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EXPLORING PHYSICIAN-ASSISTED SUICIDE: AN EXAMINATION OF THE CIRCUIT COURT DECISIONS AND PUBLIC POLICY CONCERNS

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As a member of the New York State Task Force on Life and the Law, I am sure it will come as no surprise to this assembly that I am opposed to physician-assisted suicide. After participating for many months, in fact years, in drafting the 1994 Task Force Report, *When Death is Sought*,¹ I concurred in its conclusion that neither the United States Constitution nor the New York Constitution grants individuals the right to suicide assistance or euthanasia.²

I do not believe there is "a constitutional right to die" in that sense. In my hand is the Task Force Report. The only slightly macabre thing we did was to print the cover of the Report in dark gray. At least it was not black! Actually, I think you will find the Report itself very uplifting and informative. I would recommend to anybody who has had the interest to be here today to read the Report in its entirety. It delves into many of the issues that were eloquently raised by the three speakers before me. Although we did not exchange with each other what we

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Monsignor Alesandro has served as a consultant to the National Conference of Catholic Bishops on various issues. In 1985, he was appointed by then Governor Mario Cuomo as one of the original members of the New York State Task Force on Life and the Law.

1 See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 71, 83 (1994) [hereinafter *WHEN DEATH IS SOUGHT*] (defining assisted suicide as death which is assisted by another person but in which the person takes his or her own life).

2 See *id.* (finding no constitutional basis for protecting right to physician-assisted suicide).

would talk about today, it is interesting that we are not really overlapping too much.

We have heard a lot about ethics from the law professor. We have heard a lot about medicine from the lawyer. We have heard a lot about the approach of a good trial attorney. And now you are going to hear a clergyman's view, along with the legal analysis of these court cases. This is the approach I have taken. Later this afternoon you will get much more into the policy issues, which are extremely important, and, in my opinion, more significant than the constitutional issues.

I must admit that in drawing our conclusion, neither myself nor the members of the Task Force anticipated how quickly such a question would be brought before the United States Supreme Court. Moreover, I certainly agree with Mr. Schwartz that Dr. Kevorkian's pursuit of his science of "obitiatry," as he calls it, was very instrumental in raising these questions. Although questions were raised, inadequate answers were given by the Circuit Courts. We must all give good answers no matter what position one takes in this debate.

The first occasion for the court to address end-of-life issues arose in the 1990 case of *Cruzan v. Director, Missouri Department of Health*.³ In that case, the Court did not even reach the question of whether refusal of treatment, much less suicide, was a constitutionally protected right.⁴ The Justices simply assumed it to be so, in order to address the point of the case: Whether Missouri could require clear and convincing evidence of the patient's wishes before permitting life sustaining treatment to be withdrawn.⁵ The issue involved the "clear and convincing" language, an evidentiary standard shared by only one other state, New York.⁶

3 497 U.S. 261, 278 (1990) (recognizing that existence of right to refuse medical treatment is inherent in liberty interest of Fourteenth Amendment).

4 See *id.* at 279 (assuming that United States Constitution would grant competent person constitutionally protected right to refuse life-saving hydration and nutrition).

5 See *id.* at 277 (stating that issue was whether Due Process Clause allowed Missouri to require incompetent patient in irreversible persistent vegetative state to remain on life support absent clear and convincing evidence that avoiding treatment represented patient's prior, express choice).

6 See *id.* at 282-83 (discussing clear and convincing standard of proof and explaining that standard was utilized because individual interests at stake were both "particularly important" and "more substantial than mere loss of money"); *Westchester County Medical Center v. O'Connor*, 531 N.E.2d 607, 614 (N.Y. 1988) (exploring principles which may be used in "determining whether the proof 'clearly and convincingly' evinces an intention

One should also remember that Justice Brennan, who was previously quoted, himself distinguished withholding or withdrawing life-sustaining treatment from suicide as the basis for his support of the conclusion in the *Cruzan* case.⁷ Another thing to consider when reading the *Cruzan* case is that it appears that Justice Scalia's arguments, strangely enough, do not concur with this point of view.⁸ He might not draw this conclusion, but I think that his reasoning in *Cruzan* would lend more weight to the Circuit Court's rationale in the *Quill v. Vacco* case.⁹ It would be interesting to hear Professor Gostin's views on this point. I believe that Scalia's *denial* of the distinctions, which is the focus of my discussion, is within the Circuit Court's line of reasoning, although he draws vastly different conclusions for states' rights reasons. He proffers, "[t]he Constitution does not address this issue. Get out of my court." I am just parodying this, of course, he didn't quite say that. But the idea is: "Get out of my court and go back to your legislatures and talk about it there." Although I think he reaches the proper conclusion, I am not sure I agree with the reasoning.

