Christian believers must embrace the challenge to act in a way that matches our moral belief in compassionate care for the dying.

Palliative Care Or Assisted Suicide?

By JAMES F. BRESNAHAN

The U.S. SUPREME COURT ANNOUNCED on June 26 unanimous decisions in the cases Washington v. Glucksberg and Vacco v. Quill. All nine Justices agreed in rejecting claims previously accepted by two Federal circuit courts of appeal; they denied that assistance by physicians in suicide is a constitutionally protected right of terminally ill persons and their physicians. But how real was the unanimity among the nine Justices? In fact, differences of viewpoint expressed in the several opinions of the Justices in these cases present us with a continuing challenge: Take better care of the dying.

This challenge is addressed both to those who advocate and those who oppose physician assistance to a terminally ill person in inflicting death on himself or herself to end suffering—PAD (the acronym for the euphemism, “physician-assisted dying”). The challenge will, of course, be perceived differently by proponents and opponents of PAD. Yet I believe that both sides can and should recognize a common ground for shared effort to enhance and broaden access to palliative medicine and hospice care in order to respond to the needs of the terminally ill.


At first reading, the unanimity of the court and the arguments made by Chief Justice Rehnquist in the majority opinions in these two cases may tempt opponents of PAD to rest on their oars. After all, don’t these opinions unambiguously reaffirm the traditionally accepted difference and so a distinction between PAD as “killing” and the practice of palliation as “letting die”? (See “Killing vs. Letting Die: A Moral Distinction Before the Courts” Am., 2/1.)

The majority opinions by the Chief Justice are joined directly by Justices Antonin Scalia, Clarence Thomas and Anthony Kennedy, and joined as well by Justice Sandra Day O’Connor in a single concurring opinion (applicable to both cases) that is joined by Justice Ruth Bader Ginsburg. Chief Justice William Rehnquist’s opinions not only affirm the validity of the distinction between permitting death to occur and inflicting death but rehearse the long-standing rejection of assistance to suicide to be found in U.S. common law. These opinions also accept as valid the justifications advanced for criminalizing PAD by Washington State and New York: to prevent predictable harm to
individuals and to society that would result from the practice of PAD.

First, in Quill v. Vacco, the Chief Justice explains how PAD is legally and morally different from medical practices of letting die both in the intention of the actors and in the causality of their actions. He argues that this is so whether letting die is accomplished through foregoing so-called life-prolonging treatments, or through letting a terminal disease process progress in combination with possible (but in fact rare) lethal side effects of using needed pain-relieving measures. (Use of analgesics involves some risk of accelerating death, and this can be foreseen but not directly intended when doctors try to measure the dose necessary to relieve pain and suffering.) The decisions of the two circuit courts of appeal had rejected this distinction, insisting that these two forms of letting die and PAD are now merely variations of a single growing practice of "hastening death."

Rejecting that view, the Chief Justice notes that the distinction here reaffirmed lies at the heart of all common law definitions of crime. In PAD one unambiguously intends a death-causing act to take effect and one initiates a new lethal process different from the disease or injury processes that make the patient terminal. So the causal involvement is proximate, not remote, even though in PAD it is done by cooperation of physicians with a patient's self-inflicted death rather than by the physician's own action (as in euthanasia).

Of course, the Chief Justice recognizes that both of these forms of "letting die" can be abused. A doctor can really intend to kill but disguise this by pretending to do what can be, in moral intention, an honest acceptance of an unwanted side effect, namely death. A doctor can, for instance, deliberately but covertly overdose a dying patient with analgesia. Or a doctor can forego further use of cure-oriented treatments, even though they and their patients do not reasonably judge these to be excessively burdensome. Such possibilities of homicidal abuse may often be difficult to prove, but the validity of the distinction between killing and letting die is not obliterated by that. In PAD, it remains easy to observe and prove both homicidal intention and causality.

