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First Man and Second Woman: Reflections on the Anniversaries of Apollo 11 and *Cruzan*

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FIRST MAN AND SECOND WOMAN: REFLECTIONS ON THE ANNIVERSARIES OF APOLLO 11 AND CRUZAN

George J. Annas*

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I. INTRODUCTION

THE United States Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health* marks its thirtieth anniversary in 2020.¹ This follows closely after the fiftieth anniversary of the Apollo 11 moon landing.² Anniversaries provide an opportunity for reflection and to gain perspective. We can, I suggest, gain deeper insights regarding human life and death by considering these two anniversaries together. Apollo 11 may seem far from Nancy Cruzan—but the discovery of disturbing details about the death of Neil Armstrong, the first man on the moon, is a productive introduction to the topic of death in a modern American health care institution. Both anniversaries focus on individuals—Nancy Cruzan (the second woman, after Karen Ann Quinlan, to personify the American “right to die”) and Neil Armstrong (the first man on the moon). The stories of both Nancy Cruzan and Neil Armstrong are also tied to massive built environments: the American health care nonsystem and its hospitals and complex medical procedures, and the Apollo spacecraft and its rockets and bewildering computers. These technologies have not just changed what we can do, they have changed the way we think about ourselves and our future. This article unfolds in four parts:

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1. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

2. Peter Baker, *For 50 Years Since Apollo 11, Presidents Have Tried to Take That Next Giant Leap*, N.Y. TIMES (July 19, 2019), <https://www.nytimes.com/2019/07/19/us/politics/apollo-11-anniversary-presidents.html> [<https://perma.cc/T9EP-RQB8>].

the death of Neil Armstrong; the death of Nancy Cruzan; Cruzan's progeny and physician-assisted suicide; and our failure to protect the rights of competent hunger-striking prisoners to refuse fluids and nutrition by labeling hunger striking as a suicidal act.

II. THE DEATH OF NEIL ARMSTRONG

The success of the Apollo 11 moon landing immediately made the project the most celebrated engineering feat in human history and the first man on the moon, Neil Armstrong, the most famous person in the world. It was such an astonishing accomplishment that it is routinely used to suggest that if America can put a man on the moon, it should be able to solve a host of other challenging problems, including going to Mars, curing cancer, reversing climate change, or even vastly extending human longevity.³ The fascination with technology on which the moon landing was built finds its most endearing appeal in medicine, especially medical innovations that can "save lives."

Space travel can, of course, be dangerous, and all the Apollo astronauts recognized that they were putting their lives at risk every time they boarded a space capsule.⁴ Less well recognized is that hospital care is also dangerous. Estimates of avoidable deaths in American hospitals, 300,000 or more deaths a year, make it the third largest cause of death in the United States after heart disease and cancer.⁵ After three astronauts were incinerated in a fire inside an Apollo capsule while it was on the ground, investigators concluded that NASA did not have a culture of safety but rather one that tolerated unnecessary risks.⁶ The same can, unfortunately, still be said of American medicine. Nonetheless, it was horrifying to learn from the *New York Times* in July 2019 that Neil Armstrong died not of "natural causes" but as a result of likely medical malpractice in the treatment of his heart disease.⁷

Even the most famous person in the world is at risk of a fatal error during hospitalization in America. And, of course, no matter one's fame, death is certain, and relatives may have to make a decision about terminating treatment. Armstrong's avoidable death in a hospital brings Apollo 11 back down to earth and suggests that, as we seek immortality

3. See, e.g., Charles Fishman, *The Wild, Improbable History of the Phrase 'If We Can Put a Man on the Moon . . .'*, FAST CO. (June 24, 2019), <https://www.fastcompany.com/90366583/the-wild-improbable-history-of-the-phrase-if-we-can-put-a-man-on-the-moon> [<https://perma.cc/4U2X-RYNQ>].

4. See Elizabeth Howell, *Apollo 11 Moon Landing Carried Big Risks for Astronauts*, NASA, SPACE.COM (July 19, 2014), <https://www.space.com/26576-apollo-11-moon-landing-risks.html> [<https://perma.cc/D77Y-NZ6P>].

5. Martin A. Makary & Michael Daniel, *Medical Error—the Third Leading Cause of Death in the US*, BMJ (May 3, 2016), <https://www.bmj.com/content/353/bmj.i2139> [<https://perma.cc/2UT7-DWHA>].

6. Kevin Fong, *Moon Landing: Space Medicine and the Legacy of Project Apollo*, 394 LANCET 205, 207 (2019).

7. Scott Shane & Sarah Kliff, *Neil Armstrong's Death, and a Stormy, Secret \$6 Million Settlement*, N.Y. TIMES (July 23, 2019), <https://www.nytimes.com/2019/07/23/us/neil-armstrong-wrongful-death-settlement.html> [<https://perma.cc/D5X6-34F3>].

in the stars, we remain grounded in death here on earth. Based on medical records made available to the *New York Times*, Armstrong went to the hospital with chest pain and underwent successful cardiac bypass surgery, after which he was up and walking.⁸ Some experts questioned whether the surgery should have been done at all.⁹ He was doing fine until a nurse removed the wires in his heart connected to a temporary pacemaker, which caused “significant and rapid bleeding.”¹⁰ Armstrong was rushed to the cardiac catheterization lab, but the bleeding could not be stopped.¹¹ He was then taken to an operating room for surgery but never regained consciousness.¹² In retrospect, a cardiac surgeon and an operating room should have been on standby when the pacemaker wires were removed, and he should have been brought to an operating room immediately. Taking him to a cardiac catheter lab was simply a mistake that fatally delayed proper care.¹³ In the words of an expert hired by the family, Joseph Bavaria, vice-chair of cardiothoracic surgery at the University of Pennsylvania, “The decision to go to the catheter lab was THE major error.”¹⁴ One likely explanation for the substandard care is that the hospital in which he was treated, Fairfield Hospital (now called Bon Secours Mercy Health), was a community hospital that did a low volume of cardiac surgeries.¹⁵ Low volume made it a poor choice for cardiac surgery, especially since it is in the same city as Cincinnati Medical Center, a major medical center with much higher volume that made it a much more justifiable choice.¹⁶ Armstrong never regained consciousness. He was removed from life support a week later.¹⁷ He was eighty-two.¹⁸

I have previously suggested that our inability to repair our broken health care nonsystem can be traced to four fundamental characteristics of American society. We are individualistic, technologically driven, death-denying, and wasteful.¹⁹ Of these four, death denial affects us the most. Death is the central reality of human life—but it is one we continually refuse to face. Rather, we try to give responsibility for death to physicians and lawyers. Yet this will never succeed, since death is neither a medical nor a legal problem; although, depending on where it occurs—in a space capsule or in a community hospital—it can produce significant medical

8. *Id.*

9. Gina Kolata, *Neil Armstrong Died After Heart Surgery. That May Have Been Avoidable*, N.Y. TIMES (July 25, 2019), <https://www.nytimes.com/2019/07/25/health/neil-armstrong-heart-surgery.html> [<https://perma.cc/Y6KL-NBVA>].

