1998

The Death with Dignity Movement: Protecting Rights and Expanding Options after Glucksberg and Quill

Kathryn L. Tucker

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INTRODUCTION

Increasingly, and largely as a result of modern medicine, dying patients want more control over the timing and manner of their deaths and want to have the option of a humane, physician-assisted death if their pain and suffering become intolerable.[1] Poll data consistently reflect that a substantial majority of citizens believe that competent, terminally ill patients should have the option of receiving medication that patients could self-administer to bring about a humane and peaceful death if pain and suffering become intolerable.[2] Opinion polls also reveal that a majority of physicians believe such patients should have this option.[3] However, most states have statutes prohibiting assisting

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1. An excellent overview of the developments in modern medicine that have caused this to occur is found in the first three chapters of MARILYN WEBB, THE GOOD DEATH: THE NEW AMERICAN SEARCH TO RESHAPE THE END OF LIFE (1997).

2. *See, e.g.*, Kate Stewart, *Physician Aid in Dying*, POLLING REP., July 28, 1997, at 1, 6-7 (providing polling data broken down by gender, race, age, socioeconomic status, religious affiliation, and political affiliation, and concluding: "That the American public strongly supports allowing a doctor to assist a terminally ill, suffering patient end his or her life.... [S]upport is in the 69% to 75% range.").

3. *See* Jerald G. Bachman et al., *Attitudes of Michigan Physicians and*

suicide.[4] Although it is unclear that such laws were intended to reach the act of a physician in prescribing medication that a dying patient could take to bring on a humane death, it is clear that the laws deter many physicians from doing so.[5] Despite that, a widespread underground practice of physician-assisted dying exists.[6] Thus, in the debate now raging regarding physician-assisted dying, the question is not really whether the practice should occur, but whether the practice should proceed underground and unregulated, or openly and regulated to protect patients, regularize access, and accommodate legitimate state interests.

In an effort to establish that competent dying patients have the right to choose openly a humane, physician-assisted death, the assisted suicide laws of New York and Washington were challenged on federal constitutional grounds in the cases of

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the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia, 334 NEW ENG. J. MED. 303, 306 (1996); Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89, 90-91 (1994); Melinda A. Lee et al., *Legalizing Assisted Suicide–Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 311 (1996). The American College of Legal Medicine, the American Medical Students Association, together with a coalition of nationally prominent medical clinicians and academics (as well as bioethicists, hospice professionals, and psychological associations), filed amicus briefs supporting legalizing this option in the *Glucksberg* and *Quill* cases. *See, e.g.*, Brief Amicus Curiae of the American College of Legal Medicine, *Glucksberg* (No. 96-110); Brief Amici Curiae of the American Medical Student Association and a Coalition of Distinguished Medical Professionals in Support of Respondents, *Glucksberg* (No. 96-110). The American Medical Association, as well as other medical professional associations, are at this time opposed to physician-assisted suicide and filed a brief supporting state bans on assisted suicide. *See* Brief of the American Medical Association et al., as Amici Curiae in Support of Petitioners, *Glucksberg* (No. 96-110).

4. *See* Kathryn L. Tucker & David J. Burman, *Physician Aid in Dying: A Humane Option, A Constitutionally Protected Choice*, 18 SEATTLE U. L. REV. 495, 496 & n.1 (1995).

5. In the *Glucksberg* and *Quill* cases, discussed *infra* Part I, the physician plaintiffs each attested to the deterrent effect of the state assisted suicide laws. *See Glucksberg*, 117 S. Ct. at 2261; *Quill*, 117 S. Ct. at 2295.

6. *See, e.g.*, Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 922 (1996) (asserting that 24% of Washington patients explicitly requesting medications that they could use to hasten death did in fact receive a prescription for the medication from their physician); Steve Heilig et al., *Physician-Hastened Death, Advisory Guidelines for the San Francisco Bay Area from the Bay Area Network of Ethics Committees*, 166 W. J. MED. 370, 371 (1997) (stating that the practice of physicians aiding terminally ill patients' deaths has "long occurred underground, without standards or scrutiny by the medical community"); Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, BOSTON GLOBE, Feb. 28, 1992, at 5.

