., p. 269.

On the other hand, in New York, as almost everywhere, it is illegal to aid or abet a suicide, or to kill another person, even where the individuals involved are a physician and a patient. N.Y. Penal Law, sections 125.15(3), 120.30. See also *Cruzan*, 497 U.S., p. 290-291 nn. 2-4 (O'Connor, J., concurring) (collecting various state laws). The Court of Appeals equates revocation of consent to life-sustaining treatment and assisted suicide because they both result in the death of the patient. See *Cruzan*, 497 U.S., p. 280. "But constitutional law does not work that way." *Cruzan*, 497 U.S., p. 286.[6]

For one thing, patients in each example seek to employ vastly different means to their respective ends, and it is those means which New York treats differently. As did the Ninth Circuit, the Second Circuit ignores this, adopting instead the imprecise and misleading descriptor that both patients are "hastening their deaths." N.Y. Pet. App. 29a-30a. One can equate virtually any two situations by defining the terms broadly enough, but that is not the purpose of the Equal Protection Clause. E.g., *Kelley v. Johnson*, 425 U.S. 238 (1976) (right of bodily autonomy does not include right to control personal appearance at the workplace).

Indeed, New York's ban on assisted suicide is a neutral, generally applicable body of law that proscribes conduct; it does not apply unequally to different classes of people. New York does not purport to prohibit "hastening one's own death." New York prohibits aiding and abetting a suicide.

It is true that under New York's scheme some people end up with more control over the precise timing of their deaths than others, but that is not the fault of the law. It is simply due to the biological fact that certain people will die without medical intervention while others will not. The important point for Equal Protection purposes, however, is that both classes of people have precisely the same legal rights and are subject to precisely the same legal prohibitions: the right to refuse or withdraw treatment (regardless of the expected outcome), and the prohibition against aiding and abetting suicide. The fact that results arising from the exercise of the right and from the impact of the prohibition vary with the individual is not only permissible, it is to be expected in any society made up of unique individuals. *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (Equal Protection Clause does not guarantee identical outcomes, just equal treatment under law).

B. Assisted Suicide Is Morally Distinguishable from Forgoing Life-sustaining Treatment and Pain Management, Both of Which May Hasten Death

1. Discontinuation of Treatment and Hastening Death

In Catholic teaching, assisted suicide is nothing less than killing. The dignity of the human person is not promoted through acts which destroy life. There is thus an important distinction between suicide and the choice to forgo disproportionate life-sustaining treatment.

Cardinal Bernardin is "at the end of [his] earthly life." App., infra, 1a. His decision to discontinue chemotherapy will probably hasten his death. Similarly, a decision to forgo disproportionate life-sustaining treatment (though the person may die) does not necessarily entail an intention to kill. Both decisions are consistent with Church teaching on due proportion in the use of remedies. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 11-12 (1980). As noted in the *Directives*, p. 21:

> We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome.

2. Pain Management and Hastening Death

In the course of treatment, patients often require increasing doses of medications like morphine to control their pain. In seeking to control pain, the prescribing physician runs the risk of depressing respiration, and thus while trying to manage pain, hastening death. A. Hardie, "Morphine Drip Has Little Opposition," *Atlanta Constitution*, Mar. 8, 1995, p. C3; L. Lamberg, "Treating Depression in Medical Conditions May Improve Quality of Life," 276 *JAMA* 857 (1996). In such circumstances, there is no intention to kill the patient. Death is not the object of the act. Nor is "hastening death" the *means* used to relieve pain, even though death may be foreseen.

The practice of prescribing effective pain relief that may, at the same time, hasten death as a foreseen yet unintended consequence is supported by both the medical profession and Catholic teaching:

> Medications capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death. *Directives*, p. 23; cf. *Declaration on Euthanasia*, supra, pp. 7-9; Pius XII, *Address* of 24 February 1957: *Acta Apostolicae Sedis* 49, p. 147. See also Kathleen M. Foley, "Pain, Physician-assisted Suicide, and Euthanasia," 4 *Pain Forum* 163, 164 (1995).