10. Shane & Kliff, *supra* note 7.

11. *Id.*

12. *Id.*

13. *Id.*; Kolata, *supra* note 9.

14. Shane & Kliff, *supra* note 7.

15. *Id.*

16. *Id.*

17. *See id.*; see also Scott Shane, Sarah Kliff & Susanne Craig, ‘Would Dad Approve?’ *Neil Armstrong’s Heirs Divide Over a Lucrative Legacy*, N.Y. TIMES (July 27, 2019), <https://www.nytimes.com/2019/07/27/us/neil-armstrong-heirs.html> [<https://perma.cc/6VP6-DDBZ>].

18. Shane & Kliff, *supra* note 7.

19. GEORGE J. ANNAS, *WORST CASE BIOETHICS: DEATH, DISASTER, AND PUBLIC HEALTH* 11–14 (2010).

and legal questions. The geography of death also determines what technologies will be available to try to prevent or postpone it.

American novelist Don DeLillo, perhaps America's most critical explorer of the impact of technology on how we think about ourselves and our futures, has suggested a future in which those who can afford it will have their bodies frozen and put into storage.²⁰ The idea is that a frozen body can be reawakened when technology has advanced to a point where it can be revived to go on living in some form.²¹ Of course, the broad outlines of his plot are suggested by the commercial frozen body repository, Alcor, which offers to freeze your body after death with the hope of resurrection.²² Why immortality through cryopreservation? A sales rep for DeLillo's fictional company suggests a checklist of questions to consider when making a decision to freeze (or not freeze) your body for a type of immortality:

Once we master life extension . . . what happens to our energies, our aspirations?

...

Are we designing a future culture of lethargy and self-indulgence?

...

Isn't it sufficient to live a little longer through advanced technology? Do we need to go on and on and on?

...

Won't we become a planet of the old and stooped, tens of billions with toothless grins?²³

Later, DeLillo imagines a dialogue that might go on in the "mind" of a female frozen client:

Is this the nightmare of self drawn so tight that she is trapped forever.

I try to know who I am

But all I am is what I am saying and this is nearly nothing.

She is not able to see herself, give herself a name, estimate the time since she began to think what she is thinking.

I think I am someone. But I am only saying words.

The words never go away.²⁴

Neal Stephenson also imagines reading the mind of a frozen person in his 2019 novel *Fall*.²⁵ What little can take place in a frozen brain forces us to ask whether we really want what we say we want. Is "living" on in an extremely minimalist way or living virtually as part of a computer-enabled *Matrix*-style program ("But all I am is what I am saying and this is

20. DON DELILLO, *ZERO K* (2016) (a novel about a search for immortality through cryopreservation).

21. *What Is Cryonics?*, ALCOR LIFE EXTENSION FOUND., <https://alcor.org/AboutCryonics/index.html> [<https://perma.cc/K483-BC4E>] (last visited Dec. 18, 2019).

22. *See id.*

23. DELILLO, *supra* note 20, at 69.

24. *Id.* at 161.

25. NEAL STEPHENSON, *FALL; OR, DODGE IN HELL* (2019) (a novel exploring the digital preservation and reawakening of a human brain).

nearly nothing”²⁶) worth it—or is it in the category of a fate worse than death? How does it compare to Karen Ann Quinlan or Nancy Cruzan’s lives in a permanent vegetative state? How minimal should minimal conscious be to qualify as a life worth preserving?²⁷ Or rather than interrogating quality of life, should we take the position of the state of Missouri in *Cruzan* that government can claim an unqualified interest in the lives of its citizens?²⁸

DeLillo’s characters have come a long way since his novel *White Noise* in which one character suggests that if you are worried about death you can deny it, put your faith in religion, or “[y]ou could put your faith in technology. It got you here, it can get you out. This is the whole point of technology. It creates an appetite for immortality on the one hand. It threatens universal extinction on the other.”²⁹ As the late bioethicist Daniel Callahan has noted, space travel and medical technology both face unlimited frontiers: no matter how far you go in space or how far you go with medical technology, you can always go further.³⁰ Private commercial ventures, fueled by the profit motive, now dominate both space travel and medicine. In filing a lawsuit on behalf of Armstrong’s family against the hospital in which he died, the Armstrong family lawyer, Bertha Helmick, made the commercial point in the context of branding: “Any linkage of this health provider to the death [of Neil Armstrong] could irreparably and unfairly forever taint the business enterprise. . . . No institution wants to be remotely associated with the death of one of America’s greatest heroes.”³¹ The prospect of spectacularly negative publicity was why the hospital insisted that the settlement (totaling \$6 million) be confidential.³² The business model of most American hospitals calls for routinely covering up medical malpractice rather than facing and correcting it.

As private hospitals and health insurance companies discover new ways to make money, we should expect to see parallel commercial developments in the space sector. Writer Kenneth Chang, for example, has suggested, under the category of using the moon as a business opportunity, that “[t]here could be an opening for companies that would ship the ashes of loved ones to the moon as a memorial.”³³ If we can go to the moon, shouldn’t we be able to provide everyone a “right to die”? Or is the prob-

26. DE LILLO, *supra* note 20, at 161.

27. See, e.g., Joseph J. Fins, *When No One Notices: Disorders of Consciousness and the Chronic Vegetative State*, HASTINGS CTR. REP., July–Aug. 2019, at 14, 14.

28. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 262–63 (1990).

29. DON DE LILLO, *WHITE NOISE* 285 (1985) (a novel about the side effects of modern technology).

30. DANIEL CALLAHAN, *TAMING THE BELOVED BEAST* 9 (2009).

31. Shane & Kliff, *supra* note 7.

32. *Id.*

33. Kenneth Chang, *Why Everyone Wants to Go Back to the Moon*, N.Y. TIMES (July 12, 2019), <https://www.nytimes.com/2019/07/12/science/nasa-moon-apollo-artemis.html> [<https://perma.cc/A87N-SLVW>]. See generally WALTER MCDUGALL, *THE HEAVENS AND THE EARTH: A POLITICAL HISTORY OF THE SPACE AGE* (1985).

lem of death one we will never be able to confront, at least in the context of the great American health care nonsystem?

