Analysis of including “Right to Die” as an area of a resolution listing areas, not cases.

Matt Moore, Augustana College, IL

If we are to include euthanasia, physician assisted suicide, the refusal of treatment, and other issues clumped into this debate area, then we need to find the best way to phrase it for the purposes of debate. For reasons listed below I believe that “right to die” is the best option for this case.

The phrase “right to die” is best if we are to include the entire range of end of life issues. As Kline footnotes, the Supreme Court “chose to use the terms "right-to-die," "determining the time and manner of one's death," and "hastening one's death" as opposed to the term "suicide." (Kline, 1997) Suicide tends to hold too much of a negative connotation for many. Some articles go show studies that indicate that people support a “right to die” only when it is not referred to as “assisted suicide”. (Public Agenda) There is still a risk (as we have seen with other terms in resolutions in the past like development) of some authors taking particular offense to the term, mostly because it is perceived as a term that obscures other agendas or whitewashes euthanasia. This argument does face some uniqueness problems however for a couple of reasons. First, nearly ever term involved in the debate has similar problems. Just as calling it “right to die” versus “assisted suicide” has an impact on public perception, other terms that include this area include euthanasia, “end of life issues” (although this term is too vague), and physicial assisted suicide. Second, the Court has chosen this term to avoid the pejoratives associated with some of the other phrases. (Kline 1997) Finally, this argument should not be seen as a deal breaker only because the quality of the arguments against the phrase is generally poor.

In terms of predictability, “right to die” has been defined by the Court:

The term "right to die" refers to a patient's right to refuse unwanted medical treatment or to have ongoing care withdrawn even though the patient will die if treatment is terminated. The right to die evolved as a judicial response to patients' desires to participate in making fundamental decisions about their own treatment, which had [*2022] traditionally been left to the discretion of the physician. n9 Beginning with the 1976 case of In re Quinlan, n10 courts, physicians, and the public grew to accept the idea that patient autonomy, in certain circumstances, extends to life-or-death treatment decisions. n11 The method that courts generally use to decide when a person has a right to die balances the patient's interest in self-determination against competing state interests in preserving life, protecting third parties, and preserving the medical profession's ethical image. n12 Using this balancing approach, courts have recognized the right to die in a variety of situations, including situations that involve patients who have different prognoses (terminally ill n13 or not n14), mental states (competent n15 or incompetent n16), locations (in the hospital n17 or at home n18), and treatment regimens (whether receiving "extraordinary" n19 or "ordinary" n20 care). The right to die is limited by procedural and evidentiary requirements in cases that involve incompetent patients n21 and, in some jurisdictions, the right to die is dependent on the patient's prognosis. n22 In general, competent patients who suffer from a terminal illness have a right to die by having life-saving treatment withheld or withdrawn. n23 However, no court has definitively decided whether the right to die extends to cases of physician-assisted suicide. n24 This Note explores [*2023] the rights of the competent, n25 terminally-ill n26 patient whose physician is willing to provide suicide assistance. It calls on courts to evaluate physician-assisted suicide cases under the doctrinal framework that courts have established for right-to-die cases -- that is, to balance the patient's interest in autonomy against the competing state interests at stake in each particular case. Part I of this Note defines the "right to die with assistance." It argues that current law gives patients such a right in some cases, and that this right is not categorically different from the right to die by refusing or discontinuing treatment. Part II argues that a balancing test is the best doctrinal approach for determining the scope of the right to die with assistance, and illustrates how courts can weigh a patient's interests against competing state interests. (Harvard Law Review 1992)

This article points out the why this terms fits the resolution best. First, the Court right now denies that a “right to die” in terms of physician assisted suicide does not exist. This ensures generic negative ground based on the notion of expanding individual rights. Second, the court has increasingly deferred establishing this right to the political branches (generally Congress and the states). (Savage 2006). This will help the negative in terms of activism and other court based actor arguments.

In terms of predictability, the Court is not the only one to use the term “right to die.” Advocacy groups use the phrase as well. For example, The World Federation of Right to Die Societies defines the “right to die” as:

“This phrase suggests that dying is a matter of choice rather than part of the human condition. The issue that came before the Supreme Court in 1997 was whether terminally ill, mentally competent adults have the right to request aid-in-dying from physicians to avoid intolerable suffering, and whether physicians have the legal right to provide a person with a prescription and consultation if doing so is consistent with their values.” (The World Federation of Right to Die Societies)

And it is a more precise term than other forms like euthanasia and physician assisted suicide:

The right to die includes both the technical meaning of euthanasia, the direct administration by a physician of a lethal injection, and physician-assisted suicide, the prescription of lethal medication for self-administration by the patient. Opponents of the right to die believe that taking one's own life is wrong as is assisting in a premature death of another, even in cases where [*446] the "victim" consents or requests the assistance. Proponents further distinguish among and between different forms of "self-deliverance." n9 This range of definitions is further complicated by the practice of adding the modifying terms "voluntary" or "involuntary" and "passive" or "active.” Within the "right to die" movement, these more specific terms are utilized to identify gradations of the act. For example, voluntary euthanasia is the death of an individual, at his request, by a doctor's lethal injection. Physician-assisted suicide is a form of voluntary euthanasia in which the physician prescribes a lethal dosage of medication for the patient to administer to himself. n10 The former practice is "passive euthanasia" (from the patient's point of view) while the latter is "active euthanasia." Similarly, since both of these actions were done at the request of the patient, they are voluntary. Involuntary euthanasia occurs when the procedure is done without the consent of the patient, because the patient is incapable of expressing his will, or because it is done against the patient's will. n11 While these variations may be considered the preferred definitions of the terms, it should be noted that lay people tend to use the terms euthanasia and physician-assisted suicide rather imprecisely. Regardless of definition, in most societies, from the law's viewpoint, virtually all acts that result in a person's untimely death are considered suicide, manslaughter or even homicide, no matter what the motivation. n12 (Manizone 2002).

The Georgia Journal of International and Comparative Law Spring, 2002 30 Ga. J. Int'l & Comp. L. 443 LENGTH: 13174 words ARTICLE: Is There A Right to Die?: A Comparative Study of Three Societies (Australia, Netherlands, United States) NAME: Lara L. Manzione *

The Boston Public Interest Law Journal Winter, 1997 6 B.U. Pub. Int. L.J. 527 LENGTH: 16192 words COMMENTARY: GIVE ME LIBERTY AND GIVE ME DEATH: ASSISTED SUICIDE AS A FUNDAMENTAL LIBERTY INTEREST NAME: Robert L. Kline

Harvard Law Review JUNE, 1992 105 Harv. L. Rev. 2021 LENGTH: 11383 words NOTE: PHYSICIAN-ASSISTED SUICIDE AND THE RIGHT TO DIE WITH ASSISTANCE.

World Federation of Right to Die Societies “Terms and Definitions” http://www.worldrtd.net/faqs/tnd/?id=60#60

"Doctor-assisted suicide gains ground Supreme Court rejects bid to block Ore. Law By Charlie Savage, Globe Staff | January 18, 2006" http://www.boston.com/news/nation/articles/2006/01/18/doctor_assisted_suicide_gains_ground/