So we who oppose PAD are encouraged. Six Justices have agreed that, from both a moral and legal point of view, one can act in a way that is not homicidal—sometimes to stop what is now an unreasonable medical interference with human dying, sometimes to take risks to relieve suffering. Doctors can do so because they recognize an urgent moral duty to take greater risks of unwanted but sometimes inevitable side effects of their interventions because those risks are proportionately justified where death is already at hand. They can proceed sensibly to tailor medical interventions in a way that is appropriate to the close approach of a normal human event, dying, without resort to inflicting death. Justice O'Connor's crucial concurring opinion in the Nancy Cruzan case (decided in 1988) foretelling a constitutional right of the dying to control their medical treatment is here re-enforced. Only homicide and suicide are here excluded from medical practice.

Further Reassurance: Preventing Harm to Vulnerable Individuals and to Society From PAD.

In addition, the Chief Justice's majority opinion in Washington v. Glucksberg persuasively elaborates the constitutionally valid reasons a state has for continuing to make PAD subject to criminal penalties. The states act reasonably when they anticipate harms from allowing PAD. These possible harms include: danger of undermining policies discouraging suicides due to psychological impairment, and other laws against homicide as well; danger to the ethics of the profession of medicine, whether from evasion of the restraints on the practice of PAD that all admit the states have a right to impose on doctors, or from an inevitable devolution of practice from assisting suicide to actively inflicting death at the request of those patients unable to do so themselves; danger of family participation with or in place of doctors in suicide by the terminally ill; and with all of these, danger of various kinds of coercion especially of vulnerable patients leading to less than free requests for PAD once it has become a legally accepted medical practice. These harms are reasonably foreseen and criminal penalties are reasonably crafted by a state to prevent them.

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Such arguments of the majority opinions can surely hearten those who oppose PAD. But, in spite of the apparent weight of argument against PAD, and apart from the influence this may have in discouraging state legislatures from enacting laws legalizing PAD, none of this judicial reasoning contributes directly to what is most important for dying patients. These two majority opinions do not of themselves generate efforts to foster a growth in good and appropriate use of palliative medicine and hospice-type care for those dying under medical care. That is the crucial challenge for those who claim to oppose PAD.

To understand our need to attend to this challenge, we must carefully examine the separate concurring opinions of the other five Justices.

**Limits of Reassurance Provided to Those Who Oppose PAD.**

First, consider the very succinct concurring opinion of Justice O’Connor, which Justice Ginsberg simply joins, and with which Justice Steven Breyer expresses agreement except insofar as it joins the majority opinion. Only here do we find explicit mention of alternative opportunities in current medical practice for relief of suffering available to the dying. We begin to confront some indication of possible reservations about the tenor of the majority opinions on the part of at least four and perhaps six Justices.

Justice O’Connor insists that, beside seeking to avoid the harms enumerated by the Chief Justice, the states are not to make legally unavailable to dying patients who endure great suffering the adequate palliative medical means of relieving that suffering. This, in her view, is an important justification for a state in making PAD illegal. She states explicitly:

The parties and amici agree that in these states a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.

Justice O’Connor does not state that such appropriate palliative medical care of the dying is readily available in practice. She does not claim that it is frequently and effectively given. She only emphasizes that as long as effective palliative care is not forbidden by law, by state action, no constitutional right to PAD can be claimed as the only effective means of controlling one’s
death when suffering is great. The majority opinions failed to include this observation. So it appears that this justification of the state's outlawing of PAD is for her, and for Justice Ginsberg as well, more than a casual afterthought. Stating it is necessary for them to be able to join in the majority opinions.

Second, in his single concurring opinion (applicable to both cases), Justice Breyer probes the practical medical problem of limited availability of palliative care—that it is still very infrequently provided, or even offered, to dying patients. This issue appears to weigh against his endorsing the majority opinions of the Chief Justice. Justice Breyer expresses concern that the predicament of the dying is not fully and realistically taken into account by the majority opinions in these two cases, even though he concurs in the outcomes.