III. THE DEATH OF NANCY CRUZAN

Nancy Cruzan's name is known primarily because her death was the subject of the major, and deeply flawed, Supreme Court opinion on informed consent and its corollary, the right to refuse treatment.³⁴ Prior to *Cruzan*, the most well-known right to refuse treatment case was the 1976 New Jersey case of Karen Ann Quinlan, a young woman in exactly the same physical condition (persistent vegetative state) as Cruzan, except—it was believed—Quinlan needed both a feeding tube and a ventilator to continue to survive.³⁵ Quinlan's case provoked widespread public agreement with the wishes of her parents to have her removed from her ventilator so she could die.³⁶ This was because all believed she would never regain consciousness, and most Americans are terrified of being kept alive in a permanent vegetative state by machines.³⁷ Because she was the first to raise the "right to die" as a national issue, Quinlan will always be the most famous personification of it. Cruzan will always be, like Buzz Aldrin,³⁸ second. Nonetheless, Cruzan was the first to get her case to the Supreme Court.

Chief Justice William Rehnquist wrote the opinion of the Court in *Cruzan*, which was split five to four, mischaracterizing it confusingly as a right to die and a right to cause death case.³⁹ Without deciding the issue, the Chief Justice wrote that, "[f]or purposes of this case," the Court would assume that the U.S. Constitution would grant "a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."⁴⁰ Such a right was seen as implicit in previous decisions, based on the liberty interest in the Fourteenth Amendment.⁴¹ The core of the case, however, was determining whether the State could restrict the exercise of the right to refuse treatment by a surrogate decision maker acting on behalf of a previously competent patient.⁴² The question was whether the Constitution forbids a state from requiring clear and convincing evidence of a person's expressed decision while competent to have hydration and nutrition withdrawn in such a way as to cause death.⁴³ The Court

34. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

35. *In re Quinlan*, 355 A.2d 647, 655 (N.J. 1976).

36. *See, e.g., Cruzan*, 497 U.S. at 267–68.

37. *Id. See generally* NORMAN L. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* (1987).

38. Buzz Aldrin was a member of the three-person Apollo 11 crew and was the second man to walk on the moon. *See Baker, supra* note 2. *See generally* GENE FARMER & DORA JANE HAMBLIN, *FIRST ON THE MOON: A VOYAGE WITH NEIL ARMSTRONG, MICHAEL COLLINS, EDWIN E. ALDRIN, JR.* (1970).

39. *Cruzan*, 497 U.S. at 262, 277.

40. *Id.* at 279.

41. *Id.* at 278–79.

42. *Id.* at 280.

43. *Id.*

concluded that the Constitution did not prohibit this procedural requirement.⁴⁴

Four basic reasons were given for this conclusion. The first reason was that this evidentiary standard (clear and convincing evidence) promotes the State's legitimate interest "in the protection and preservation of human life."⁴⁵ The second reason was that "the choice between life and death is a deeply personal decision"⁴⁶ The third reason was that abuses can occur if no "loved ones [are] available to serve as surrogate decision makers."⁴⁷ Finally, the fourth reason was that the State may properly "simply assert an unqualified interest in the preservation of human life"⁴⁸

The Court also thought that use of the clear-and-convincing standard was appropriate because it was better to err on the side of continuing treatment, noting that "[a]n erroneous decision not to terminate results in a maintenance of the status quo[] [and] the possibility of subsequent developments such as advancements in medical science, . . . [while an] erroneous decision to withdraw life-sustaining treatment . . . is not susceptible of correction."⁴⁹

Justice William Brennan, writing for three of the four dissenting Justices, persuasively outlined the majority opinion's shortcomings.⁵⁰ He argued that the right to refuse treatment is a fundamental constitutional right and cannot be restricted unless the state can demonstrate a compelling interest—something more than just a general interest in life.⁵¹ Even if a rational basis test was adopted, Brennan argued the State could not meet even this low bar because its rule could result in more deaths by discouraging trials of therapy, by making them too difficult to end when they are not successful.⁵² Justice Brennan argued that the only legitimate interest the State had was in ascertaining the patient's wishes.⁵³ Because the clear-and-convincing standard excludes considerable evidence that could help the decision maker determine the patient's wishes, application of this high evidentiary standard effectively "transform[ed] [incompetent] human beings into passive subjects of medical technology."⁵⁴

Justice Sandra Day O'Connor used her concurring opinion to discuss surrogate decision makers and encouraged everyone to appoint a proxy decision maker.⁵⁵ She emphasized that *Cruzan* "does not preclude a future determination that the Constitution requires the States to implement

44. *Id.* at 286–87.

45. *Id.* at 280.

46. *Id.* at 281.

47. *Id.*

48. *Id.* at 282.

49. *Id.* at 283.

50. *Id.* at 301–30 (Brennan, J., dissenting).

51. *Id.* at 305.

52. *Id.* at 314.

53. *Id.* at 317–19.

54. *Id.* at 325.

55. *See id.* at 287–92 (O'Connor, J., concurring).

the decisions of a duly appointed surrogate.”⁵⁶ This is reasonable advice, but even if we all had health care proxies, this would not solve our problems with death or the use of medical technology to postpone it. Moreover, given that every indication is that Cruzan would have chosen either her mother or father to speak on her behalf, it is an empty triumph of procedure over substance to deny Cruzan’s parents the right to speak on their daughter’s behalf.

In addition to Justice Brennan’s listing of the major flaws in *Cruzan*, there are other flaws that I noted at the time in an essay in the *New England Journal of Medicine* written for physicians.⁵⁷ The first one is blatantly obvious: physicians are not even mentioned in the opinion and are called simply “hospital employees” with no role and no specific doctor-patient relationship or medical obligations to the patient.⁵⁸ No attention is paid at all to medical reality or how decisions are actually made in health care institutions. The second, and most important point, is that “the *Cruzan* opinion [did] not change the law in any state or in any way alter what physicians could or could not do before the opinion.”⁵⁹ I did, however, suggest that if states wanted to review their evidentiary rules they should recognize that most families can and should be permitted to make medical decisions for their incompetent family members.⁶⁰ Moreover, the burden should be on the state to prove by clear and convincing evidence that the family’s wishes are inconsistent with the wishes of the patient before removing decision-making authority from the family.⁶¹ I also suggested that it would be prudent to adopt the type of health care proxy arguably endorsed by Justice O’Connor,⁶² a step taken by Massachusetts almost immediately after the opinion was published.⁶³

On the thirtieth anniversary of *Cruzan*, it seems reasonable to conclude that its most significant legacy is the physician-assisted suicide cases that followed it, which, like *Cruzan*, Chief Justice Rehnquist assigned to himself.⁶⁴ In a striking contrast to *Cruzan*, both of these opinions were unanimous.⁶⁵

56. *Id.* at 292.

