

RATIONALITY AND INJUSTICE IN PHYSICIAN-ASSISTED SUICIDE

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“If you can keep calm when everyone around you is losing it, then you don’t really understand the situation.” So goes the modern variation on the old saying, but the dominant vocabulary in our contemporary public discussions about physician-assisted suicide ignores this wisdom. In litigative or academic forums, the talk tends to focus on abstract principles and hypothetical cases. It is the abstractions and hypotheticals that obscure the complexity, the grittiness, and the disturbing reality of this subject. To remain coolly rational about physician-assisted suicide is, in a fundamental sense, to misunderstand all that is truly at stake.

Constitutional adjudication is especially vulnerable to this kind of rationalistic and distanced misunderstanding. The judicial deliberation revealed in the Ninth and Second Circuit court opinions is a prime example of this affliction.¹ Consider the way that both courts addressed whether withholding or withdrawing life-prolonging medical treatment was different from providing treatment intended to hasten death. Both courts asserted that there was no logical difference between physicians’ conduct in these two circumstances.² The Second Circuit made this logical claim the center-piece of its ruling that it was irrational for the state to authorize physicians to withhold or withdraw care while prohibiting assisted suicide.

It is of course true that under both circumstances, the patient’s death is the foreseeable result of the physician’s conduct and in this sense, at least, there is no difference between the two circumstances. But when the courts asserted that there were no other salient or important differences between the physician’s conduct under the two circumstances, they ignored the testimony of many physicians—including the assembled representative physicians in the

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1. See *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev’d*, 138 L. Ed. 2d 834 (1997); *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *rev’d sub nom.* *Washington v. Glucksberg*, 138 L. Ed. 2d 772 (1997).

2. See *Compassion in Dying*, 79 F.3d at 822-23; *Quill*, 80 F.3d at 728-30.

American Medical Association³—that acquiescing in a patient's refusal of life-saving treatment *feels* different from injecting or even prescribing lethal medication at a patient's request. Perhaps the distinction is irrational; perhaps it is logical to say that the physician is killing the patient in both cases. However, overriding the asserted difference on logical grounds amounts to a claim that the public forum's distinctively abstract and remote mode of talking about these events is the correct mode of understanding.

If we give ourselves room for the disturbing, unsettling, and often powerfully irrational elements that attend the intimacies of the death watch, we would—and I believe we should—be much more respectful of this testimony from physicians. More than most people, physicians are in regular and recurrent contact with death. This does not mean that most physicians are comfortable with this contact.⁴ Relentless technological assaults against the possibility of dying, and refusals to ever acquiesce in the inevitability of death, are common behavior among physicians. The very relentlessness of this physician behavior speaks to the disturbing and aversive character of their confrontations with death. During the past two decades, many people outside and inside the medical profession have struggled to change this technological assaultive ethos and to make physicians more comfortable with acquiescing in the inevitability of death and remaining available to comfort their dying patients. One of the principal instruments for promoting this change has been to cultivate physicians' respect for patients' wishes to refuse or to discontinue life-prolonging treatments. This cultivation has itself not been easy to accomplish, even though its logical force seems unassailable. In the words of a 1970s Broadway play later made into a popular movie, the core question should be "Whose Life Is It, Anyway?" The obvious logical answer to this question is that the life is the patient's not the physician's; therefore, the patient should decide what the physician can and cannot do to prolong his life.

Whatever the source for physicians' resistance to this logic, that resistance has been strong and has not been overcome in the

3. See Council on Scientific Affairs, American Med. Ass'n, *Good Care of the Dying Patient*, 275 JAMA 474, 477 (1996); see also Amicus Curiae Brief of the American Medical Association et al., app. B at 11a, *Vacco v. Quill*, 117 S. Ct. 36 (1996) (No. 95-1858).