The article that I published on physician-assisted suicide originated as a paper for Professor Polestino. If any of you have taken his courses in criminal law you might notice a few of those little cases in there that he always likes to talk about. In that article, I asserted rather boldly that there is no recognized constitutional right to commit suicide and that it is unlikely that such a right will develop in the foreseeable future.¹⁰

And then I opined, rather naively as a law student, that, if anything, the trend is in the opposite direction. (This is actually written down—Never write too much down, let me tell you!) The courts are justifying any application of the right to privacy in the medical treatment field by expressly *disassociating* such matters

by the patient to reject life prolonged artificially by medical means"); *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1981) (utilizing "clear and convincing" standard and determining that evidence satisfied such standard).

⁷ See *Cruzan*, 497 U.S. at 304-308 (finding that right to refuse life-sustaining treatment is distinguishable from sanctioning physician-assisted suicide).

⁸ See *id.* at 292-301 (Scalia, J. concurring).

⁹ 80 F.3d 716 (2d Cir.), *rev'd* 117 S. Ct. 2293 (1997) (finding New York statute banning physician-assisted suicide unconstitutional).

¹⁰ See Msgr. John A. Alesandro, *Physician-Assisted Suicide and New York Law*, 57 ALB. L. REV. 819, 912-13 (1994) (asserting that physician-assisted suicide is forbidden under current penal law and predicting that courts will uphold this prohibition).

from suicide.¹¹ It was perfectly true, but my prediction was not. Then a few days before the Second Circuit handed down its decision in *Quill v. Vacco*,¹² I publicly predicted, on a television program, that it would probably affirm the lower court. With that track record, you can appreciate the fact that I am loath even to think about what may loom on the legal horizon, much less say it.

Nonetheless, I would like to state in this introductory presentation my conclusions, such as they are, concerning some of the issues surrounding physician-assisted suicide. These conclusions will appear in a more developed form in the soon-to-be published position paper by the Task Force.

The Ninth and Second Circuit decisions, both of which are currently on appeal before the Supreme Court, are, to me, flawed in their legal reasoning and conclusions. In order to save time, I will not discuss these flaws because they have been stated already and also appear in my paper. Both decisions, despite their unique approaches, reject the legal significance of two very important distinctions that should not be so easily discarded. The first is the distinction between refusal of life-sustaining medical treatment and suicide,¹³ and the second is the difference between the use of drugs to relieve pain and the use of drugs to cause death.¹⁴

The Ninth Circuit concluded that *Cruzan's* recognition of a liberty interest that includes a refusal of artificial provision of life-sustaining food and water is necessarily a simultaneous recognition of a liberty interest in "hastening" one's own death.¹⁵ The

11 See Christine H. Noonung, *Surrogate Health Care Decision Making: The Pennsylvania Supreme Court Recognizes the Right of an Individual in a Permanent Vegetative State to Refuse Life-Sustaining Measures Through a Surrogate Decision Maker*, 35 DUQ. L. REV. 849, 855 (1997) (discussing Supreme Court's pending decision on issue of whether liberty interest within Due Process Clause protects right to hasten one's own death).

12 80 F.3d 716 (2d Cir.), *rev'd*, 117 S. Ct. 2293 (1997).

13 See Kenneth R. Thomas, *Confronting End-of-Life Decisions: Should We Expand the Right to Die?*, 44 FED. LAW 30, 36 (1997). Often the distinction between active euthanasia and assisted suicide is blurred. *Id.* The distinction between the two terms is legally and practically significant because in the case of assisted suicide, the actual fatal procedure is completed by the patient, whereas the situation is quite different if another person implements the procedure. *Id.*

14 See *id.* (describing intent of palliative care as relief of pain); see also *Oral Arguments in Vacco v. Quill*, 12 ISSUES L. & MED. 417, 420 (1997) (responding to questioning by Justice Ginsberg, New York Attorney General Dennis Vacco pointed out difference between drugs that cause death, death from the underlying illness, and withdrawal of nutrition and hydration).