This analysis is consistent with the principle of double effect, Thomas O'Donnell, *Medicine and Christian Morality* 29 (1976), as understood in both the Catholic moral tradition and the medical profession. E.g., D. Gianelli, "Assisted Suicide or Pain Relief?" *American Medical News*, July 1, 1996, p. 3; D. Wintersheimer, "The Role of Courts in Terminating Nutrition and Hydration for Incompetent Patients," 10 *Issues in Law & Medicine*, 453, 457 (1995). Moreover, it points out the fallacious reasoning of the Ninth Circuit, which concedes its lack of appreciation for the concept:

> More specifically, we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the

patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other. Wash. Pet. App. A-82.

Of course, in the case of palliative care and forgoing disproportionate life-sustaining treatment "the intended result" is *not* death, but the alleviation of pain or burden. The fact that killing and withdrawal of treatment might both "hasten death" does not render them morally equivalent.

Accordingly, those who forgo life-sustaining medical interventions and those who seek a fatal dose of medication from a physician are not "similarly situated." Physicians respecting the right of a patient to refuse life-sustaining treatment are not similarly situated to physicians who comply with a patient's request for the means to accomplish a fatal drug overdose. Statutory schemes permitting the former and prohibiting the latter simply reflect society's respect for bodily integrity and its condemnation of homicide. As such, they are not subject to judicial review under the Equal Protection Clause.

III. The Government Has a Paramount Interest in Preventing the Killing of Human Beings That (1) Outweighs Any Purported Liberty Interest in Receiving Aid from a Physician to Kill Oneself, and (2) Justifies Treating Assisted Suicide Differently from the Withdrawal of Life-Sustaining Treatment

Even if the Court were to find that there is a liberty interest in "hastening one's death" by assisted suicide, or that those seeking to "hasten death" by forgoing life-sustaining treatment and by assisted suicide are "similarly situated," the government may still prohibit assisted suicide if it can demonstrate a sufficient interest in doing so. For Equal Protection purposes, the state need only show a rational basis for the legislation. N.Y. Pet. App. 21a. For Due Process purposes, a balancing test may be employed. E.g., Wash. Pet. App. A-22. In either case, the Washington and New York statutes should be upheld because those states have a compelling interest in prohibiting assisted suicide, sufficient to outweigh any purported liberty interest in private consensual killing, and sufficient to justify distinguishing between revocation of consent to life-sustaining treatment and receiving physician assistance in killing oneself.

A. Preserving Life

The Ninth Circuit accurately describes the state's unqualified interest in preserving life:

> [T]he State may assert an unqualified interest in preserving life in general. As the Court said in *Cruzan*, "we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life. . . ." *Cruzan*, 497 U.S. at 282. Thus the state may assert its interest in preserving life in all cases, including those of terminally ill, competent adults who wish to hasten their deaths. Wash. Pet. App. A-65.

Unfortunately, the court then ignores its own observation, concluding that Washington does *not* have an interest in preserving life simply because, like most states, it permits patients to refuse or revoke consent for life-sustaining medical treatment. Id. The Second Circuit employs essentially the same argument. See N.Y. Pet. App. 32a.

This approach is flawed in two ways. First, it simply begs the question of whether forgoing life-sustaining treatment can be equated with aiding a person in committing suicide. As demonstrated above, it cannot. Washington and New York do not value life any less simply because their citizens have the right to be free from non-consensual touchings. See RCW 70.122.010 (basing right to withdraw treatment on the right to individual autonomy); N.Y. Pub. Health Law, section 2892 (codifying state common law to same effect).

Second, after paying lip service to the principle that "'a state may properly decline to make judgments about the "quality of life" that a particular individual may enjoy,'" the Ninth Circuit employs the most dangerous form of utilitarian reasoning, unjustifiably devaluing the lives of terminally ill persons: "When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling." Wash. Pet. App. A-72. The Second Circuit is even more blunt:

> [W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. . . . What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life . . .?" The greatly reduced interest of the state in preserving life compels the answer to these questions: "*None.*" N.Y. Pet. App. 31a (emphasis added).

Both courts below have fallen into the same conceptual trap. They have looked to language in *Casey* and in this Court's other abortion cases which weigh against the rights of the woman, the variable state interest in protecting the life of a fetus, a state interest which this Court has found to vary with the fetus's increasing "potentiality" for life. See *Casey*, 505 U.S., p. 869-73.[7] These precedents are totally inapposite, notwithstanding the fact that they do accord "potential life" at least some weight in the balance. See *Casey*, 505 U.S., p. 871 (abortion may be restricted after viability).

