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The Right to Die

John A. Powell, J.D.,* and Adam S. Cohen

The recent controversy over Dr. Jack Kevorkian and his role in assisting twenty patients to end their lives has once again brought to the fore the issue of the right to die. Our society continues to struggle with the question of how and under what circumstances people may end their own lives and when they should be allowed to enlist others to help them in doing so.

This article will suggest that the right to die is rooted in principles that have long antecedents in American law and tradition—privacy, the right to control one's own body, and liberty. It will also suggest that courts and commentators have been too willing to allow an individual's desire to end her life to be outweighed by other considerations or by onerous burdens of proof.

The touchstone in right to die cases should be the autonomy of the individual involved. Courts faced with right to die cases should make every effort to give effect to the wishes of the person whose life is at issue. They should work to identify and eliminate coercion from family, the medical profession, or society generally that may obscure the individual's true wishes.

This is not to say that families and religious communities should play no role in helping an individual to think through the sensitive issues surrounding the right to die. Individuals do not live in isolation, and individuals and groups to whom they have meaningful ties no doubt will and should have some influence over their views about ending their lives. However, after those groups have exerted whatever proper influence they may have, the ultimate decision must remain with the individual herself.

It is also important to note that the state does not stand in the same position as families and smaller communities to which an individual may feel an allegiance. The state does not have the same personalized ties to the

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1This article uses the term right to die. While we are aware of the trend toward distinguishing among the right to refuse life-sustaining treatment, physician-assisted suicide, and active voluntary euthanasia, we believe these distinctions are unnecessary when discussing individual autonomy. For purposes of assessing autonomy rights implicated when ending one's own life, it matters not that one refused medical care, requested physician assistance to die, and so forth. The autonomy issue remains the same throughout.
individual as these subgroups do, and its interest in an individual's decision about whether to end her life should be far less. The state also has at its disposal the ultimate form of coercion—criminalization—a tool that should be used only in very limited circumstances.

Legal Bases for the Right to Die

Although recognition of the right to die is often presented as a fairly recent legal development, it is rooted in principles that have a long history in American law. The right to die draws on three strains that have worked their way through American law in the past century: the right to control one's own body, the right to privacy, and the due process liberty interest. In *Cruzan v. Missouri Department of Health* and other cases, the U.S. Supreme Court and state courts have relied on each of these principles to establish that individuals have at least some right to die.

The rights to control one's own body against government intrusions and to protect one's person against general unwanted touching have long been recognized in American law. In 1891 the U.S. Supreme Court decided the case of *Union Pacific Railway Co. v. Botsford*, in which a woman passenger sued a railroad company for injuries that she suffered in a fall from an upper berth of a railway car. The railroad sought a court order allowing it to perform a surgical procedure on the woman to determine the extent of her injuries. The Supreme Court, in rejecting the railroad's request, stated that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."4

In the medical context, this right to have control over one's own body is closely connected to the doctrine of informed consent. At common law, informed consent "is viewed as generally encompassing the right of a competent individual to refuse medical treatment."5

A number of state courts have based the right to die on this principle. In *In re Conroy*, for example, the New Jersey Supreme Court relied in part on an individual's common law right to control her own body as a basis for upholding a patient's right to refuse medical treatment. The court in *Bouvia*

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3141 U.S. 250 (1891).
4Id. at 251.
5*Cruzan*, 497 U.S. at 277.
6486 A.2d 1209 (N.J. 1985).
v. Superior Court of Los Angeles also based a right to refuse medical treatment on the right of an adult to determine what is done to her body.

The right to privacy is also by now well established. In 1965 in Griswold v. Connecticut, the U.S. Supreme Court held that the U.S. Constitution protected a "penumbral" right to privacy, and on that basis the Court invalidated state restrictions on the use and distribution of contraceptives. In Roe v. Wade, the Court held that the right to privacy is "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." A plurality of the Court in Moore v. City of East Cleveland relied on the right of privacy to strike down a zoning ordinance that restricted households to members of a traditionally defined nuclear family.

The right to privacy has also provided a basis for the right to die. In In re Quinlan, the New Jersey Supreme Court, in a decision appointing Quinlan's father to be her guardian and authorizing him to terminate her respirator, stated of the right to privacy: "Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."