15 See *Jon L. Spargur, Jr., First Healthcare Corp. v. Rettinger: Are Living Wills Dead*

Court also determined that assisted suicide is not distinguishable from the administration of opiate pain medication, whose known effect is to hasten the end of the patient's life.¹⁶

The Second Circuit, in *Quill v. Vacco*, also concluded that in every case in which death is "hastened"—it is very important to remember this word when you read these two cases—it is by means that are not natural in any sense whether by withdrawal of life-sustaining treatment or by self-administration of prescribed drugs.¹⁷ Claiming application of the lowest level of scrutiny, the Second Circuit concluded that any distinction that may exist is not rationally related to any legitimate state interest.¹⁸ Both Circuits have ignored a long tradition of cases which have not only upheld the distinction between refusal of life-sustaining treatment and suicide, but have actually based their reasoning in permitting refusal on that very distinction.¹⁹

New York is a very interesting state in which to explore the issues revolving around the legal recognition of a right to refuse treatment, in relation to both the common law and the Constitution. There has been much resistance here to labeling the refusal of treatment as a constitutional right.²⁰ The lines have become blurred in the end, as is exemplified by *Fosmire v.*

in North Carolina?, 32 WAKE FOREST L. REV. 591, 602 (1997) (reiterating Ninth Circuit's narrow holding that "the provision of Washington law which criminalized aiding a suicide, as applied to terminally-ill, competent adult patients who wanted life-ending medication prescribed by their physicians to hasten their deaths, violated the Due Process Clause").

¹⁶ *Quill*, 80 F.3d at 729-30 (2d Cir. 1996) (equating administration of palliative drugs with assisted suicide).

¹⁷ *Id.* at 729 (stating that these means of hastening death are "not natural in any sense").

¹⁸ *Cruzan*, 497 U.S. at 280-285. The Court discussed the State of Missouri's interest in preserving an individual's autonomy, while simultaneously safeguarding against potential abuse of this autonomy. *Id.* at 281.

¹⁹ See, e.g., *Kevorkian v. Thompson*, 947 F. Supp. 1152, 1167 (E.D. Mich. 1997) (relying on assumption that United States Constitution "would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition"); *Deel v. Syracuse Veterans Administration Medical Center*, 729 F. Supp. 231, 233-34 (N.D.N.Y. 1990) (finding patient's right to refuse life-sustaining medical treatment outweighed state's interests in preserving life and preventing suicide); *Gray v. Romero*, 697 F. Supp. 580, 589 (D.R.I. 1988) (reasoning that state interest in preventing suicide was not an issue, due to obvious distinction between deliberate ending of life by artificial means and allowing nature to take its course).

²⁰ See John D. Arras, Ph.D., *Physician-Assisted Suicide: A Tragic View*, 13 J. CONTEMP. HEALTH L. & POL'Y 361, 375 (1997) (posing question: "If we have a protected liberty interest in determining the time and manner of our deaths, then to what extent will various regulatory schemes cut too deeply into our personal choices?").

Nicoleau,²¹ a constitutionally based decision. Regardless of a common law or constitutional analysis, there is no case requiring recognition of a right to assistance in suicide.²² The two matters are legitimately distinct.

First, the right to refuse medical treatment arises from the right to be free of intrusion, in this case, the right to be free of battery, and is unrelated to the so-called "right to hasten death."²³ The right in question is the right to make decisions regarding one's medical treatment, even when foregoing that treatment may result in one's death. For both Circuit Courts to ignore the well developed tradition on the relation of battery and informed consent to medical treatment is a very major weakness in their analysis.

This is the doctrine that has developed in our modern age to deal with technologically extended dying processes.²⁴ I am not trying to say this was all black and white and that there are not very extreme cases. Mr. Schwartz has already poignantly described these to us and we must address those issues.

This doctrine has been applied, however, to life-sustaining devices because of the simple fact of the development of these life-sustaining devices.²⁵ As *Cruzan* states, ". . . with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treat-

21 75 N.Y.2d 218 (1990) (holding that patient had right to determine course of her own medical treatment, including right to decline blood transfusions, and noting that there was no showing that State had superior interest in matter).