In the case of assisted suicide, the value of life is not subject to a sliding scale. There is no disputing the status of terminally ill persons: they are persons at all times and for all constitutional purposes, and their lives have as much value and meaning as the life of any other person. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (striking statute permitting physician-assisted suicide by terminally ill persons because it denied them equal protection of the law). Thus, Washington and New York each have a paramount interest in preserving life, and in ensuring equal protection of the law for all lives, including the lives of those who are terminally ill.

B. Preventing Suicide

Washington and New York have decided that suicide is so dangerous to their citizens and to the social order that it ought to be a crime to aid or abet a person attempting to kill themselves. As shown above, these states are not alone, for suicide and assisted suicide have traditionally been prohibited. See Wash. Pet. App. A-39 to A-47; N.Y. Pet. App. 18a-19a; section I.B., supra. Indeed, under most states' laws, those contemplating suicide

are *per se* subject to involuntary commitment, and citizens have a privilege to interfere with anyone attempting to commit suicide. *Cruzan*, 497 U.S., p. 298 (Scalia, J., concurring).

Neither Court of Appeals disputes the state's legitimate interest in preventing suicide. Instead, both courts apply the same flawed reasoning to this interest as they do to the state's interest in preserving life. In both cases, the courts below devalue the lives of terminally ill persons simply because they express a wish to die and are going to die anyway. However, the state's interest in preventing suicide does not diminish simply because a suicidal person "wants" to die.[8]

C. Protecting the Integrity of the Medical Profession, Especially in a Managed Care Environment

The state also has an important interest in protecting the integrity of the medical profession or, as Judge Noonan put it, denying to physicians "the role of killers of their patients." See *Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9th Cir. 1995), vacated, 79 F.3d 790 (9th Cir. 1996) *(en banc)*. See also Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good,* pp. 205-206 (1988); Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice* (1981). The courts below dismiss this by simply assuming that states will adopt safeguards to protect patients, but the states' power to adopt safeguards does not lessen their interest in the first instance in seeking the most effective way to guard against the perversion of the role of a physician. Similarly, a health care environment dominated by managed care might create economic incentives which the state must properly offset through criminal legislation.

In response to the dramatic rise in health care expenditures, cost-conscious insurers have increasingly adopted principles of managed care (AMA, Council on Ethical and Judicial Affairs, "Ethical Issues in Managed Care," 273 *JAMA*, p. 330 (1995). Managed care plans' techniques to control provider costs include fixed per-patient payments, restricted treatment options and financial incentives to promote efficient care. Id. The most tightly managed plans pay fixed sums for enrolling a patient. The amount of the provider's payment, therefore, is not dependent on whether services are rendered to the patient.

Managed care can serve many legitimate health policy purposes. Yet, managed care requirements can place physicians and other providers in situations rife with difficult ethical concerns. The needs of patients can conflict with the financial interests of providers. Id., p. 331. In managed care settings, providers often accept some financial risk in the treatment of their patients. This risk may be substantial when treating terminally ill patients who often require expensive treatment. In addition, the economic incentives of managed care can be structured so as to inappropriately reward minimum treatment and the shortest possible hospital stays. Cf. Newborns' and Mothers' Health Protection Act of 1996, P.L. 104-204, 1996 HR 3666, 110 Stat. 2874, 2935 (Sept. 26, 1996) (requiring health plans offering childbirth benefits to provide minimum inpatient coverage for at least 49 hours following vaginal deliveries and 96 hours following cesarean sections). Health care providers feel these economic pressures. Porter Storey, M.D., medical director of the Texas Medical Center's hospice in Houston, has stated, "[T]he [financial] incentives in managed care make euthanasia the most cost-effective choice." R. Sorelle, "Fear of Pain," *Houston Chronicle*, Oct. 21, 1996, p. 1.