4. See generally FREDERIC W. HAFFERTY, *INTO THE VALLEY: DEATH AND THE SOCIALIZATION OF MEDICAL STUDENTS* (1991).

day-to-day practice of medicine.⁵ This resistance persists even though the abstract principle has been unanimously endorsed in almost every imaginable public forum—including the Supreme Court in its 1990 *Cruzan* opinion which assumed, though it did not quite proclaim, that patients had a constitutionally protected liberty interest to refuse life-prolonging medical treatment.⁶ Nevertheless, for some set of stubbornly persistent reasons, many physicians have difficulty in acting on the rational premise that, in their struggles against illness and death, only the patient's life is at stake.⁷

As a society we may be close to overcoming this physician resistance; it may be that the principle of respect for patient's wishes to terminate treatment and accept the inevitability of death is now within the possibility of realization in the practice of medicine. I am convinced that this is a correct principle and a

5. See Mildred Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14 (1993). Solomon notes that:

[P]hysicians and nurses hold some views that make it difficult for them to act in ways that would be consistent with their own expressed support for patient autonomy. Although clinicians' views are congruent in many ways with those put forth by authorities in ethics and law, on at least three critical issues—withdrawal of treatment, the distinction between 'ordinary' and 'extraordinary' treatment, and the provision of nutrition and hydration—many clinicians differ with current national recommendations. . . . Most clinicians interviewed were uncertain about what the law, ethics, and their respective professional standards say. . . . In addition to this uncertainty, the interviewed respondents reported being less likely to withdraw treatments than to withhold them for a variety of other reasons, including psychological discomfort with actively stopping a life-sustaining intervention; discomfort with the public nature of the act, which might occasion a lawsuit from disapproving witnesses even if the decision were legally correct; and fear of sanction by peer review boards.

Id. at 19.

6. See *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). The Court in *Cruzan* stated:

[T]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

....

... [F]or purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Id. at 278-79.

7. Commentators have reported that

[S]ome of the physicians expressed discomfort about openly soliciting patients' views on what would constitute an acceptable quality of life. They tended not to acknowledge explicitly to patients (or their families) that many termination-of-treatment decisions involve personal judgments about quality of life as well as clinical considerations about medical efficacy.

See Solomon et al., *supra* note 5, at 19.

wholesome corrective to past assaultive medical practices. For the moment, moreover, I am prepared to assume that the resistance of many physicians (and non-physicians) to acknowledge the logical equivalence of acting on a patient's wish to refuse life-prolonging treatment and a patient's wish to obtain death-dispensing treatment is itself irrational. Does it then follow that the proper course of action, as the Second and Ninth Circuit courts have held, is to override this illogical resistance and to proclaim that because patients have a right to discontinue life-prolonging medical treatment, they also have an equivalent right to physicians' assistance in hastening death?

The Fourteenth Amendment demands that all persons be guaranteed the equal protection of the laws. The constitutional syllogism would thus appear to require that irrational distinctions between logically equivalent people must be overturned. If the law's logic is the proper way to think about physician-assisted suicide, then judicial invalidation of the state prohibitions would seem to follow ineluctably.

But I want to explore a different kind of logic for thinking about this issue: a logic that starts from the premise that death is a deeply disturbing event for all its witnesses. I want to explore what we might call a logic of irrationality. I must of course speculate in this exploration. We know that most people find it disturbing to confront death, and that physicians in particular experience considerable discomfort. There is, however, very little firm data explaining the sources of this discomfort; and, in particular, there is almost no data about the psychological impact on physicians when they view themselves as responsible for, or as participants in, their patients' deaths.⁸ We do know that physicians work strenuously to avoid the death of their patients; this is the normatively approved social role of physicians, and not aberrational or irrational conduct. We also know that in pursuing this socially sanctioned goal, many physicians have been unwilling to accede to, or even to acknowledge the existence or propriety of, patients' refusals of life-prolonging medical treatment.⁹

8. See, e.g., Miles Edwards & Susan Tolle, *Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish*, 117 ANNALS OF INTERNAL MED. 254 (1992).

9. See Howard Brody et al., *Withdrawing Intensive Life-Sustaining Treatment—Recommendations for Compassionate Clinical Management*, 336 NEW ENG. J. MED. 652 (1997) (“[Hospital s]taff members are highly skilled in aggressive life-extending treatment Forced to choose between what they were trained to do and what they were

I would speculate that this stubbornly persistent unwillingness among physicians is based on a widespread belief that their acquiescence in patients' refusals would somehow render physicians responsible for, and direct participants in, their patients' deaths. It is easy to identify the logical error in this belief. A patient and his physician are separate individuals; and when the patient makes an autonomous choice for death, that decision is his responsibility alone.