57. George J. Annas, *Nancy Cruzan and the Right to Die*, 323 NEW ENG. J. MED. 670, 672 (1990) [hereinafter Annas, *Nancy Cruzan and the Right to Die*].

58. *Id.*

59. *Id.* This point was also made by a group of bioethicists who were meeting at a national conference when the *Cruzan* opinion was issued. George J. Annas et al., *Bioethicists’ Statement on the U.S. Supreme Court’s Cruzan Decision*, 323 NEW ENG. J. MED. 686, 686 (1990).

60. Annas, *Nancy Cruzan and the Right to Die*, *supra* note 57, at 672.

61. *Id.*

62. *Id.*

63. MASS. GEN. LAWS ch. 201D, § 4 (2019). A form that satisfies the provisions of this law is available online from the Massachusetts Medical Society. *Health Care Proxies and End of Life Care*, MASS. MED. SOC’Y, <http://www.massmed.org/Patient-Care/Health-Topics/Health-Care-Proxies-and-End-of-Life-Care/Health-Care-Proxies-and-End-of-Life-Care/#.XfpUIGRKg2w> [https://perma.cc/E7WG-AEWT] (last visited Dec. 18, 2019).

64. *See infra* Part IV (discussing *Washington v. Glucksberg*, 521 U.S. 702 (1997), and *Vacco v. Quill*, 521 U.S. 793 (1997)).

65. *See Glucksberg*, 521 U.S. 702; *Quill*, 521 U.S. 793.

IV. CRUZAN'S PROGENY

Risking death in space travel is not suicide, or even risking suicide; it is selecting and pursuing a risky profession. Nonetheless, astronauts, like all of us, can commit suicide, and suicide was acknowledged as a concern by the third member of the Apollo crew, Michael Collins. As Armstrong and Aldrin were walking on the moon, Collins was orbiting the moon in the mother ship and contemplating what he would do should Armstrong and Aldrin not return from the surface of the moon.⁶⁶ Collins, as he described, decided he would not commit suicide.⁶⁷ In his words, "If they fail to rise from the surface, or crash back into it, I am not going to commit suicide . . . [and] I will be a marked man for life, and I know it."⁶⁸ Collins provokes us mostly to deny that the moon landing had anything to do with suicide. Similarly, the Supreme Court ultimately ruled in the two physician-assisted suicide cases following *Cruzan* that refusal of medical treatment has nothing to do with suicide.⁶⁹

By ceding constitutional authority over life and death decisions to the individual states in *Cruzan*, the Court set the stage for decades of state legislative activity in the area of physician-assisted suicide and for two additional Court decisions. Although I believe it was wrong and counter-productive for the Court to ignore physicians altogether in *Cruzan*, I also think the subsequent post-*Cruzan*, post-*Quinlan* obsession with granting legal immunity to physicians for specific end-of-life actions is equally misplaced. Neither increasing state power over physicians nor increasing physician power over patients will help us confront death.

After *Cruzan*, right-to-die proponents on both coasts adopted a *Roe v. Wade*-type strategy⁷⁰ to promote a new constitutional right: the "right to physician-assisted suicide." Two complimentary arguments made it to the Supreme Court and were consolidated there: *Washington v. Glucksberg*⁷¹ and *Vacco v. Quill*.⁷² In *Glucksberg*, it was argued that the Due Process Clause of the Fourteenth Amendment contained a substantive constitutional right to access to physician-prescribed drugs that could be used by

66. See Stephen Witt, *Apollo 11: Mission Out of Control*, WIRED (June 24, 2019, 6:00 AM), <https://www.wired.com/story/apollo-11-mission-out-of-control/> [https://perma.cc/85NJ-RPCD].

67. See *id.* Norman Mailer also discusses suicide in contemplating what would happen if the lunar module (Eagle) failed to make its return to the mother ship. NORMAN MAILER, *OF A FIRE ON THE MOON* 373–75 (1970).

If that ascent engine had not worked—there were no suicide capsules on the Eagle. They would not have needed them. When the frustration of being trapped on the moon proved too great, they would only have had to open the hatch, and remove their helmets. That could not have felt much worse than being a drowning man.

Id. at 373–74.

68. *Id.*

69. *Glucksberg*, 521 U.S. at 725–26; *Quill*, 521 U.S. at 807.

70. See generally *Roe v. Wade*, 410 U.S. 113 (1973) (recognizing a right to privacy, including a women's qualified right to terminate her pregnancy).

71. 521 U.S. 702.

72. 521 U.S. 793.

a terminally ill patient to commit suicide.⁷³ In *Quill*, it was argued that it was a denial of the Fourteenth Amendment's Equal Protection Clause to permit the withholding or withdrawal of treatment that could lead to death, and not to permit access to physician-prescribed drugs that could be used for suicide for patients who were not dependent on medical technology for survival.⁷⁴

Unlike *Cruzan*, these two cases involved no live patients; instead, they were based on physician affidavits in which physicians asserted that they could not help their patients kill themselves because they were worried about potential legal liability for so doing.⁷⁵ As in *Cruzan*, Chief Justice Rehnquist assigned himself the majority opinion in both cases.⁷⁶ He used the cases to clarify some of his language in *Cruzan*, which the proponents of a new constitutional right argued supported their cause. In *Glucksberg*, for example, Chief Justice Rehnquist noted the respondents' contention that, in the *Cruzan* holding, the Court

“acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death” and that “the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming legal medication.”⁷⁷

The Chief Justice also quoted the conclusion of the court of appeals that “*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognize[d] a liberty interest in hastening one's own death.”⁷⁸ But Chief Justice Rehnquist was summarizing these arguments only to reject them:

The right assumed in *Cruzan*, however, was not simply deduced from abstract concepts of personal autonomy. Given the common-law rule that forced medication was a battery, and the long tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. In *Cruzan* itself, we recognized that most States outlawed assisted suicide—and even more do today—and we certainly gave no intimation that the right to refuse unwanted medical treatment could be some-how transmuted into a right to assistance in committing suicide.⁷⁹

73. *Glucksberg*, 521 U.S. at 723–24.

74. *Quill*, 521 U.S. at 798.

75. *Glucksberg*, 521 U.S. at 705–08; *Quill*, 521 U.S. at 796–98.