Third, Justice David Souter in his two concurring opinions explicitly refuses to join the majority opinions. At considerable length he develops a different way of determining whether the claim of a 14th Amendment right can be made and whether a state has sufficient reasons to limit or deny that right claimed. He requires a careful and detailed weighing of the claims of rights of the dying and their doctors against the dangers for the prevention of which states claim a need to forbid PAD. In the end, this weighing of claims of right against claims of preventing harm leads him to accept the decisions in these particular cases. But he appears to accept, in a way the majority does not, the strong case that might be made for a right of some terminally ill persons to have assistance in ending unendurable suffering by self-inflicted death.

Fourth, though he concurs in these two decisions, in his single concurring opinion Justice John Paul Stevens expresses forthright reservations about the scope of the holdings. Indeed, in his arguments he appears very close to writing a dissent. He, more emphatically than the other four concurring Justices, recognizes a right to control the circumstances of one's dying, and so he anticipates cases in which better arguments for a constitutional right to PAD could well be made by doctors and patients in particularly difficult circumstances. Justice Stevens states that he might well evaluate such arguments in a way that will qualify or even reverse the decisions in these two cases.

Thus, Justices Stevens, Souter and Breyer are much less than irrevocably committed to the votes they have cast in these two cases against a constitutional right to PAD. They indicate in different ways that the needs of the dying for appropriate relief of suffering must receive more explicit attention than the Chief Justice and his three colleagues have accorded them.

And by indicating the crucial role in their votes played by their concern that dying persons not be legally denied access to adequate medical relief of suffering, Justices O'Connor and Ginsberg may be positioned at least partway on the road to forming a new majority of five Justices. For instance, they might vote differently if it were demonstrated

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to them that some form of government action in fact presents a barrier to the effective practice of palliative medicine in the care of the dying.

Since these five Justices might reconsider the holdings in these two cases denying constitutional protection to claims of a right to PAD, the apparent unanimity of the Supreme Court could turn out to be a short-lasting papering-over of profound differences. Opponents of PAD have not won the war by this decision, perhaps not even a decisive battle in this war, possibly only a preliminary skirmish.

Unfinished Business: Caring Well for the Dying.

From the point of view of traditional medical morality and Catholic moral analysis, the majority opinions of the Chief Justice and the three Justices who join directly in his opinion seem to me too much preoccupied with ruling out homicide in care of the dying in a merely legalistic way. They express too little insight into the realities of medical experience, to what medical people experience as they struggle against a previously dominant medical vitalism in order to care well for the dying. Preoccupied with simply excluding homicide and suicide, the Chief Justice and his three colleagues fail to take into account that this medical vitalism continues to cause too many physicians actually to oppose use of palliative medicine and hospice care and to seek to "prolong life" at whatever cost the patient must bear in suffering and expense. They ignore the harm that this medical vitalism has perpetrated in the name of a war against death and the role this has played in fostering claims to the right to have PAD.

By contrast, Justice Breyer, and in some lesser degree Justices O'Connor and Ginsberg, show informed insight into these realities of medical experience of the needs of the dying in a high-technology medical system—an insight very rarely displayed in previous judicial opinions. This appears to be the result of several amicus curiae briefs that were devoted to elaborating a picture of current practice in care of the dying and its limitations. Justice Souter's style of constitutional analysis appears designed to give great weight to such insight in future cases. And Justice Stevens seems eager to take this insight fully into account if a stronger case is made for desperate needs of dying patients.

I believe that the opinions of these five Justices give no cause for opponents of PAD to rest on their oars, and give every reason for those who seek better care of the dying to renew their dedication to this challenge.

Opportunity for Proponents of Physician-Assisted Suicide.