What if there is a different logic at work between many physicians and patients, a logic of irrationality arising from the psychological stress of impending death and its attendant dissolution of the conventionally perceived boundaries of an "intact self"? What if this irrational sense of dissolved boundaries is especially salient to physicians as a group, more so than to patients, because the daily work of physicians brings them constantly into contact with dying and its attendant stresses? This might explain the persistent unwillingness among physicians to acknowledge that their autonomous patients were alone responsible for choosing their deaths.¹⁰ If this explanation is credible, what will happen to this widespread belief in the new era—this relatively recent and still imperfectly implemented era—when physicians are normatively obliged to assent to their patients' decisions to refuse life-prolonging treatment? Here are two possibilities: (1) perhaps physicians who have strenuously, and until quite recently, ignored the logical proposition that they and their dying patients are autonomously separate individuals, will suddenly awaken to the force of this proposition, and will no longer be afflicted by their past irrational views; (2) or perhaps physicians still hold this irrational view, confusing themselves with their dying patients, but this persistent irrationality will find a different expression in this new era of mandated respect for patients' autonomous rights.

never trained to do, physicians and nurses may continue aggressive therapy well beyond the point at which patients or families (or the health care professionals themselves) would prefer to stop."); see also Alfred Connors et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591, 1594 (1995) (providing statistics showing that when patients expressed preferences to various hospital staff members for withholding cardiopulmonary resuscitation, "only 47% of their physicians accurately reported this preference").

10. For a speculative exploration of the psychology of boundary dissolutions in interactions between patients and physicians where death is inevitable, see ROBERT A. BURT, *TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS* 92-123 (1979).

If the first possibility is the truth of the matter, then we might confidently conclude that, whatever other objections might be considered regarding physician-assisted suicide, we should acknowledge the logical equivalences between physician involvements in patient deaths, whether those deaths occur through physicians' actions withdrawing a ventilator or injecting lethal medication. If, however, the second possibility is the truth, then we should hesitate.

I do not know which possibility is the truth. It is extraordinarily difficult for anyone to know this truth—to discern the existence and the practical consequences in action of subjective attitudes among individuals, much less among collectivities. We run considerable personal and social risks, however, if we ignore the subjective dimensions of our individual and collective lives, if we assume that rational objectivity will govern our conduct simply because we believe it should do so, or judges tell us it must do so.

Let me articulate one speculation about the possible harm that would fall on many patients with life-threatening illnesses if physician-assisted suicide were to be legally approved, notwithstanding the persistence of irrational confusions between physicians and patients. If numerous physicians have resisted acknowledging their patients' wishes for death because of some deep subjective conviction that this acknowledgment would compromise the physicians' own struggles against feared death—if, we might say, the physicians' empathic identification with their patients spilled into an over-identification with them—then the physicians who now understand themselves to be participating in their patients' deaths (whether by acquiescing in their treatment refusals or by engaging in some more active assistance) must somehow accommodate their prior over-identifications with patients. One possible route is to relent in their prior resistance to patients' deaths by denying any empathic identification with them—by, we might say, an under-identification with patients, by a heightened aversion to the possibility of death that finds expression as a too-quick support for the patients' hastened death and disappearance in order to deny the force of the persistent underlying belief that the patients' death threatens the physicians' personal integrity.

There are already many identifiably powerful social pressures that are conspiring toward this speeded end: financial pressures from the new organizational structure of health care services into

managed care settings that reward nontreatment of patients,¹¹ the socially marginalized and devalued status of many dying people such as the impoverished elderly in nursing homes and AIDS-infected drug abusers; and the heightened public fears about the dying process that have made Jack Kevorkian a folk hero, in the media and before successive criminal juries, notwithstanding his obvious flouting of legal constraints and his bizarre personal characteristics.¹² The “conscience of the medical profession” has often been invoked as a claimed counterweight to these social forces pressing toward hastened deaths of patients; but this counterweight disappears if physicians can persuade themselves that morality demands acquiescence in their patients’ expressed wishes for death, no matter how tentative, ambivalent, or premature those expressed wishes might be. What a happy conjunction, then, if “doing good” for one’s patients—doing the socially approved act of hastening the patient’s death—also “felt good” to the physician who, by this hastening, could avoid any anxiety-provoking acknowledgment of the personal threat embodied in the patient’s death.