Finally, courts have based the right to die on a due process liberty interest. The Supreme Court in Cruzan recognized that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment. The Court cited a recent decision concerning the unwanted administration of antipsychotic drugs, in which it held that "[t]he forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."
The Scope of the Right to Die

Recognizing that individuals have at least some limited right to die begins, rather than ends, the inquiry. This can be seen by starting with what is arguably the "easiest" case for a right to die—if one can speak of any case of this kind as being "easy"—an elderly, completely competent, terminally ill patient with no family or dependents, who is in severe pain and who decides on her own to cease heroic medical measures. In this case the patient's interest in ending her life is at its greatest, and the state's interest in interfering with that decision is the least compelling.

For many courts and commentators, the issues become more difficult when any of these stipulated conditions is altered. What if the individual is not competent to make the decision by herself? What if the individual seeks not the cessation of medical care but affirmative steps to end her life? What if the individual is not terminally ill but simply wants to end her life? What if the individual is not elderly but rather a young parent with children who rely on her for financial and emotional support?

In fact, the debate over the right to die has often followed along these lines. Many people, and many courts, support the right to die in the abstract but cease to do so when the facts depart from the "easy case" scenario. As conditions become more removed from the easy case, some courts and commentators begin to hold that the state's general interest in the preservation of life must prevail over the interests of the individual. Although these factual differences may make the right to die seem less intuitively appealing, none of them provides a principled basis for departing from a commitment to an individual's right to die or is especially helpful in drawing lines between particular instances of the taking of a life, as to what should be permitted or forbidden.

When the Individual Is Not Competent to Decide

It is easiest for a court to recognize an individual's right to die when the individual is competent and able to make an unambiguous request to end her life. In many right to die cases, however, the individual whose life is at stake is not able to make a statement about whether she wants to live or die. This was the case in Cruzan. Nancy Cruzan, who was rendered incompetent as a result of an automobile accident, was unable to play any role in the decision about whether to terminate her life. Similarly, Karen

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15For evidence of this, one need only look at the insistence by medical ethicists that we distinguish among physician-assisted suicide, suicide, active voluntary euthanasia, and the right to refuse life-sustaining medical treatment.
Ann Quinlan, who was in a “debilitated and allegedly moribund state,” was unable to state her wishes.\footnote{See In re Quinlan, 355 A.2d 647, 651 (N.J. 1973).}

Many courts consider cases like these to be more complicated for a number of reasons. First, it is difficult for a court to determine whether an incompetent person would have chosen on her own to end her life under the particular circumstances. A court is required to sift through an evidentiary record, often including statements from the individual before she became incompetent and testimony of family and friends, and decide what the individual would want if she were competent. This was the situation of the courts in Cruzan, which had to decide how much weight to give to Cruzan’s general statements about not wanting to be kept alive if she could not live a normal life.

Second, cases of this kind require courts to determine how much discretion should be given to an incompetent person’s family to decide whether to terminate her life. The idea of giving the incompetent person’s family “surrogate” authority has considerable appeal, but it also has some dangers. In the absence of a clear statement from the individual, it might be argued, her loved ones are more entitled to make this very sensitive decision than the state and are more likely to accurately reflect the wishes of the incompetent person. Presumably, the New Jersey Supreme Court was motivated in part by such a view of Karen Ann Quinlan’s father when it reversed the trial court and appointed Mr. Quinlan as his daughter’s legal guardian.\footnote{The applicable guardianship statute established an initial presumption of entitlement to appointment as guardian in the next of kin. 355 A.2d at 670.}

Authorizing an incompetent person’s family to make decisions of this kind raises problems as well. The Cruzan Court, in its decision declining to allow Nancy Cruzan’s family to end her life, noted that “even where family members are present, ‘[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.’”\footnote{497 U.S. at 281 (citation omitted).}

There are many reasons a family might not accurately reflect an incompetent person’s wishes. In some cases, the family members might have different views about the morality of ending a life than the incompetent person would. For example, very religious parents who oppose ending a life might resist terminating life-sustaining treatment even if their child had no such hesitations. In other cases, family members may be motivated by more selfish concerns, like concern over the expense and inconvenience of prolonging the patient’s life. When family members do not accurately reflect the wishes of the incompetent person, the state’s interest in intervening in the decisional process increases. The state’s
primary interest, however, is not an independent one: the interest in determining what the incompetent person herself would have wanted and seeing that those wishes are effectuated.