22 See Stephen L. Mikochik, *Assisted Suicide and Disabled People*, 46 DEPAUL L. REV. 987, 991-992 (1997) (illustrating our Nation's "scant support for a right to die" by noting that "[t]oday, Oregon, alone of the fifty states, sanctions assisted suicide).

23 WHEN DEATH IS SOUGHT, *supra* note 1, at 72. The report noted:

[T]he right to refuse treatment has a well-established history in the laws of informed consent and battery. . . [but] individuals have never been granted a right to control the timing and manner of their death; indeed, suicide was illegal in many states for most of this nation's history, and, even after decriminalization, society continues to discourage suicide and seek to prevent individuals from taking their own lives.

Id.

24 See Kathleen M. Boozeing, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITT. L. REV. 549, 555 (1997). The shift in our focus from understanding and preparing for death coincides with the ability of technology to prolong the dying process. *Id.*

25 Adam A. Milani, *Better Off Dead than Disabled?: When Doctors Fail to Honor Patients' Advance Directives?*, 54 WASH. & LEE L. REV. 149, 151 (1997) (stating that these types of cases and statutes have arisen because advances in medical technology have drastically changed the way physicians treat patients).

ment have burgeoned.”²⁶ The patient has a right against intrusion, not a general right to control the timing and manner of death.²⁷ The Task Force asserts that restrictions on suicide, in contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.²⁸

Aside from the legal tradition regarding intrusion, equating refusal of life-sustaining treatment with intentionally causing one's own death is alien to the modern sense of a patient's autonomy in his or her medical care. It dismisses as legally irrelevant the fact that people die from underlying diseases and medical conditions, circumstances and outcomes to which they are resigned, as was very well stated today.

In a sense, the courts have put on blinders by limiting their reasoning to but-for causation rather than legal causation with respect to policy considerations, which, as I stated before, is the most important question.²⁹ The inevitable result is that the phrases “allowing one to die” and “causing death” eventually come to mean the same thing. Ethically, legally, or personally, however, they are not identical concepts. Similarly, to term both the ingestion of lethal drugs and the refusal of technological life-sustaining treatment or measures as unnatural, is really equivocal, and is even disingenuous on the part of the Court.³⁰

The denial of the traditional distinctions undermines the

²⁶ *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 270 (1990).

²⁷ See *WHEN DEATH IS SOUGHT*, *supra* note 1, at 71. The Report states explains that it is “this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment.” *Id.*

²⁸ Brief of United States Catholic Conference et al., as Amicae Curiae in Support of Petitioners, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (No. 95-1858), available in 1996 WL 656248, at *11 (citing *WHEN DEATH IS SOUGHT*, at 71). The Brief notes that the four critical differences between declining treatment and assisting suicide (1) does not implicate the interest in being free of bodily invasion, (2) has been consistently criminalized under the common law and by statute, (3) does not involve death from natural causes, and (4) involves a direct and unambiguous intention to cause death. *Id.*

²⁹ See Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371, 374-75 (1997) (offering compelling reasons to maintain traditional line between killing and letting die, and describing authors' initial analysis as philosophical, moral, and pragmatic).

³⁰ See Edward R. Grant & Paul B. Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 OR. L. REV. 449, 460 (1995) (asserting statutes and judicial decisions in area of physician-assisted suicide have recognized distinction between directly causing death by affirmative act ending life and allowing death to occur by withholding or withdrawing life-sustaining medical treatment); see also, Robert F. Weir, *The Morality of Physician-Assisted Suicide*, 20 L. MED. & HEALTHCARE 116, 118 (1992) (arguing distinction exists between acts of assisted suicide and acts of voluntary euthanasia).

court's proposed limitation of the right, thereby giving meaning to the term "slippery slope." This "slope" is not so much about abuses, but more about the risks that we face.³¹ That is the consequentialist argument that Professor Gostin aptly mentioned. But here I want to talk about the slippery slope not merely in terms of abuse, but with respect to the proposed limits of the legal change.

The Circuit Courts are proposing a legal change, and there are proposed limits to that legal change, hence giving rise to the slippery slope. The right to refuse life-sustaining treatment is not currently limited to the terminally ill, nor in many states, to the competent.³² If there is a legal identity of the two rights, by what rationale would the right to suicide assistance be restricted to the terminally ill? Why does it not apply to any person in pain and suffering, or, for that matter, to anyone at all? Incapacitated patients, too, are able to refuse life-sustaining technology in various ways. For example, through the use of advanced directives, health care agents, or surrogates in the decision-making process.³³ Why would those desirous of ending their lives by suicide be treated any differently?