The conjunctive impact of these psychological forces with other social pressures toward hastening the death of vulnerable patients would create considerable problems not only for the proper implementation of legally recognized physician-assisted suicide but also for patients’ legal rights to refuse treatment. The Second Circuit glibly concluded that because “[t]here is no clear indication that there has been any problem” regarding implementation of the widely recognized legal right to refuse treatment, “there should be none” as to physician-assisted suicide.¹³ But we know that there

11. See, e.g., Steven Miles et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 W.J. MED. 302 (1995).

12. See, e.g., Keith Bradsher, *Kevorkian Is Also Painter. His Main Theme Is Death*, N.Y. TIMES, Mar. 17, 1997, at A10 (describing a public exhibit of his “oil paintings depicting severed heads, moldering skulls and rotting corpses” including a “painting about genocide [for which] Dr. Kevorkian said that he had drawn blood from his own veins to stain the pine frame ‘I wouldn’t recommend anyone hanging them on a wall,’ he said at a press preview on Saturday. ‘They’re for enjoying; they’re for thinking.’”).

13. *Quill v. Vacco*, 80 F.3d 716, 730 (2d Cir. 1996), *rev’d*, 138 L. Ed. 2d 834 (1997). The court stated,

Physicians do not fulfill the role of “killer” by prescribing drugs to hasten death any more than they do by disconnecting life-support systems. Likewise, “psychological pressure” can be applied just as much upon the elderly and infirm to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death.

Id.

are current widespread problems in implementing the refusal right.

The problems, at the moment, are excessive physician omissions rather than commissions—extensively documented failures by physicians generally to understand clearly stated legal rules that patients are as much entitled to discontinue treatment as to refuse its initiation¹⁴ and, in large numbers of individual cases, physicians' failures to acknowledge patients' expressed wishes to refuse or discontinue treatment.¹⁵ Many people see these failures as evidence of physician stubbornness, even arrogance, and wrongdoing. From the alternative perspective that I have been pursuing here, these failures would convey a different implication. Physicians' misperceptions of the legal rules and of their patients' wishes to refuse treatment, and their resistance to this acknowledgement might indicate many physicians' persistent inability to draw objective, logical distinctions between their patients' lives and their own, between their own safety and their patients' vulnerability: their continued confusion about "whose life is it, anyway." From this perspective, the intensity with which many physicians insist on the sharp differentiation between "passive acquiescence" in their patients' refusal of life-prolonging treatment and "active assistance" in hastening their patients' death may be part of the physicians' intense struggle to differentiate themselves from their dying patients. Drawing sharp lines (even obviously illogical lines) about different degrees of involvement in patients' deaths may be an instrument in a difficult struggle to hold fast to their traditional ways of maintaining psychological balance in facing the unsettling force of death.

Even if these psychological speculations were true, this would not necessarily be a convincing argument for indefinite maintenance of obviously illogical distinctions. But if these distinctions are, as I speculate, playing an important psychological role for many physicians' conceptions of themselves as different from, and safely distant from, the dying of their patients; and if the legal system overrides these distinctions and deprives many physicians of their customary self-protective instruments, then we must expect physicians to satisfy these persistent psychological needs in some other way. It is not at all clear that patients at death's edge would be better protected under this new regime. This new regime may help some patients. It may be that some patients—those who are

14. See generally Solomon et al., *supra* note 5 (providing statistics regarding the state of physicians' knowledge and understanding of patients' legal rights).

15. See Connors et al., *supra* note 9, at 1594.

clearly in command of themselves, and firmly want or firmly refuse hastened death—can, by their assured self-definitions, resist the force of their physicians' confusions and cognitively unacknowledged self-protective maneuvers. More vulnerable patients would perhaps be swept into a *folie a deux* with their physicians and bear the heaviest burden of this shared confusion and disturbance in the face of death.