Vacco v. Quill[7] and *Washington v. Glucksberg*.[8] The United States Supreme Court decided both cases in its 1996 Term. These cases, and the legal issues both addressed and ignored by the Court, are discussed in Part I. Part II explores state legislative avenues that remain viable after *Glucksberg* and *Quill* to provide the option of a legal, humane, and dignified physician-assisted death to competent dying patients. Part III discusses the state court challenges available to safeguard these patients' liberty under applicable state constitutional provisions.

In addition to mounting federal and state constitutional challenges to state laws prohibiting assisted suicide, patient rights advocates also are working to prompt improved pain care at the end of life and are exploring litigation to establish that there is a constitutional right to receive adequate pain medication. This is explored in Part IV. Part V examines application of medical disciplinary and medical malpractice actions to physician failure to adequately treat the pain of dying patients.

I. THE FEDERAL CONSTITUTIONAL CLAIM TO PHYSICIAN-ASSISTED DYING

A. BACKGROUND

Patients, doctors and the public interest group Compassion in Dying challenged the assisted suicide laws in New York and Washington to the extent that they prohibited doctors from providing medications to competent dying patients that the patients could use to hasten death if they so chose. Liberty and equality guaranteed by the Fourteenth Amendment of the U.S. Constitution formed the basis of the claims.[9] Two federal courts of appeals, including the Ninth Circuit sitting en banc, agreed that statutes preventing patients from exercising this option were unconstitutional.[10] These cases were then reviewed by the United States Supreme Court in its 1996 Term. The Court reversed these decisions, but, as discussed below, left the door

7. 117 S. Ct. 2293 (1997).

8. 117 S. Ct. 2258 (1997).

9. For a full discussion of the nature and scope of the claims, see generally Tucker & Burman, *supra* note 4. These cases have been the subject of extensive commentary.

10. *See* Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 117 S. Ct. 2293 (1997); Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc), *rev'd sub nom.* Washington v. Glucksberg, 117 S. Ct. 2258 (1997).

open to both future successful federal constitutional claims and to legislative reform.

B. WHERE DO WE STAND FOLLOWING *GLUCKSBERG* AND *QUILL*?

The Court rendered unanimous decisions upholding the laws challenged in *Glucksberg* and *Quill.* Five Justices, a majority of the Court, wrote or joined concurring opinions that limited the scope of the majority's ruling and carefully reserved issues for future cases. These five concurring justices have left the question of federal constitutional protection of the choice at issue very much open to future developments.

The majority decision, written by Chief Justice Rehnquist, did not actually resolve the narrow question posed by those challenging the states' laws. Instead, the Court answered a more general and easily resolved question, one on which the parties were not in dispute: "[W]hether the 'liberty' specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so."[11] The Court recognized that the more difficult question, whether a dying, suffering patient has a protected right to choose physician assistance in dying, was not foreclosed by its ruling on the more general question.[12]

Justice O'Connor, in casting the deciding vote, revealed in her concurrence that she joined the majority only on the understanding that the question decided by the majority was the "easy" question, writing:

> The Court frames the issue in this case as whether the Due Process Clause of the Constitution protects a 'right to commit suicide which itself includes a right to assistance in doing so'.... I join the Court's opinions because I agree that there is no generalized right to 'commit suicide."[13]

Justice O'Connor went on to state explicitly that on the "difficult" question, she has reserved judgment and remains open to deciding that issue favorably in a future case:

> [R]espondents urge us to address the narrower question whether a mentally competent person who is experiencing great suffering has a constitutionally cognizable interest in controlling the circumstances of his or her imminent death. I see no need to reach that question in the

11. *Glucksberg*, 117 S. Ct. at 2269.

12. *See id.* at 2275 n.24 (stating that the court's "opinion does not absolutely foreclose such a claim").

13. *Id.* at 2303 (O'Connor, J., concurring).

context of the facial challenges to the New York and Washington laws at issue here.[14]

Justice O'Connor as well as Justice Breyer, in a separate concurrence, explicitly expressed the view that a viable constitutional claim remained for a future case, specifically involving patients who could not obtain relief with palliative care.[15] Interestingly, Justices O'Connor and Breyer stated the view that provision of pain-relieving medication to a patient which hastened death would not violate state laws prohibiting assisted suicide. For example, Justice O'Connor stated that "a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."[16] She further wrote, "There is no dispute that dying patients ... can obtain palliative care, even when doing so would hasten their deaths."[17]