**When So-Called Affirmative Steps, Or the Assistance of Another, Is Required**

A second complicating factor is what action or omission is necessary to end the individual's life. There is a superficial appeal in dividing right to die cases into those that involve the cessation of medical treatment and those in which an individual seeks to have affirmative steps taken to end her life. To some minds, the former is merely a benign example of a patient determining the amount of medical treatment he or she wishes to receive. The latter, however, appears more akin to an active suicide attempt.

Yet distinctions of this kind are extremely difficult to maintain in practice. Life is not neatly divided up into affirmative “acts” and passive “omissions.” Human life depends on a broad range of measures to survive—including food, water, shelter, and in some cases more specialized forms of medicine or medical procedures. There is no easy way to determine when the decision not to benefit from one of these measures is a passive omission rather than an affirmative act. As one commentator expresses the issue, “Is a physician who turns off a functioning respirator ‘actively’ turning off a machine or ‘omitting’ to provide air? Is a patient who refuses food and water ‘actively’ starving or ‘omitting’ to eat?”

The decision about what constitutes an action and what constitutes an omission inevitably collapses into a moral judgment about the facts of a particular case. For example, the Connecticut Supreme Court recently held that “the removal of a gastronomy tube is not the ‘death producing agent’. . . . [D]eath will be by natural causes underlying the disease, not by self-inflicted injury.” If the patient had wanted the tube to remain, and someone with ill motives had broken into her hospital room and ripped out the tube, it is hard to imagine a court taking such a casual view of the connection between the removal of the tube and the death.

Nor should the matter turn on whether another person is enlisted to end the life. If an individual may end her own life, she should be free to do so by the means that she selects. Indeed, in the case of some persons with physical incapacities, assistance from another person may be necessary if they are to effectuate their desire to end their lives. The same principles that


support an individual's right to end her own life—the right to control one's own body, privacy, and liberty—apply equally when another person is enlisted to help end that life.

When another person is involved in ending a life, the situation is made more complicated in a number of respects. From the perspective of the person who apparently wants to die, this surrogate assistance introduces the possibility that the person who ends the life will not accurately reflect the true desires of the individual whose life is ended. Courts should be vigilant to ensure that people who assist others in ending their lives do so only when the individual actually wants to die. In addition, courts must make clear that ending a life in any case other than when the individual wants her life ended is homicide. Thus the reports that Dr. Kevorkian "assisted" a person to die despite the fact that the person changed his mind at the last minute and asked to be allowed to live—reports that Dr. Kevorkian has denied—should be troubling and should give rise to criminal liability if true. There is also the perspective of the persons who are being asked for assistance. They may have a number of reasons, including personal morality and professional ethics, why they might decline such a request. Even if a person has a right to die and to receive help from a willing source, this does not entail the right to compel assistance from someone who finds such participation objectionable.

The role of the person assisting raises a number of other concerns. What competencies if any should the helping party have? Should she be in the medical profession, or should the law also permit lay people to assist? What kind of immunity should the helper receive and under what conditions? While it seems clear that a person should be able to legally


24This is a complicated issue especially with regard to the medical profession. The public and the government have an interest in maintaining the ethical integrity of the profession. Some have argued that allowing medical professionals to assist in suicide could undermine the integrity of the profession. This is a serious concern that would have to be addressed, but it goes to the integrity of the profession, not the right to obtain assistance. In addition, while a person generally has a right to refuse to assist for personal or ethical reasons, this is not absolute, especially for the medical profession. For example, what if a doctor refused to treat a patient for reasons of the patient's race or nationality? We are not likely to say that the doctor has unlimited discretion in such a case. Similarly, if a patient has a right to die, there may be circumstances where the doctor's refusal to assist goes beyond the scope of legitimate personal discretion.

25The medical profession has a special role, given its expertise and role in our society. In addition, there are special ethical concerns related to the profession.
receive help from a willing and competent helper, even where the person's wishes to die are obvious, numbers of unanswered questions remain.