76. See *Glucksberg*, 521 U.S. 702; *Quill*, 521 U.S. 793.

77. *Glucksberg*, 521 U.S. at 725 (internal citations omitted).

78. *Id.* (quoting *Compassion in Dying v. State of Wash.*, 79 F.3d 790, 816 (9th Cir. 1996)).

79. *Id.* at 725–26 (internal citations omitted).

In *Quill*, Chief Justice Rehnquist found the Equal Protection argument even easier to dispose of. He noted first that “*Cruzan* . . . provides no support for the notion that refusing life-sustaining medical treatment is ‘nothing more nor less than suicide.’”⁸⁰ Therefore, he did not agree with the respondents’ argument that “the distinction between refusing lifesaving medical treatment and assisted suicide is ‘arbitrary’ and ‘irrational.’”⁸¹ Rather, New York can constitutionally treat the refusal of life-sustaining medical treatment and physician-assisted suicide differently. In Chief Justice Rehnquist’s words, “By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.”⁸²

The Court’s two decisions kept the police power in the hands of the states, suggesting that states could, among other things, enact new laws that protected physicians from criminal and civil liability for assisting a terminally ill patient to commit suicide. Oregon was the first such state to do so, and over the years, a handful of states have joined Oregon, most recently California.⁸³

Constitutional lawyers had mixed reactions to the physician assisted-suicide cases. Some insisted that the Court should have expanded the right to privacy to include a peaceful death; others that the laws against assisted suicide were properly endorsed. Erwin Chemerinsky, for example, argued that the Court made a serious mistake—he believes that the Constitution contains “a fundamental right to assisted death for terminally ill patients,” and that prohibiting the exercise of that right could not meet the compelling-government-interest standard.⁸⁴ On the other hand, no constitutional limits could be placed on citizens exercising this constitutional right on the basis of their age, life expectancy, medical diagnosis, or any other arbitrary characteristic. Moreover, although the Court explicitly approved of “terminal sedation” as a legitimate application of the principle of the double effect,⁸⁵ it failed to note that it can be simply good medical practice to prescribe drugs for a legitimate medical purpose, such as pain relief or sleeping pills, that patients could then use to kill themselves, as in the case of Timothy Quill and his patient, Diane.⁸⁶

Chemerinsky began and ended his argument by referring to the death of his father.⁸⁷ His father was terminally ill with lung cancer and asked his

80. *Quill*, 521 U.S. at 807.

81. *Id.*

82. *Id.* at 808.

83. REBECCA A. ENGLISH ET AL., NAT’L ACADS. OF SCIS., ENG’G, & MED., PHYSICIAN-ASSISTED DEATH: SCANNING THE LANDSCAPE: PROCEEDINGS OF A WORKSHOP 46–47 (2018).

84. Erwin Chemerinsky, *Washington v. Glucksberg was Tragically Wrong*, 106 MICH. L. REV. 1501, 1502–03 (2008).

85. *Quill*, 521 U.S. at 807 n.11.

86. Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 693 (1991).

87. Chemerinsky, *supra* note 84, at 1501–02, 1516.

physician to administer drugs to end his life.⁸⁸ His father had, he believed, only a few days left to live and was in great pain and suffering.⁸⁹ His father's physician refused.⁹⁰ Chemerinsky felt powerless to help but, as he wrote, "[t]hankfully [his father] only lingered for a few days after his request."⁹¹ The practicalities of adopting a right to physician-assisted suicide are highlighted in this case and should not be missed. All states want to help prevent suicide and, therefore, want to prevent virtually all suicides of people with more than six months to live. Moreover, so the state can be sure of their intent, every state that permits the practice of physician-assisted suicide requires a fourteen to fifteen day waiting period.⁹² This means people in the position of Chemerinsky's father, who make a request with less than two weeks to live, would simply not qualify for physician assistance, even in states that have enacted physician assisted-suicide laws. This is one reason why only an extremely small number of patients have made use of physician-assisted suicide laws. For example, even in Oregon where the law has existed the longest, in 2018, fewer than 200 people died using lethal medications obtained under the statute.⁹³ This is hardly a "solution" to our problem with death. It is worth noting that although all existing laws authorizing physician-assisted suicide grant physicians legal immunity from criminal lawsuits,⁹⁴ this is mostly an imaginary problem in the minds of some physicians. As a matter of fact, no physician, other than the rogue pathologist Jack Kevorkian, has ever been charged, let alone convicted, with physician-assisted suicide for prescribing lethal drugs that a competent patient could use to end their lives.⁹⁵ We will have to look elsewhere for a solution for hard deaths.

V. HUNGER STRIKES

Cruzan is probably best known by the slogan "right to die." But it is also celebrated as the case that put an end to the "fluids and nutrition" debate, specifically whether these interventions are a form of comfort care that must be routinely provided or whether they are a medical treatment that can be refused. The Supreme Court had no trouble categorizing them as medical treatment.⁹⁶ It is legally permissible to stop cardiopulmonary resuscitation (CPR) or any other medical intervention

88. *Id.* at 1501, 1516.

89. *Id.* at 1501.

90. *Id.*

91. *Id.* at 1502.

92. David Orentlicher, *Comparative Analysis of Legal Rules: Withdrawal of Treatment Versus Physician-Assisted Death*, in *PHYSICIAN-ASSISTED DEATH: SCANNING THE LANDSCAPE: PROCEEDINGS OF A WORKSHOP* 15, 17 (2018).

93. *Oregon Death with Dignity Act: Annual Reports*, *DEATH WITH DIGNITY*, <https://www.deathwithdignity.org/oregon-death-with-dignity-act-annual-reports/> [<https://perma.cc/9BUV-SCS4>] (last visited Oct. 21, 2019).

94. Orentlicher, *supra* note 92. For an example, see *COLO. REV. STAT. § 25-48-116(1)* (2016).

95. JACK KEVORKIAN, *PRESCRIPTION: MEDICIDE* 221-31 (1991).

96. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 279 (1990).

that is sustaining life, including mechanical ventilators, feeding tubes, IVs, and dialysis.⁹⁷ Moreover, none of these actions have ever constituted suicide for the patient or assisted suicide for the physician: they are all routinely categorized as treatment refusals. *Glucksburg* and *Quill* simply affirmed these conclusions from *Cruzan*.⁹⁸ But one area remains vigorously contested and is a fitting topic on which to end my anniversary reflections: hunger strikes by competent prisoners.