The challenge to those who advocate PAD is obvious enough. The majority opinions of Chief Justice Rehnquist, as well as the concurring opinion of Justice O'Connor joined by Justice Ginsburg, offer hope for eventual victory through legislation. These six Justices say that state legislatures remain the appropriate forum in which the dispute about the moral appropriateness and practical feasibility of decriminalizing, and so permitting, some kind of carefully constrained physician assistance in self-inflicted death by the terminally ill can be examined and, perhaps, experimented with. The other three separately concurring Justices, Souter, Breyer and Stevens, in no way deny this invitation.

In Oregon, where a ballot initiative permitting PAD had already been passed by a narrow vote of the general electorate in 1994, we may witness the first experiment with open practice of PAD. "May"—because the Oregon legislature mandated a second vote on this measure in the 1997 general election. (The legislature is, perhaps, concerned that Oregon, as the only state with such a law, will become a resort for terminally ill persons seeking assisted suicide.) A decision of the 9th Federal Circuit Court of Appeals (Lee v. Oregon, 1997) upholding the constitutionality of this Oregon law has recently been denied review by the U.S. Supreme Court and is thus left in effect. Of course, since the Oregon electorate ratified this law again last November, the Supreme Court may eventually reconsider the constitutionality of that statute. Not until the law is put into practice will we have concrete experience of the impact on medical practice of PAD, especially on the rights of vulnerable patients. If harms from such practice become manifest, a new case challenging the constitutionality of PAD might win review and a majority of the present Justices.

However practice evolves in Oregon, the advocates of PAD can be expected to accept the express invitation of the Justices in Glucksberg and Quill to continue to advance their cause within the other 49 state legislative assemblies of our nation. Nonetheless, I believe that proponents of PAD are genuinely concerned about the plight of dying patients; they should and will be willing also
to work hard to advance the cause of good palliative medicine and hospice care. Almost all of the physician proponents have proclaimed their support for such care, even as something that would be required before accepting a patient’s request for PAD. They advocate decriminalizing PAD because they claim it is needed as a last resort only in rare cases.

The Challenge to Those Who Support Good and Effective Care of the Dying.

What should we expect in the next stage of our North American struggle to provide good care of the dying? I believe it is time for all who have any true sense of compassion toward the dying, and who expect to receive compassionate care when they themselves are dying, to work unremittently to foster adequate practice of palliative medical care of the dying and wider and wider practice of a constantly improved hospice care of the dying. And governmentally reimbursed programs such as Medicare and Medicaid must be led decisively into the fold—they are not there yet. We have a chance now to make support of hospice care of the dying a sine qua non of all health insurance. We are challenged now to make this hospice practice available to all the dying who are without health care coverage—as Mother Teresa did so compassionately for the destitute of India and elsewhere.

Above all, people involved in health care have now what may be a brief window of opportunity to increase their efforts to improve and refine palliative medicine and hospice practice so that fewer and fewer persons imagine that PAD is their only hope, as they live in fear of unrelieved suffering and indignity in their dying as a consequence of medical neglect. The various hospice programs strongly emphasize not only exquisite attention to relieving the suffering of the dying but also, perhaps most important of all, to supporting the dying persons in their need to care for their caregivers as a final expression of their life values.

Unfortunately, some vociferous opponents of PAD tell us little about what they want, affirmatively, to do for the dying. That is the fatal weakness that I am convinced will destroy their efforts to prevent legalization of PAD in state legislatures. If what they really want is merely the status quo—a sterile medical vitalism—they doom their own cause. More serious from a moral standpoint, that approach fails in the solemn obligation we have to provide dying persons the sort of realistic and compassionate caring that they need in the final moments of their life’s journey.

We who are Christian believers must now embrace the challenge to action, to an orthopraxis that matches our orthodox moral belief in compassionate caring for the dying. We believe that, in the final moments of living, we and those for whom we care are being drawn into the dying of Christ. That is a supreme moment for love and compassion, by caregivers of the dying and by the dying for their caregivers.