I don't know how many patients would be more helped than harmed by a new legal regime. I don't know how many physicians are actually struggling in the way that I have depicted. I don't know the importance for physicians' struggle of the currently regnant legal distinction between refusing life-prolonging treatment and hastening death. I don't know how many physicians consciously disregard these distinctions and purposely hasten their patients' death; and among these law-breaking physicians, I don't know how many find the condemnation of their acts in the formal—though not enforced—law to be a welcomed inhibition, a secretly reassuring constraint that mirrors their own discomfort with their actions. But for all that I do not know, I am confident that if we ignore all of these uncertainties and change the legal regime in a way that deeply unsettles the current conception of physician-patient relations, and directly contravenes the conventional proposition that "good physicians do not kill patients," we cannot now know who and how many will be hurt more than helped.

Some people say that the current legal regime itself makes it impossible to resolve these questions as well as many other uncertainties, that we can never find answers until physician-assisted suicide is practiced openly and is thereby amenable to public scrutiny and regulation.¹⁶ The paradox in this position is that we can't gain adequate knowledge about whether we want to change our social arrangements until after we change our arrangements. The paradox equally afflicts those who resist change for fear of its unknown consequences. Perhaps it is possible to try small dosages of legal change, to self-consciously experiment in these matters in order to test their consequences without committing ourselves irrevocably to the questionable changes in social practice and self-conceptions. But of this, too, I am confident: that constitutionally mandated

16. See Franklin Miller et al., *Regulating Physician-Assisted Death*, 331 *NEW ENG. J. MED.* 119, 120 (1994); see also Lawrence Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 *J.L. MED. & ETHICS* 94, 98 (1993). But cf. Ann Alpers & Bernard Lo, *Physician-Assisted Suicide in Oregon: A Bold Experiment*, 274 *JAMA* 483 (1995).

change in the existing legal regime is not a sufficiently fine-tuned instrument for this kind of experimentation.

The sweepingly incautious and abrupt character of the constitutional rulings by the Second and Ninth Circuits is, in many ways, the most extraordinary aspect of these decisions. The practical effect of these rulings, if they are affirmed by the Supreme Court, would be to overturn the legal regime in every state except for Oregon. Assisted suicide is now explicitly prohibited in some 26 states and would almost certainly be considered criminally punishable in other states that have not clearly authorized the practice.¹⁷ Only Oregon has explicitly approved physician-assisted suicide; this approval occurred in a popular referendum in 1994 and, because of a pending constitutional challenge, the law has not yet come into effect.¹⁸ Accordingly, the constitutional right found by the circuit courts had been recognized by almost no other authoritative body and had not been practically implemented anywhere in the entire country.

According to the formal ideology of constitutional law, this virtually total absence of popular recognition should have no significance: constitutional rights are supposed to override popular approval, not depend on it. It is nonetheless striking that the circuit court rulings are further removed from any popular recognition, and more abruptly imposed in the face of popular resistance, than any other judicial ruling in the history of the constitutional adjudicative enterprise. For sheer scope of judicial ambition, the closest precedents in this century, and even in our entire history, are the Supreme Court's rulings in *Brown v. Board of Education*¹⁹ and *Roe v. Wade*.²⁰ But *Brown* overturned race segregation laws in effect only in a minority of states (essentially in the former Confederacy and a few immediately bordering states). Moreover, before issuing its constitutional proclamation that separate race facilities were "inherently unequal," the Court had issued a highly visible series of decisions during the preceding fifteen years that incrementally but steadily undermined the constitutionally approved status of the

17. See James Bopp & Richard Coleson, *The Constitutional Case against Permitting Physician-Assisted Suicide for Competent Adults with "Terminal Conditions,"* 11 ISSUES L. & MED. 239, 249 n.42 (1995).

18. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995).

19. 347 U.S. 483 (1954).

20. 410 U.S. 113 (1973).