Hunger strikes generally occur in a prison setting, with one or more prisoners refusing to eat (and sometimes drink) until the prisoners' demands (e.g., for freedom, better prison conditions, visitors, etc.) are met.⁹⁹ Prisoners have a constitutional right to refuse to eat or drink.¹⁰⁰ The question is, Does the prison (the state) have a "compelling" interest to force feed the prisoner, and if so, what constitutes the "least restrictive" or invasive method?

Hunger strikes were obviously not at issue in *Cruzan*; nonetheless, some comments by the Justices in *Cruzan* are relevant to our discussion. First, on the nature of force-feeding by nasogastric tube (the most common method used), Justice O'Connor notes in her concurring opinion:

Feeding a patient by means of a nasogastric tube requires a physician to pass a long flexible tube through the patient's nose, throat, and esophagus and into the stomach. Because of the discomfort such a tube causes, "*many patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube.*"¹⁰¹

Justice O'Connor later describes the extent of the bodily invasion involved in force-feeding:

Requiring a competent adult to endure such procedures against her will *burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment.* Accordingly, the liberty guaranteed

97. A good example of the public's understanding of this is the death of James A. Michener, the author of *Space*, among many other best-selling books. See Stephanie Simon, *Blockbuster Author Michener Dies*, L.A. TIMES (Oct. 17, 1997), <https://www.latimes.com/archives/la-xpm-1997-oct-17-mn-43745-story.html> [<https://perma.cc/V2HX-8AQP>]. Michener decided he was sick of undergoing dialysis and publicly announced that he was discontinuing it. See Paul Galloway, *Author James A. Michener, 90, Dies After 50-Year Writing Saga*, CHI. TRIBUNE (Oct. 17, 1997), <https://www.chicagotribune.com/news/ct-xpm-1997-10-17-9710170247-story.html> [<https://perma.cc/3MUU-6SRH>]. He died about two weeks later. See *id.* In all of the publicity around his decision and death, no reporter or commentator anywhere in the United States characterized his decision to discontinue life-sustaining dialysis as suicide.

98. See *Washington v. Glucksberg*, 521 U.S. 702, 703 (1997); *Vacco v. Quill*, 521 U.S. 793, 801–02 (1997).

99. PAULINE JACOBS, *FORCE-FEEDING OF PRISONERS AND DETAINEES ON HUNGER STRIKE* 3 (2012).

100. Stephanie Clavan Powell, *Constitutional Law-Forced Feeding of a Prisoner on a Hunger Strike: A Violation of an Inmates Right to Privacy*, 61 N.C. L. REV. 715 (1983).

101. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 288–89 (1990) (O'Connor, J., concurring) (emphasis added) (quoting David Major, *The Medical Procedures for Providing Food and Water: Indications and Effects*, in *BY NO EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER* 21, 25 (J. Lynn ed., 1986)).

by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.¹⁰²

Chief Justice Rehnquist deals with force-feeding only tangentially and in the context of the state's interest in preserving life. In his words, "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death."¹⁰³ Chief Justice Rehnquist adds: "Finally, we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an *unqualified interest in the preservation of human life* to be weighed against the constitutionally protected interests of the individual."¹⁰⁴

Hunger strikes have a long history in American prisons but did not gain widespread attention in the United States until after the September 11 attacks.¹⁰⁵ Hunger strikes began almost immediately after at Guantanamo Bay Naval Base Prison, and they were widespread by 2005.¹⁰⁶ To break a 2005 hunger strike at Guantanamo, military officials imported emergency "restraint chairs" to immobilize the prisoner so he could be force fed via a nasogastric tube,¹⁰⁷ as described by Justice O'Connor. The prisoner can be strapped into the chair using eight-point restraints (hands, feet, shoulders, head, and torso).¹⁰⁸ The ethics of force-feeding was at the center of a press conference about the U.S. Department of Defense's 2006 Instruction¹⁰⁹ on treatment of prisoners at Guantanamo.¹¹⁰ The Assistant Secretary of Defense for Medical Affairs, William Winkenwerder, equated hunger striking with suicide, saying, "There is a moral question. . . . Do you allow a person to commit suicide? Or do you take steps to protect their health and preserve their life?"¹¹¹ The Department of Defense has argued that it is following rules similar to those adopted by the U.S. Department of Justice's Bureau of Prisons for dealing with hunger strikers, which have generally been endorsed by the

102. *Id.* (emphasis added).

103. *Id.* at 280 (majority opinion) (emphasis added).

104. *Id.* at 282 (emphasis added).

105. George J. Annas, *Hunger Strikes at Guantanamo: Medical Ethics and Human Rights in a "Legal Black Hole"*, 355 *NEW ENG. J. MED.* 1377, 1377 (2006) [hereinafter Annas, *Hunger Strikes at Guantanamo*].

106. *Id.*; Eric Schmitt & Tom Golden, *Force-Feeding at Guantánamo Is Now Acknowledged*, *N.Y. TIMES* (Feb. 22, 2006), <https://www.nytimes.com/2006/02/22/world/middleeast/forcefeeding-at-guantanamo-is-now-acknowledged.html> [<https://perma.cc/ZS3M-NPLW>].

107. Annas, *Hunger Strikes at Guantanamo*, *supra* note 105, at 1377.

108. Len Rubenstein & George J. Annas, *Medical Ethics at Guantanamo Bay Detention Centre and in the US Military: A Time for Reform*, 374 *LANCET* 353, 353 (2009).

109. U.S. DEP'T OF DEF., INSTRUCTION 2310.08, MEDICAL PROGRAM SUPPORT FOR DETAINEE OPERATIONS (2006).

110. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, Media Roundtable with Assistant Secretary Winkenwerder (June 7, 2006) (transcript available on the U.S. Department of Defense website).