Providing constitutional protection for physician-assisted suicide would provide a new treatment "option" for patients. In order to satisfy the doctrine of informed consent, a physician could be legally obligated to disclose an "option" to physician-assisted suicide to terminally ill patients. See Barry R. Furrow, et al., *Health Law,* section 6-11(e), p. 424 (1995). See also Patient Self-Determination Act, 42 U.S.C., sections 1395cc(f)(1)(A)(i)-(ii), 1396a(w)(1)(A)(i)-(ii) (hospitals must inform patients of state law health care rights). Due to the financial incentives inherent in managed care, the physician could benefit financially from a patient's decision to commit suicide. This development may place a physician in a serious dilemma between the ethical constraint to "do no harm" and the ability to gain financially should the patient choose the now "legitimate" treatment option of physician-assisted suicide.[9] Of course, rather than trusting their providers, patients will then have to question the providers' motivations to discern the most appropriate course of treatment.

Recognizing a right to assisted suicide also raises a host of difficult questions for health care providers which were dismissed by the lower courts as mere regulatory matters. Wash. Pet. App. A-102 to A-104; N.Y. Pet. App. 34a n. 4. What if the physician morally objects to assisted suicide? Must hospitals which institutionally object to assisted suicide (e.g., Catholic hospitals) be required to cooperate in the performance of such a procedure or allow physicians on staff who perform these acts? Cf. *Directive 60* (App. B). How must payors cover assisted suicide costs? These are not merely hypothetical questions. E.g., *Lee*, 891 F. Supp. 1429.

Recognizing a "right" to physician-assisted suicide will subvert the integrity of the medical profession. States not only have an important interest, but a compelling reason, to protect their citizens from abuses and to protect the integrity of the health care profession.

D. Preventing Abuse

The state can and should prevent the involvement of third parties in so grave a matter as suicide. Even if suicide itself is not illegal, allowing others to take part in the process will increase the risk of abuse, and expose vulnerable patients to family and financial pressures from which they should be insulated.[10]

The state also has an interest, as it always has when enacting criminal legislation, in avoiding the adverse consequences anticipated from the actions it seeks to prohibit. E.g., *People v. Kevorkian*, 210 Mich. App. 601, 534 N.W.2d 172, 175 (1995)(Dr. Kevorkian's "actions implicate the criminal law and his words and actions amount to an advertisement for criminal and unethical conduct"), appeal denied, 549 N.W.2d 566 (Mich. 1996), cert. denied, 65 U.S.L.W. 3287 (U.S. Oct. 15, 1996) (no. 96-135). Here, the state can legitimately point to the fear of abuse, undue influence and the improper killing of people in situations that are not truly voluntary. This has already happened in the Netherlands, where assisted suicide has been virtually legal for 15 years. Unfortunately, the attempt in the Netherlands to afford "compassion" to the dying has devolved into state-sanctioned non-voluntary euthanasia.

Between 1981 and 1991, the Dutch inexorably moved along a continuum from a heavily regulated regimen of physician-assisted suicide for the informed, competent adult to the non-voluntary euthanasia of infants ("Physician-Assisted Suicide and

Euthanasia in the Netherlands," *Report to the Constitution Subcommittee of the House Committee on the Judiciary*, 104th Cong., 2d Sess. (1996) (*"Constitution Subcommittee Report"*).

In 1991 the Dutch Attorney General issued the Remmelink Commission Report (id., p. 12), finding that in 1990 there were:

> 2,300 cases of voluntary euthanasia; 400 cases of physician-assisted suicide; and more than 1,000 cases of non-voluntary euthanasia.

In order to justify these non-voluntary euthanasia cases, the Commission explained that

> [T]he ultimate justification for the intervention is in both cases the patient's unbearable suffering. So, medically speaking, there is little difference between these situations and euthanasia, because in both cases patients are involved who suffer terribly. *Constitution Subcommittee Report*, p. 13, quoting Ministerie van justitie, Netherlands, *Outlines Report Commission into Medical Practice with Regard to Euthanasia* 3 (1990).

The Commission also found that 14 percent of the non-voluntary euthanasia cases were performed on patients who were fully competent and 11 percent of the patients were partially competent. Id.

The Commission also found that of the 8,100 cases of morphine overdose in 1990, in 36 percent of the cases the physician's single intent or partial intent was that the morphine kill the patient. Id. In over 50 percent of the cases, the physicians administered the morphine overdose without the patient's consent. Id. Twenty-seven percent of these non-consenting patients were fully competent. Id. The Commission also reported on 25,000 cases of withdrawal of life-sustaining treatment without the patient's consent. Id.