“separate but equal formula.”²¹ And immediately after formally proclaiming its new doctrine in *Brown*, the Court announced that this ruling would be implemented only gradually; “with all deliberate speed,”²² was the Court’s cautious watchword for fourteen years after its apparently sweeping decision in *Brown*. The Court abandoned this self-conscious incrementalism only after the United States Congress had enacted three landmark Civil Rights laws, in 1964, 1965 and 1968, that signified overwhelming national popular approval for the course that the Court had cautiously embraced in 1954.²³

Roe v. Wade was a more precipitous imposition of judicial authority than *Brown* had been. There is even some reason to think that the Justices construed the apparent popular approval of the Court’s exercise of authority in *Brown* as a generalized endorsement of its role as constitutional censor and thus emboldened it regarding the abortion controversy. But even so, *Roe* was a less radical departure from the existing and popularly approved legal regime than the current circuit court assisted suicide rulings. When *Roe* was decided in 1973, abortion was a legally recognized medical procedure in every state, though in some two-thirds of the states limited only to save the mother’s life. In one-third of the states, however, legal abortion was available under relatively liberalized circumstances (typically to protect the “mental” as well as general “physical health” of the mother)²⁴—so liberal that in some of these states, at least, abortion was practically available on demand.²⁵ Moreover, during the three years prior to *Roe*, the legislatures of four states—New York, Washington, Alaska and Hawaii—had explicitly approved abortions on demand.²⁶ Thus, when the Court proclaimed in *Roe* that states could not constitutionally prohibit a first-trimester abortion requested by a woman and accepted by her personally chosen physician, there was considerable prior popular approval of and extensive prior social experience with the medical

21. See Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 DUQ. L. REV. 159, 159-60 (1996).

22. *Brown v. Board of Educ.* II, 349 U.S. 294, 301 (1955).

23. See *Green v. County Sch. Bd.*, 391 U.S. 430 (1968).

24. See *Roe*, 410 U.S. at 139-40, 40 n.37; MARY ANN GLENDON, *ABORTION AND DIVORCE IN WESTERN LAW* 48 (1987).

25. See KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 88-95 (1984) (regarding California law).

26. See LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 46-50 (1990).

practice. There is nothing like this prior approval and no prior experience at all with legally recognized physician-assisted suicide.

This apparently unprecedented character of the exercise of judicial authority in the physician-assisted suicide cases—its distance from popularly accepted practice and its abrupt sweep—does not necessarily demonstrate its wrongfulness as a matter of constitutional principle. The logic of constitutional decision-making is not rigidly confined by past precedent. John Marshall's famous declaration in 1819 that "we must never forget, that it is *a constitution* we are expounding"²⁷ apparently endorses an expansive interpretive role for the judiciary in construing the sparse terminology of the constitutional document. This formulation can readily support an equally expansive conception of judicial authority; the sweeping moral proclamation enunciated in *Brown* might in retrospect eclipse its cautious incrementalism in implementation—a retrospective reading which is given impetus by *Roe* and finds full flowering in a judicial proclamation that extends *Roe*'s substantive privacy principle to overturn state laws banning physician-assisted suicide.²⁸ I cannot refute the internal coherence of this constitutional argument. My instrumental concerns about the unknown consequences of the radical, abrupt shift in social practice regarding legal recognition of physician-assisted suicide are, within the internal logic of this argument, subordinate to the command of constitutional principle. This command is reminiscent of the old legal maxim *fiat justitia ruat coeli*, "let justice be done though the heavens fall." Though some might wish that this instrumental consequence could be somehow averted, proscribing injustice may nonetheless be preferable, a more noble if riskier course.

The very idea of constitutional justice depends, however, on a methodology of rational discourse: on the possibility of reasoned argument conducted in a language with acknowledged intersubjective meaning. The conventional depiction of this methodology treats rationality rather like a ticket of admission for participation in moral discourse; the participants are obliged, that is, to come into the enterprise already committed to and engaged in the use of objective reasoning and mutually recognized language. This is, however, a misleading depiction; rationality is better conceived as the goal of moral discourse not as its precondition.

27. *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819).