As Judge Reinhardt of the Ninth Circuit alluded to in a footnote, a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.³⁴ Furthermore, the constitutional rationale for legalizing assisted suicide will erode its legal distinction from active euthanasia. Can a doctor or a surrogate be prevented from an "overt act," which is the legal phrase that makes the distinction, if the patient has been recognized to have a right to assistance in committing suicide and yet is incapable of self-administering lethal

³¹ See Margaret P. Miller, *Bootstrapping Down a Slippery Slope in the Second and Ninth Circuits: Compassion in Dying is Neither Compassion Nor Constitutional*, 30 CREIGHTON L. REV. 833, 833 (1997) (concluding that Constitution does not support right to physician-assisted suicide, and that judiciary is ill-suited to create such rights).

³² See Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevoorkian? An Essay on Roe, Casey & the Right to Die*, 44 AM. U. L. REV. 803, 824 (1995) (reiterating New York State Task Force on Life and the Law's position that "a majority of individuals who kill themselves suffer from depression that is treatable" and that "most doctors are not adequately trained to diagnose depression especially in complex cases such as patients who are terminally ill").

³³ See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 274-75 (1990) (discussing refusal of treatment by "surrogate decisionmaker").

³⁴ *Compassion in Dying v. State of Washington*, 79 F.3d 790, 832 n.120 (9th Cir.), *rev'd sub nom*, *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997); *Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *rev'd*, 117 S. Ct. 2293 (1997).

drugs?

Finally, note that the balancing of benefits and risks is quite different for cases of assisted suicide in comparison to treatment refusal, because the latter are usually limited to hospitals or controlled hospice programs, rather than doctors' offices.³⁵ Moreover, the patients affected by an underlying condition requiring life-sustaining treatment are much fewer than those who may choose suicide.³⁶

The second distinction raises to mind the old term, "unconscionable."³⁷ I know it is utilized in the economic field, but it applies here as well. The Ninth Circuit's suggestion that the administration of legitimate opiate pain medication is indistinguishable from suicide assistance is especially unfortunate. Such accepted medical practice is not some sort of euphemism for euthanasia. For one thing, the proper administration of morphine builds up a gradual tolerance in the patient which avoids the side effect of depressing respiration.³⁸

Secondly, even if it did depress respiration, that side effect should be viewed as a legitimate risk of an otherwise sound and prudent form of palliative treatment. The traditional "double effect" justification³⁹ is the only point about which I really take strong issue with Professor Gostin. I think that the Professor

35 See *id.* at 802, 818 (noting that Congress favors permitting adult patients to refuse life-sustaining treatment by advance directive and requires hospitals receiving federal financial support to notify adult patients of their rights to execute powers of attorney, health care proxies, or similar instruments upon admission).

36 See *id.* at 820-21 (explaining that while state has legitimate interest in preventing suicides, interest is substantially diminished in case of terminally ill competent adults who wish to die).

37 See BLACK'S LAW DICTIONARY 1525 (6th ed. 1990). The term "unconscionable bargain or contract" is defined as:

A contract, or a clause in a contract, that is so grossly unfair to one of the parties because of stronger bargaining powers of the other party; usually held to be void as against public policy, . . . one which no man in his senses, not under delusion, would make, on the one hand, and which no fair and honest man would accept, on the other.

Id.

38 Cf. Robert Barry & James E. Maher, *Indirectly Intended Life-Shortening Analgesia: Clarifying the Principles*, 6 ISSUES L. & MED. 117, 130-31 (1990) (discussing various new drugs that may be employed to replace morphine if respiratory depression occurs and describing new synthetic non-opiate pain relievers that are equivalent pain relievers but without respiratory side effects).