Our society has known from its earliest times that it was dangerous to allow any ambiguity in the rule against killing. The "rights" recognized by the Ninth Circuit and the Second Circuit are no innocuous grants of personal freedom. *Compassion in Dying* and *Quill* strike at the most fundamental ethical tenets of Western culture. Indeed, they are an invitation to murder. As Cardinal Bernardin states, "[T]here can be no such thing as a 'right to assisted suicide' because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent is self-administered. Creating a new 'right' to assisted suicide will endanger society and send a false signal that a less than 'perfect' life is not worth living." App., p. 2a.

Conclusion

The decisions of the United States Courts of Appeals for the Second and the Ninth Circuits should be reversed.

Appendix A
Statement of Joseph Cardinal Bernardin

The Supreme Court of the United States
Washington, D.C.

Dear Honorable Justices:

I am at the end of my earthly life. There is much that I have contemplated these last few months of my illness, but as one who is dying I have especially come to appreciate the gift of life. I know from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention.

In this case, the Court faces one of the most important issues of our times. Physician-assisted suicide is decidedly a public matter. It is not simply a decision made between patient and physician. Because life affects every person, it is of primary public concern.

I have often remarked that I admire the writings of the late Father John Courtney Murray, who argued that an issue was related to public policy if it affected the public order of society. And public order, in turn, encompassed three goods: public peace, the essential protection of human rights, and commonly accepted standards of moral behavior in a community.

Our legal and ethical tradition has held consistently that suicide, assisted suicide, and euthanasia are wrong because they involve a direct attack on innocent human life. And it is a matter of public policy because it involves a violation of a fundamental human good.

There can be no such thing as a "right to assisted suicide" because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent of death is self-administered. Creating a new "right" to assisted suicide will endanger society and send a false signal that a less than "perfect" life is not worth living.

Physician-assisted suicide also directly affects the physician-patient relationship and, through that, the wider role of physicians in our society. As has been noted by others, it introduces a deep ambiguity into the very definition of medical care, if care comes to involve killing. Beyond the physician, a move to assisted suicide and, perhaps beyond that, to euthanasia creates social ambiguity about the law. In civilized society the law exists to protect life. When it begins to legitimate the taking of life as a policy, one has a right to ask what lies ahead for our life together as a society.

In order to protect patients from abuse, and to protect society from a dangerous erosion in its commitment to preserving human life, I urge the Court not to create any right to assisted suicide.

With cordial good wishes, I am

Sincerely yours,
Joseph Cardinal Bernardin
Archbishop of Chicago
Chicago, Illinois
November 7, 1996

Appendix B

The National Conference of Catholic Bishops has directly dealt with euthanasia and assisted suicide. *Directive 60* states:

> Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, p. 23 (1995).

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Physician-Patient Relationship Would Be Threatened

"Physician-assisted suicide also directly affects the physician-patient relationship and, through that, the wider role of physicians in our society. As has been noted by others, it introduces a deep ambiguity into the very definition of medical care, if care comes to involve killing."

One of the cardinal's final points is that a right to physician-assisted suicide could cause a deep rift between physician and patient. The integrity of the medical profession has always been based on the physician's role as healer. We already hear allegations that the financial incentives involved in managed care undermine the physician's fiduciary responsibility to patients. When a physician is at financial risk in patient care, fiscal considerations can become more central to the physician-patient relationship. The legitimization of physician-assisted suicide could only undermine the trust necessary to this relationship. Physicians who assist in killing patients, even for supposedly sympathetic reasons, would ultimately undermine their rightful position as healers.

These observations regarding the relationship between physician and patient are relevant to the Court because of the state's traditional role as the primary regulator of the professions. If the state believed that it was necessary to outlaw a practice that could undermine the trust between physician and patient—namely, physician-assisted suicide—a court might well find that this state interest justifies a criminal ban on the practice. Neither the Ninth Circuit nor the Second Circuit believed that this state interest justified the application of the criminal statutes at issue in the context of physician-assisted suicide for competent terminally ill patients.