28. See Robert A. Burt, *Alex Bickel's Law School and Ours*, 104 *YALE L.J.* 1853, 1868-69 (1995).

For most questions, the difference between these two depictions may not be especially sharp or consequential. For most questions, interchange—even among passionate adversaries—rather quickly finds a common language, a shared understanding of the terms of the argument, even if ultimate substantive agreement does not readily emerge. There are some issues, however, where these preconditions for rational deliberation are not easily reached—where the very terms of discourse are heavily freighted with subjective and ordinarily inexpressible significance for one or another of the participants. In deliberations about such issues, the goal of rationality may seem unattainable and, at the same time, the costs of abandoning that goal may seem enormous and even terrifying. The social costs may involve resort to violence as the only means of addressing a high stakes but apparently irresolvable conflict. The individual costs may involve a frightening sense of personal isolation and incoherence as a consequence of the inability to make one's deeply felt needs intelligible, much less persuasive to others. For such issues, these fears set the stage for a kind of forced march to an apparent rationality—a suppression of, an intolerance for, rather than a comfortable resolution of the radical subjectivities that are obstructing the cherished goal of mutual intelligibility. Sometimes this suppression may itself be a mutually shared enterprise, an implicit or unacknowledged agreement to ignore the mutual inability to find a common language or metric for resolving controversy. In such circumstances, the apparent resolution is usually quite tenuous; disagreements and tensions are likely to arise soon and often.²⁹ At other times, one party who is for whatever reason stronger than the other simply imposes his terms on the dispute and overrides the persistent though deeply felt incommensurability of the other. This too is an unstable, but not uncommon, resolution.

American society today seems transfixed by the problem of incommensurate disputes: conflicts that traverse the possibility not only of mutually satisfactory resolution but even of rational discourse. Our current struggle with the meaning of multiculturalism—whether recognition of racial, religious, ethnic, gender differences is inconsistent with or a pathway toward a unifying national self-definition—is one expression of this obsession. I believe

29. For an insightful discussion of the social uses of tenuous dispute resolutions, see Cass R. Sunstein, *The Supreme Court, 1995 Term—Foreword: Leaving Things Undecided*, 110 HARV. L. REV. 4 (1996).

that the sudden public salience of disputes about death and dying is another such expression.

If this is true, then public deliberations cannot begin with the assumption that the preconditions for rational moral discourse have been satisfied for these disputes. We must instead devise some means for engaging in a public deliberative process that can lead to a common language and commensurate metric for moral resolution of the dispute. Though judicial interventions can play a valuable facilitative role in this deliberative process, essentially by focussing public attention on the existence of deep moral conflict and offering guidance toward the possibilities of acknowledging shared premises, the judiciary—because of its social remoteness and its dependence on rational principle—must not impose an authoritative and conclusive resolution of the dispute when its terms are still morally incommensurable, when the dispute is not yet amenable to rational discourse among the adversaries.³⁰

By this criteria, the Supreme Court's sweepingly conclusive resolution of the abortion controversy in *Roe v. Wade* was premature; and the morally incommensurable terms in which the abortion debate was then, and continues to be, debated also shows why the physician-assisted suicide controversy is still far from morally resolvable. The centrally disputed question in the abortion debate about whether the fetus is a "person" who is a recognized member of our social community in itself points to the absence of a shared morality to which the disputants can appeal. If we have no common basis for agreement on the identity of the constituent members of the community, there is no "we" to engage in discourse but only mutually unintelligible and therefore socially and morally isolated individuals.

The "personhood" dispute points to one underlying theme in particular that is common to the claims about abortion and the right to die: that passage into or out of the human community involves extraordinary vulnerability; that the threats come not only or even primarily from biological risks but from social abuses; and that the medical profession is directly responsible for the infliction of these abuses. The proposed technique for protecting against abuse is also similar in the two contexts, though it differs in strategic details of

30. My model for this kind of self-restrained, morally illuminating judicial pedagogy is the Supreme Court's carefully staged deliberative process in *Brown v. Board of Educ.*, 347 U.S. 483 (1954), and during the sixteen years before and fourteen years after that decision. See ROBERT A. BURT, *THE CONSTITUTION IN CONFLICT* 271-310 (1992).