When the Individual Is Not Terminally Ill

Recognizing the right to die for patients who are terminally ill is perhaps the least problematic. In such cases the individual can be seen not as affirmatively choosing death but rather as choosing to hasten and make less unpleasant a death that is already inevitable. (It is this notion of a "good death" that formed the Greek origins of the word euthanasia.) A number of courts and commentators contend that the right to die should extend only to patients refusing medical treatment but not to those requesting assistance in suicide.\(^2\)

Like so many distinctions in the right to die area, the distinction between terminally ill persons and everyone else turns out not to have much meaning in practice. At the most basic level, all human beings are terminally ill in the sense that they are mortal and on a progression toward death—as John Maynard Keynes put it, "In the long run we are all dead." It is now recognized that conditions that kill adults late in life, such as heart disease, often begin as early as childhood. If a sixty year old man who dies of a heart attack first experienced hardening of the arteries in his teens, was he terminally ill at that early age? In fact, there simply is no consensus on a medical definition of terminal.\(^2\)

Of course, even if a clear distinction existed between terminally ill persons and everyone else, it is not clear why this distinction should be significant for the right to die discussion. There are many reasons why a healthy person might choose to end her life: e.g., because she wants to become a religious martyr and ensure a place in heaven; because she has determined that life is not worth living without a particular person or without world peace and brotherhood; because she has always been independent and does not want to live in a state of dependency; or because she does not want to be a burden to her children in her old age. It is problematic for the state to choose among these motivations and single out terminal illness as the only acceptable, or rational, reason for wanting to end one's life.

When Others Depend on the Individual

Finally, some argue that an individual's right to die should not be recognized, or not recognized as readily, when she has small children or

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\(^2\)See Note, supra note 20, at 2023 n.26 (citation omitted).
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others who depend on her. Although this position has an intuitive appeal, it is also problematic. The general rule in American law is that people do not have a duty to care for others if they do not wish to do so. Even if we believe that there is a duty to care for others, it is not clear that such a duty can be enforced beyond narrow limits. For example, although there is some legal basis for the duty of parents to care for their children, parents in all states are free to terminate their relationship with their children by putting them up for adoption.

Clearly, most people would like to think that an individual will consider the effect that her death will have on others, particularly those who depend on her for support. However, it is difficult to see why the state should be given the authority to place this one factor above all others if the individual herself does not.

Toward an Approach That Respects Individual Autonomy

Our commitment to the principles of an individual's right to control her own body, privacy, and liberty should lead us to approach the issue of the right to die with a commitment to respect the autonomy of the individual whose life is involved. Adopting this approach does not mean that society has no interest at all in the decision that is being made. It does, however, mean that, after appropriate safeguards are put in place to ensure that individual autonomy is being respected, the individual's own choice must be regarded as paramount.

Recognition that individual autonomy must be the guiding principle in right to die cases does not mean that society has no legitimate interest in these determinations. Society's legitimate interests, including its interest in the preservation of life, should be recognized and given appropriate credit. These societal interests do not dictate that the right to die should not be recognized, but rather that appropriate care and safeguards are established to protect the interests of the individual.

In applying the principle of respect for individual autonomy, courts should look to see that life is ended only if it is the true wish of the individual involved. In making this determination, distinctions between suicide and euthanasia, or between taking affirmative steps to die rather than ceasing heroic lifesaving measures, are not particularly useful. Instead, courts should be most concerned with (a) exploring all available evidence of what the individual wants or would have wanted if she were competent to decide; and (b) identifying coercive forces of various kinds that could distort the court's analysis of the wishes of the individual.

Society's Interest in the Individual's Choice

To say that individual autonomy should be the touchstone of right to die cases does not mean that society has no interest at all in the decision. Society has legitimate interests, including an interest in the preservation of life, that are implicated in such cases. Courts should ensure that appropriate precautions are taken to ensure that the right to die is not applied in a way that eviscerates these legitimate societal interests.