111. Tim Golden, *Tough U.S. Steps in Hunger Strike at Camp in Cuba*, *N.Y. TIMES* (Feb. 9, 2006), <https://www.nytimes.com/2006/02/09/politics/tough-us-steps-in-hunger-strike-at-camp-in-cuba.html> [<https://perma.cc/V99S-B4VS>].

courts.¹¹² This is only partially correct: the Bureau of Prisons mandates that only a physician may administer force-feeding and that the physician do so in accordance with good and accepted medical procedures.¹¹³ Physicians can order forced feeding in Department of Justice facilities only when consistent with the Constitution.¹¹⁴ This means that the prison must demonstrate a compelling state interest, sometimes described as a “legitimate penological interest” (which have included preventing suicide and maintaining order in the prison).¹¹⁵

It should be recalled that Chief Justice Rehnquist ignored physicians altogether in his discussion of the right to die in *Cruzan*.¹¹⁶ On *Cruzan*’s thirtieth anniversary, the most controversial force-feeding cases are hunger strikes, and the physician’s role is no longer marginalized but central. In this context, medical ethics becomes critical. In medical ethics, the position of the World Medical Association on the physician’s role in hunger strike is the clearest and most authoritative: “Forced feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment.”¹¹⁷

As in *Cruzan*, the claim that a treatment refusal can be a form of committing suicide is front and center. Nonetheless, as in *Cruzan*, suicide is a red herring—the hunger striker is not trying to kill himself, he is trying to get the prison administration to change their policies or to change the conditions of his imprisonment.¹¹⁸ He has no desire to die but is willing to risk death to improve the chances of changing the conditions of confinement or even the chances of release.¹¹⁹

The constitutionality of force-feeding at Guantanamo did not get a full hearing in a U.S. federal court until 2014.¹²⁰ U.S. District Court Judge Gladys Kessler was asked to prohibit the forced cell extraction followed

112. See U.S. DEP’T OF DEF., REVIEW OF DEPARTMENT COMPLIANCE WITH PRESIDENT’S EXECUTIVE ORDER ON DETAINEE CONDITIONS OF CONFINEMENT 56 (2009); Rubenstein & Annas, *supra* note 108, at 353.

113. Rubenstein & Annas, *supra* note 108, at 353–54.

114. *Id.* at 354.

115. *Washington v. Harper*, 492 U.S. 210, 224–26 (1990).

116. See *infra* notes 57–58 and accompanying text.

117. World Med. Ass’n, *Declaration of Malta on Hunger Strikes* para. 23, Nov. 1991, rev. Oct. 2017, available at <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/> [<https://perma.cc/HTT5-2XAS>] [hereinafter 2017 Declaration of Malta]. “A hunger striker is a mentally competent person who has indicated that he has decided to embark on a hunger strike and has refused to take food and/or fluids for a significant interval.” World Med. Ass’n, *Declaration of Malta on Hunger Strikes*, Guidelines for the Management of Hunger Strikers para. 1, Nov. 1991, rev. Sept. 1992, available at <https://www.legislationline.org/documents/id/8591> [<https://perma.cc/DSU9-ZCQ5>].

118. See Annas, *Hunger Strikes at Guantanamo*, *supra* note 105, at 1377–78.

119. See *id.* The only legitimate state interest is in the orderly running of the prison, and this will be discussed later.

120. *Dhiab v. Obama*, 952 F. Supp. 2d 154, 154–55 (D.D.C. 2013); Charlie Savage, *A Practice Goes on Trial: Force-Feeding a Detainee*, N.Y. TIMES (Oct. 6, 2014), <https://www.nytimes.com/2014/10/07/us/a-practice-goes-on-trial-force-feeding-a-detainee.html> [<https://perma.cc/FD9U-GMAS>].

by forced feeding in a restraint chair of Abu Wa’el Dhiab.¹²¹ Dhiab had been a prisoner at Guantanamo for eleven years, was never charged with a crime, and was cleared for release in 2009.¹²² Judge Kessler initially ruled that all force-feeding must end (the first such order in the history of Guantanamo and the only one to date).¹²³ The case nonetheless was complex. Dhiab was not opposed to voluntary enteral feeding at the hospital, only to being involuntarily fed in a painful manner in the restraint chair.¹²⁴ The Department of Defense remarkably refused his request for voluntary feeding.¹²⁵ Judge Kessler described the Department of Defense’s refusal as presenting her with an anguishing Hobson’s choice: to “reissue another Temporary Restraining Order . . . despite the very real probability that Mr. Dhiab will die . . . [or] allow the medical personnel on the scene to take the medical actions to keep Mr. Dhiab alive, but at the possible cost of great pain and suffering.”¹²⁶ She decided to permit the physicians at Guantanamo to resume force-feeding because she did not believe she had the legal authority to prohibit it.¹²⁷

The cruelty of this method of force-feeding would be apparent to anyone seeing the videotapes of Dhiab’s force-feeding. Judge Kessler ordered these videotapes made public, but ultimately, an appeals court ruled that the Department of Defense need not release them because they could be used in terrorist “propaganda and in carrying out attacks on Americans.”¹²⁸ Before Judge Kessler could hold a follow-up hearing on Dhiab’s treatment, Dhiab, a Syrian, was released to Uruguay, a country he had no connection with, and his current whereabouts are unknown.¹²⁹

121. *Dhiab*, 952 F. Supp. 2d at 154–55. Forced cell extraction is a method of violently removing the prisoner from his cell using guards in riot gear. See *Cell Extractions*, HUM. RTS. WATCH, <https://www.hrw.org/reports/2006/us1006/2.htm> [https://perma.cc/Y6B2-2PM2] (last visited Jan. 14, 2020).

122. *Dhiab*, 952 F. Supp. 2d at 154–55.

123. Charlie Savage, *Guantánamo Inmate’s Case Reignites Fight Over Detentions*, N.Y. TIMES (May 23, 2014), <https://www.nytimes.com/2014/05/24/us/judge-allows-military-to-force-feed-guantanamo-detainee.html> [https://perma.cc/93LH-96K5].

124. *Dhiab v. Obama*, No. 05-1457 (GK), 2014 WL 2134491, at *1 (D.D.C. May 22, 2014).

125. *Id.*

126. *Id.*; Josh Gernstein, *Judge Lets Guantanamo Inmate’s Force-Feeding Resume*, POLITICO (May 23, 2014, 8:39 AM), <https://www.politico.com/blogs/under-the-radar/2014/05/judge-lets-guantanamo-inmates-force-feeding-resume-189099> [https://perma.cc/Y3RT-6NU4].

127. The appeals court later ruled that she did have the authority to prohibit force-feeding. *Aamer v. Obama*, 742 F.3d 1023, 1026 (D.C. Cir. 2014); Charlie Savage, *Appeals Court Allows Challenges by Detainees at Guantánamo Prison*, N.Y. TIMES (Feb. 11, 2014), <https://www.nytimes.com/2014/02/12/us/appeals-court-clears-way-for-guantanamo-challenges.html> [https://perma.cc/F7VK-RE2N].

128. *Dhiab v. Trump*, 852 F.3d 1087, 1089, 1097 (D.C. Cir. 2017); Charlie Savage, *Videos of Force-Feeding at Guantánamo Will Stay Secret, Court Rules*, N.Y. TIMES (Mar. 31, 2017), <https://www.nytimes.com/2017/03/31/us/politics/guantanamo-detainees-force-feeding-videos.html> [https://perma.cc/GL2E-R765].