application. The basic protective technique is to control the timing of the socially recognized designation of “personhood.” To guard against iatric abuse via abortion, the social status of “personhood” is bestowed at increasingly earlier stages of fetal and even embryonic biological development; to guard against iatric abuse via technological inflictions—mechanical ventilators, nasogastric tube feeding, etc.—during the process of dying, the social status of “personhood” is revoked at increasingly earlier stages of biological decline. There is one central strategic difference in establishing the locus for controlling the timing of this social proclamation. For the beginning of life, advocates for a “right to life” insist that “personhood” must be communally and univocally defined. For the end of life, advocates for a “right to die” insist that each individual must be free to revoke “personhood” by his or her own idiosyncratic conception, though constrained by a single communal conception of “mental competence” so that only a socially recognized “person” would be free to revoke “personhood.”³¹

These strategic differences are of course significant; but the heated debates between these antagonists, regarding the virtues of pluralist vs. univocal standards of “personhood” at both the beginnings and the endings of life, have obscured a more fundamental similarity in perspective. Both camps view biological dependency as a fearful state of social isolation which is not just vulnerable but is highly likely to attract abuse. The imagery of a “silently screaming” fetus, suffering terribly but unattended, has been popularized by right to life advocates, but it is an equally apt image for the fearful invocations by right to die advocates of dying people intubated and tethered to high-tech machinery in impersonal hospital or nursing home settings.

This commonality between the pro-life and pro-choice advocates—their shared sense of social isolation and vulnerability—is, ironically enough, the basis for their shared diagnosis that the medical profession in particular has betrayed its caretaking role and is the principal source of abuse. This common ground is not, however, a comfortable basis for enlisting physicians, as a group or as

31. For “mentally incompetent” people, some advocate a communally and univocally defined standard to revoke personhood for those without various indicia of cognitive or “higher brain” function. Opponents of the “right to die” claim that this revocation would inevitably and exponentially expand over current categories of senile and mentally retarded people. For many difficulties in applying standards of mental incompetence and voluntariness regarding requests for physician-assisted suicide, see Burt, *supra* note 21, at 164-77.

individuals, in any socially ameliorative enterprise. It may be that the physicians who choose to perform abortions are sufficiently habituated to an impersonal conception of fetal status that they have no difficulty in declining to see themselves as murderers. The widespread, openly acknowledged practice of legalized abortions throughout the United States prior to *Roe v. Wade* did provide some basis for confidence on this score. On the available evidence regarding physician-assisted suicide, however, there is much less grounds for comfort. Physicians who feel troubled about assisted suicide would, as with abortion practice, be free to refuse participation. But if my speculation is correct—if the psychological stakes are as high as I believe for physicians in particular, and if the psychological mechanisms of denial or other suppressions or displacements of disturbing thoughts are as readily available as I believe—the stage is set for much confusion between physicians and patients, much self-justificatory and self-protective conduct by physicians and persistent, perhaps even intensified, experience of social isolation by patients. This is not a confidence-engendering basis for communal embrace of practice which depends on subtle and sympathetic appreciation by physicians of their patients' hard-to-articulate ambivalences and fears; but adequately protective implementation of physician-assisted suicide crucially requires this capacity.

The unusual abruptness of the judicial intervention by the Second and Ninth Circuit courts, the fact that both courts were in effect prepared to impose on the entire country through constitutional command a practice that had been approved only recently in just one state and not yet implemented even there, was an effort to reach moral resolution by a forced-march to close off, rather than to confront difficult questions.

Is it possible that there is no just result regarding physician-assisted suicide? Is it possible that there is no uniform evaluative matrix for weighing the conflicting needs and interests of vulnerable people who will be harmed by its legalized availability and self-assured people who will be helped by it, and therefore no justified basis for bestowing the trumping card of "rights-bearer" on one of these claimants? Is it possible that death so utterly dissolves personal identity, the conventionally conceived "self" engaged in mutually recognized interchange with others, that the preconditions for our social conceptions of moral discourse are traversed, that death itself renders rationality and justice unrecognizable? The judges in the ruling majorities of the Second and Ninth Circuit ap-

parently denied these possibilities; but they must be sympathetically considered.