This is so not merely because of a moral belief in the sanctity of all human life, but because of the interests civil society has in its own preservation. John Locke's Second Essay Concerning the True Original Extent and End of Civil Government points out that 'the preservation of the society and (as far as will consist with the public good) of every person in it' is 'the first and fundamental natural law which is to govern even the Legislative, itself.' And thus, when the ability to use lethal means becomes a matter of individual choice, rather than a matter tightly constrained by the threat of official force, society returns to Locke's 'State of Nature,' and civil government loses its unique authority.29

Clearly, the right to die implicates to some extent society's interest in preserving human life. But it is a considerable slide down the slippery slope to suggest that permitting people to end their own lives under carefully regulated circumstances will undermine society's opposition to homicide generally or turn America into a Lockean "State of Nature" in which "civil government loses its unique authority." Society can be preserved from anarchy, and its opposition to homicide defended, even in a legal regime in which the right to end one's own life is recognized.

In addition, allowing society's interest in preserving life to determine the decision to end one's own life fails to comport with the centrality of an individual's autonomy in the present legal landscape. There may be good reasons to challenge the dominant approach to the existing divide between societal interest and autonomy. Yet our current divide severely limits societal interest in favor of individual autonomy. Unlike the legal world envisioned by some communitarians, many feminist thinkers, and critical legal theorists, American law does not revolve around very strong notions of connectedness or community. Good Samaritan laws, for instance, are rare. Group harms and group remedies are less well settled in property, torts, and constitutional law than are individual actions and recoveries. To insist that society may dictate whether one may end one's own life in right

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29Robert Destro, The Scope of the Fourteenth Amendment Liberty Interest: Does the Constitution Encompass a Right to Define Oneself Out of Existence? An Exchange of Views with john a. powell, Legal Director, American Civil Liberties Union, 10 ISSUES IN LAW & MED. 183, 207-08 (1994).
The Right to Die cases, but not hold liable the person who watches another person drown in a shallow pool, is unacceptably hypocritical.

Where society's interest in the preservation of human life should be credited, however, is in establishing appropriate guidelines for the exercise of the right to die. Society's interest in the preservation of life is most compromised when the right to die is perverted from a principle that permits individuals to end their own lives to one that is used to end individuals' lives against their will. It is in such cases that the right to die doctrine—or a mutation of it—threatens to create a situation in which human life in general is devalued.

For this reason society has a legitimate interest in ensuring that the right to die is exercised only by or on behalf of those who actually want to end their own lives. To ensure that this is so, society has an interest in having courts determine whether the individual has expressed the desire to end her life under the circumstances or would do so. It also has an interest in ensuring that the individual has not been unduly coerced in that decision—whether by family, medical staff, or society itself.

Identifying the Individual's Wishes

Assuming that the touchstone of a court's analysis of a right to die case should be the individual's own wishes about whether to continue her life, courts will have to determine the individual's wishes. This requires that courts engage in a case by case evaluation of the evidence before them.

In some cases the wishes of the individual will be clear. For example, she may be fully competent at the time that the decision is being made,30 or she may have left clear instructions about what steps are and are not desired.31

In other cases the wishes of the individual will not be as clear. As was the case with Nancy Cruzan and Karen Ann Quinlan, the person whose life is at issue may have had a sudden and severe accident that rendered her incompetent before she could make her wishes known. Or the individual may have become incompetent over time and simply never expressed her views before becoming incompetent.

In these more difficult cases, courts should endeavor to determine the wishes of the affected individual from all available evidence. In this analysis courts should give weight to any general statements the person may have made over the course of her life about whether she would want her life prolonged in similar circumstances. For example, Nancy Cruzan had made


statements to family members and a close friend that she would not want to live in a vegetative state.\textsuperscript{32}

In assessing the individual's wishes, the evidentiary standard that a court requires is important. There will, of course, be some cases in which an incompetent person has made a "living will" that speaks directly to the question.\textsuperscript{33} But in the vast majority of cases, it is likely that there will not be such a clear statement. As Justice Brennan noted in his dissenting opinion in \textit{Cruzan}:

While it might be a wise social policy to encourage people to furnish such instructions, no general conclusion about a patient's choice can be drawn from the absence of formalities. The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences. Some may not wish to dwell on their own physical deterioration and mortality. Even someone with a resolute determination to avoid life support under circumstances such as Nancy's would still need to know that such things as living wills exist and how to execute one.\textsuperscript{34}

Because people do not always speak with great specificity and legal niceties on this subject, imposing an unduly onerous standard of proof can result in thwarting an individual's true wishes.