129. David Kimbal-Stanley, *Force Feeding Videos Remain Sealed*, LAWFARE (Apr. 3, 2017, 1:14 PM), www.lawfareblog.com/force-feeding-videos-remain-sealed [https://perma.cc/3CLZ-62XJ].

The context of the War on Terror and Guantanamo is hardly conducive to a dispassionate view of the interests of the state in force-feeding a terrorist suspect hunger striker. Nonetheless, the anniversary of *Cruzan* provides us with an opportunity to at least recognize that the prevention of suicide is not a legitimate rationale for force-feeding, just as it is not a legitimate reason to prevent a patient from refusing life-sustaining treatment. This leaves orderly prison administration as the only potential compelling state interest to justify force-feeding a competent hunger striker. Historically, courts, including the Supreme Court, have granted prison officials wide latitude in making management-justified prison policies, including using routine invasive, mandatory strip searches.¹³⁰

Since prisons can almost always accommodate hunger strikers (e.g., by moving them to a separate wing of the prison or isolating them from the general population), if prisons were required to present actual evidence of prison disruption (the type of clear and convincing evidence that the *Cruzan* court required of Cruzan's family), force-feeding competent prisoners would seldom, if ever, be constitutionally justified. Alternatively, courts could (and should) simply label force-feeding of restrained competent prisoners as cruel and unusual punishment and a violation of the Eighth Amendment. And, of course, if overseen by a physician, an unequivocal violation of internationally recognized medical ethics.

VI. CONCLUSION

The passage of decades gives us a new perspective on events, and it can help us learn lessons from juxtaposing events that had never seemed related but actually are. *Cruzan*, a case that Nancy Cruzan's parents lost, for example, paradoxically fortified the right to refuse treatment and removed any doubt that it applied to all life-sustaining medical interventions, including fluids and nutrition, and was never rightly classified as suicide. Nor is a terminal diagnosis required to exercise this right. There is also a third woman, Terri Schiavo, and her case, which included more than two dozen judges, Congress, and the President, underlined how solid the right to refuse treatment is after *Cruzan*.¹³¹

Remaining battles on the "right to die" front continue to be fought on the state level over statutes that provide physicians with legal immunity for participation in physician-assisted suicide. These battles in the state legislatures and in state ballot initiatives are personified in a fourth woman, Brittany Maynard.¹³² The legal system has been supportive of the

130. *Florence v. Bd. of Chosen Freeholders of Burlington*, 566 U.S. 318, 322 (2012); see George J. Annas, *Strip Searches in the Supreme Court—Prisons and Public Health*, 367 *NEW ENG. J. MED.* 1653, 1654 (2012).

131. LOIS SHEPHERD, *IF THAT EVER HAPPENS TO ME: MAKING LIFE AND DEATH DECISIONS AFTER TERRI SCHIAVO* 1–2 (2009); George J. Annas, "Culture of Life" Politics and the Case of Terri Schiavo, 352 *NEW ENG. J. MED.* 1710, 1710 (2005).

132. Brittany Maynard, *My Right to Death with Dignity at 29*, CNN (Nov. 2, 2014, 10:44 PM), <http://www.cnn.com/2014/10/07/opinion/maynard-assisted-suicide-cancer-dignity/index.html> [https://perma.cc/C4TC-TBTD].

rights of young women with serious medical conditions as the progeny of *Cruzan*, but not the *Cruzan* case itself, well illustrate. Litigation has, however, provided little support for the human rights of hunger strikers or for prisoners in general. This problem could, somewhat ironically, be addressed by providing physicians with more authority over treatment decisions in prisons. This would move the decision-making to the doctor-patient arena, where force-feeding of competent hunger strikers is simply not permitted by medical ethics.¹³³

Apollo 11 did not lead to a Mars landing or even to further manned exploration of space. The major lethal tragedies in the space program—the incineration of three astronauts in an Apollo capsule¹³⁴ and the explosion of the Space Shuttle *Challenger*¹³⁵—did, however, help lead to the adoption of a culture of safety in other industries. The U.S. health care industry has yet to adopt a culture of safety, as spectacularly illustrated by its negligent, lethal treatment of the first man on the moon and its attempt to cover-up its ineptitude. The “moon shot” is now linked to the National Cancer Institute and its government funded attempts to develop a cure for cancer, research widely endorsed by our politicians as nonpartisan and popular, while patient safety remains marginalized.

Physics has been displaced as our planet’s leading science in our quest for “progress.” The emphasis is now on biological advances, most notably in the genetics realm. This means space engineering has given way to genetic engineering, and the “right to die” slogan has been displaced by a competing slogan, the “right to try.”¹³⁶ We have also begun a global debate about whether to strive for immortality by modifying our bodies or by redesigning them in ways that will make them suitable for interplanetary travel. We now spend much more energy trying to design a “better human” rather than working on how to control, or even influence, climate change.

The compelling photos of Earth from space have not been powerful enough to incite global action to save our fragile planet. Commercial interests continue to overwhelm environmental interests, just as national-security interests continue to overwhelm the promotion of basic human rights. Likewise, the race to the moon between the United States and the former Soviet Union has morphed. It is now a scientific struggle between the United States and China to capture and sustain leadership in the fields of genetic engineering and artificial intelligence.

133. See 2017 Declaration of Malta, *supra* note 117, at para. 3.

134. Jan. 27, 1967: 3 Astronauts Die in Capsule Fire, WIRE (Jan. 26, 2009, 9:00 PM), <https://www.wired.com/2009/01/jan-27-1967-3-astronauts-die-in-capsule-fire-2/> [https://perma.cc/P48Y-C2YB].

135. Michael Hirsley, *Space Shuttle Explodes*, CHI. TRIBUNE (Jan. 28, 1986), <https://www.chicagotribune.com/news/ct-xpm-1986-01-29-8601080078-story.html> [https://perma.cc/R8DB-FMA6].

136. Julie Jacob, *Questions of Safety and Fairness Raised as Right-to-Try Movement Gains Steam*, 314 JAMA 758, 758 (2015).

Both *Cruzan* and Apollo 11 suggest that we humans cannot predict the future—but our present day human rights and scientific endeavors suggest that the coming three decades could be crucial ones in determining both how we die and what kind of a planet we will inhabit. There is, unfortunately, nothing in our past three decades to suggest we will seriously deal with death in our health care nonsystem. More likely, we will continue to deny it and counterproductively concentrate on using our technology to try to increase our length of life even at the expense of our quality of life. In continuing to pursue life extension we may paradoxically make the case for physician-assisted suicide much more compelling than it is now.