Cardinal Left A Message of Hope

It is certain that we will all eventually face the same journey our brother Joseph traveled. We know we must die. But, because of the cardinal's openness and pastoral guidance, we may better understand the inevitability that confronts us. As the authors of this article have tried to show, Card. Bernardin's appeal to the Supreme Court states the legal argument against assisted suicide well. But it does more. The cardinal's observations, derived from his experience as a religious leader and policymaker, offer us hope that we too can confront death without fear, in the assurance that we will be cared for by competent and compassionate caregivers. The authors hope, moreover, that the Court will consider the cardinal's teachings and experience and reject constitutional protection for assisted suicide. □

CHA Amicus Curiae Brief

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NOTES

1. "Disproportionate means are those that in the patient's judgement do not offer a reasonable hope of benefit or entail an excessive burden . . ." (*Directives*, pp. 22-23).
2. Catholic teaching has historically been a major force in the development of Western thought (R. J. Araujo, "Thomas Aquinas: Prudence, Justice and the Law," 40 Loy. L. Rev. 897, 913-915, 921 [1995]; G. N. Herlitz, "The Meaning of the Term 'Prima Facie,'" 55 La. L. Rev., 391, n.5 [1994]). On end-of-life issues, courts have referred freely to historical Catholic teachings in their examination of this society's moral traditions (e.g., Wash. Pet. App. A-131 to A-134 [Beezer, J., dissenting]; *In re Quinlan*, 355 A.2d 647, 659-60 [N.J.], cert. denied, 429 U.S. 922 [1976]).
3. E.g., the Council of Arles (452), the Council of Braga (563), the Antisidor Council (590) and the Synod of Nimes (1274) (T. Marzen, M. O'Dowd, D. Crone, and T. Balch, "Suicide: A Constitutional Right?" 24 Duquesne L. Rev. 1, 57, 60 [1985]).
4. The Court's decision in *Casey* was heavily influenced by the doctrine of stare decisis, leading certain members of the Court to recognize a liberty interest in having abortion in deference to *Roe. v. Wade*, 410 U.S. 113 (1973), even if they might not have done so in the first instance (505 U.S., p. 853). Thus, the Court set the case apart: "Abortion is a unique act. . . . [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." Id. "[O]ne could classify *Roe [v. Wade]* as *sui generis*." Id., p. 857 [plurality]. Accord id., p. 952 [Rehnquist, C.J., concurring and dissenting]). Indeed, "because *Roe*'s scope is confined by the fact of its concern with postconception *potential* life, . . . any error in *Roe* is unlikely to have serious ramifications in future cases." Id., p. 859 (emphasis added). The abortion precedents are simply not applicable in other contexts, and cannot provide a basis for extending "privacy" or "liberty" to assisted suicide.
5. E.g., *Cruzan*, 497 U.S., p. 279, n.7: Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional, right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest. See *Bowers v. Hardwick*, 478 U.S. 186, 194-195 (1986).
6. The assertion that different courses of conduct are equivalent simply because they cause the same result is absurd. Accidents, self-defense, and murder all cause deaths. Abortion and feticide both kill fetuses. Illegal drugs and alcohol both cause intoxication. The law treats all of these matters differently because they all involve different conduct. Of course, the source of the Ninth Circuit's confusion is that it improperly identifies the effect (i.e., causing death) as the right assumed in *Cruzan* instead of the means (i.e., withdrawal of life-sustaining treatment). Cf. Bernardin, App., infra, 1a-2a.
7. Of course, this Court's entire abortion discussion proceeds from the assumption that the fetus is something less than a "person" recognized at law. See *Casey*, 505 U.S., p. 982 (Scalia, J., concurring and dissenting). The CHA does not agree with the Court's conclusion, nor with its approach to statutes restricting or prohibiting abortion, but the Court's devaluation of the life of the fetus in abortion cases is still distinguishable from this case, involving other living persons.
8. Of course, everyone who attempts suicide *claims* to "want" to die. However, as the Ninth Circuit admits, "[S]tudies show that many suicides are committed by people who are suffering from treatable mental disorders." Wash. Pet. App. A-73.
9. The physician's Hippocratic oath states "[I will] abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel." AMA, *The Health Care Almanac* 120 (1995).
10. The Ninth Circuit acknowledges the risk of these pressures, but appears unconcerned: "We are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration [in requesting assistance in committing suicide]." Wash. Pet. App. A-87.

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