The majority in the \textit{Cruzan} case did precisely this. The record in the case contained clear statements from Nancy Cruzan to family and a friend that she did not want to be kept alive in a vegetative state.\textsuperscript{35} However, the \textit{Cruzan} majority, in adopting the exacting "clear and convincing" proof standard—higher than the usual civil standard—upheld the Missouri Supreme Court's determination that these statements were not sufficient proof of Cruzan's wishes.\textsuperscript{36} The dissenters rightly took the majority to task for "overrid[ing] Nancy's choice . . . indirectly through the imposition of a procedural rule."\textsuperscript{37}

Another source that courts should look to in determining an individual's wishes is that person's family. Family members will often be in a better position than a court to know what the person would have wanted.\textsuperscript{38} Clearly, family members may have interests that depart from

\textsuperscript{32}See \textit{Cruzan}, 497 U.S. at 321 n.19 (Brennan, J., dissenting).
\textsuperscript{33}See, e.g., \textit{Bludworth}, 452 So. 2d 921.
\textsuperscript{34}See \textit{Cruzan}, 497 U.S. at 323 (Brennan, J., dissenting).
\textsuperscript{35}See \textit{id. at 321-22 & nn.19-20 (Brennan, J., dissenting).}
\textsuperscript{36}See \textit{Cruzan}, 497 U.S. at 285.
\textsuperscript{37}See \textit{id. at 317 (Brennan, J., dissenting).}
\textsuperscript{38}See, e.g., \textit{In re Quinlan}, 355 A.2d 647, 664 (1976)("The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best
those of the individual herself, but, in the absence of such conflicts, a court should not lightly reject a loving family's account of what the individual would have wanted.

**Controlling for Coercive Forces**

When a court approaches a right to die case, it should be particularly careful to identify and control for coercive forces that may overshadow the actual wishes of the individual. These coercive forces may be at work with competent individuals as well as incompetent ones. These distortive influences can come from a number of actors, including the individual's family, her attending medical staff, and society generally.

When family members are acting out of a sincere interest in effectuating the wishes of the individual, their views should be given appreciable weight by courts. In some cases, however, a family will have interests that conflict with those of the individual. These interests could make the family either more or less likely to favor ending the individual's life. There will no doubt be families that are motivated by saving the expense, inconvenience, and personal anguish of keeping an individual alive. There will no doubt be financially motivated family members whose decision is influenced by when they will be able to claim their inheritance. There will also be families whose religious or ethical beliefs make them less receptive to ending a life than the individual whose life is at issue, and a court should be sensitive to the possibility of this kind of bias as well.

Courts must also be wary of coercion by doctors and hospitals. Again, this coercion could occur in either direction. Some doctors may have religious, moral, or professional objections to granting an individual's right to die. Other doctors or medical institutions may be biased in favor of ending lives rather than keeping incompetent patients alive indefinitely. Courts should be vigilant about ensuring that medical practitioners do not coerce competent patients into ending their lives, and that they do not end the lives of incompetent patients when the evidence suggests that these patients would prefer to be kept alive.

Of course, no medical practitioner should be required to assist in terminating a life if she has ethical or religious objections to doing so. Doctors and other medical workers should be permitted to transfer their patients into the care of other practitioners who do not have such compunctions. But in no case should the practitioner's objections be allowed to trump the desires of the individual whose life is at issue.

Finally, courts must be wary against coercion that occurs at the societal level. Opponents of the right to die often make a slippery slope judgment, subject to the qualifications herein stated, as to whether she would exercise it in these circumstances).
argument: that if individuals are allowed to end their lives voluntarily, before long society will be compelling them to do so against their wishes.39 This is a legitimate reason for a court to be mindful of these societal pressures and to ensure that they are not being allowed to overcome the individual's own wishes. Nevertheless, it does not justify rejecting the preferences of individuals who actually do want to end their lives.

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39See, e.g., Leon Kass, Is There a Right to Die? HASTINGS CENTER REP., Jan.-Feb. 1993, at 34, 42 ("No one with an expensive or troublesome infirmity will be safe from the pressure to have his right to die exercised").