39 See Miller, *supra* note 31, at 855 (noting that although some "drug therapies have 'double effect' of providing pain relief, while simultaneously hastening death, the value of the pain relief is such that the American Medical Association permits such therapy, despite its detrimental effects").

provided us with a caricature of double effect,⁴⁰ and not the actual principles of double effect, which is a very hallowed ethical tradition quite applicable even to more extreme cases when death seems inevitable.⁴¹

If the Supreme Court upholds the Circuit Courts' sort of reasoning, a chilling effect will surely settle on the medical community when faced with the true challenge of compassion to a dying patient, to wit, the provision of effective pain control and other palliative measures to take away fear. Finally, I would be remiss not to point out that the Task Force's position against physician-assisted suicide is founded in major part, not on one particular ethical view, but on the practical risks associated with legalization and which imply public policy issues.⁴²

I simply assert the unanimous conclusion of this rather diversified group of doctors, other health care professionals, lawyers, ethicists, clergy and patient advocates, including a representative of the New York Civil Liberties Union:⁴³ The legalization of assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable.⁴⁴ The risks would be most severe for those who are elderly, poor, socially disadvantaged or without access to good medical care.⁴⁵ These public policy issues are extremely germane to the Supreme

40 See Lawrence Gostin, *The Constitutional Right to Die: Ethical Considerations*, 12 ST. JOHN'S J. LEGAL COMMENT. 599 (1997).

41 See Miller, *supra* note 31, at 855-56 (explaining principles of double effect).

42 See *Oral Arguments in Washington v. Glucksberg, in the Supreme Court of the United States (Verbatim)*, 12 ISSUES L. & MED. 393, 395 (1997) (placing protection of life first, prevention of abuse and undue influence second, and interest in regulation of medical profession third, in hierarchy of state interests).

43 See WHEN DEATH IS SOUGHT, *supra* note 1, at 102, ii-iii (pointing out that Commission, appointed by New York Governor Mario Cuomo, was comprised of eight medical doctors, two bioethicists who were not medical doctors, four lawyers, six clergymen, state commissioner of health, state commissioner on quality of care for mentally disabled, and member of New York Civil Liberties Union, along with three medical doctors and one nurse, serving as consultants).

44 *Id.* at 74 n.112. The Task Force noted:

[T]he number of people genuinely harmed by laws prohibiting euthanasia or assisted suicide is extremely small, and . . . legalizing euthanasia or assisted suicide for the sake of these few—whatever safeguards written into the law—would endanger the lives of a far larger group of individuals, who might avail themselves of these options as a result of depression, coercion, or untreated pain.

Id.

45 See *Washington v. Glucksberg*, 117 S. Ct. 2258, 2267 (1997) (quoting N.Y. State's Task Force on Life and the Law in its conclusion that "[l]egalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. . . [T]he potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved").

Court's deliberations. In my opinion, they overwhelmingly support the conclusion that this matter is one for duly elected legislatures and the political process to work out.⁴⁶ It is not for judges to settle with a broad mantle of constitutional authority.

In the end, this issue touches on the relationship of the individual to society and on the very nature of law itself. I think one can see this point from everything that has been said today. How far should the Constitution extend to protect individuals from the political process that shapes and governs their lives? Does ordered liberty require that individuals be able to kill themselves?⁴⁷ Does the Constitution solely safeguard the rights of individuals, or does it somehow imply a certain kind of society and enshrine defined values? Is it constitutionally acceptable for a society, as a whole, to believe and to assert that citizens should not kill themselves, and use its laws to prevent people from facilitating such deaths?

Is autonomy devoid of any social meaning? Is it only the old legal aphorism, that one's right to throw out one's fist ends at another's jaw? Is that the only meaning of autonomy? If so, I see no rationale at all for limiting any change in our legal stance about this. That autonomy right will be complete, it will be absolute. In fact, it will be just like the right that underlies the withholding or withdrawing of life-sustaining treatment. The latter is hardly limited; it is nearly absolute.

At this most fundamental level, where the lives of vulnerable individuals are at stake, I hold that our society has the right and the duty to define itself and to promote that vision for all of its citizens.

Thank you.

⁴⁶ See Miller, *supra* note 31, at 833 (concluding that judiciary is ill-suited to create right to physician-assisted suicide, and that "Congress or State legislatures not only have power, but are more uniquely suited, to address the entire question with all of its ancillary requirements").

⁴⁷ See Grant & Linton, *supra* note 30, at 450 (noting that if society accepts physician-assisted suicide, it is difficult to imagine that it will deny similar "relief" to those patients who request it but are unable or unwilling to take their own lives).