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14. *Id.*

15. *See id.* at 2303, 2312. Justice Ginsberg joined Justice O'Connor's concurrence. *See id.* The available data indicate that while most patients will be able to get relief with palliative care, some patients have intractable pain that cannot be relieved short of sedation to an unconscious state. *See, e.g.*, Ada Jacox et al., *New Clinical-Practice Guidelines for the Management of Pain in Patients with Cancer*, 330 NEW ENG. J. MED. 651 (1994) (finding that pain in up to 90% of cancer patients can be controlled). See generally the fourth chapter of WEBB, *supra* note 1. The subset of patients whose pain cannot be controlled with medication appear to have a claim that the five concurring justices in *Quill* and *Glucksberg* would find within the scope of liberty protected by the Fourteenth Amendment.

16. *Glucksberg*, 117 S. Ct. at 2303 (O'Connor, J., concurring).

17. *Id.*; *see also id.* at 2311-12 (Breyer, J., concurring). The practice of sedating patients with intractable pain into unconsciousness and withholding food and water until death inevitably ensues is known as terminal sedation and was endorsed as an acceptable option, indeed one seen as negating the need for assisted suicide, by the AMA and other amici in the *Quill* and *Glucksberg* cases. For some patients this may be an acceptable option; others (and their families) abhor the option of accepting an induced coma and a lingering demise while family members stand vigil for the week or ten days it takes for dehydration and starvation to bring about death. Moreover, it is not certain that a patient sedated in this manner is free of pain. The medical literature documents that patients under general anesthesia for surgery, a much deeper form of sedation, may well experience pain. *See* N. Moerman et al., *Awareness and Recall During General Anesthesia: Facts and Feelings*, 79 ANESTHESIOLOGY 454, 492, 497 (1993); *see also* J.M. Evans, *Patients' Experiences of Awareness During General Anaesthesia*, *in* CONSCIOUSNESS, AWARENESS AND PAIN IN GENERAL ANAESTHESIA 184 (M. Rosen & J.N. Lunn eds., 1987); J.E. Utting, *Awareness: Clinical Aspects in* CONSCIOUSNESS, AWARENESS AND PAIN IN GENERAL ANAESTHESIA, *supra*, at 171, 172-73; R.C. Cork et al., *Is There Implicit Memory After Propofol Sedation?*, 76 BRIT. J. ANAESTHESIA 492 (1996) (discussing relationship between recall of pain dur-

Justice Breyer concurred in the judgments upholding the states' challenged laws, but disagreed with the majority's "formulation of [the] claimed 'liberty' interest."[18] Justice Breyer expressed the view that on the narrower, more difficult question, there was "greater support" in "our legal tradition" for a "right to die with dignity."[19] He explicitly reserved judgment on that question, writing:

> I do not believe, however, that this Court need or now should decide whether or a [sic] not such a right is 'fundamental.' That is because, in my view, the avoidance of severe physical pain (connected with death) would have to comprise an essential part of any successful claim and because, as Justice O'Connor points out, the laws before us do not *force* a dying person to undergo that kind of pain.[20]

Unfortunately, and contrary to the assumption of these Justices, legal barriers to obtaining medication sufficient to adequately relieve pain do exist. Indeed, it is widely recognized that physicians fail to prescribe adequate medication for relief of pain,[21] and legal constraints contribute to that situation.[22]

Thus, Justices O'Connor and Breyer appear to have answered a question that the parties had not actually posed, and

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ing anesthesia and after effects). Thus, it is possible that patients subjected to terminal sedation only *appear* to be free of pain, perhaps easing the burden on observers, but not necessarily the patient.

18. *Glucksberg*, 117 S. Ct. at 2311 (Breyer, J., concurring).

19. *Id.*

20. *Id.*

21. *See* Jacox et al., *supra* note 15, at 651 (stating that the pain associated with cancer is frequently undertreated); *see also* The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591 (1995).

22. *See* Robyn S. Shapiro, *Health Care Providers' Liability Exposure for Inappropriate Pain Management*, 24 J.L. MED. & ETHICS 360, 363 (1996) (identifying "fear of legal penalties, especially disciplinary action, . . . as one of the most important reasons" health professionals undertreat pain). Shapiro cites a California survey revealing that "69% of physicians . . . stated that the potential for disciplinary action had made them more conservative in their use of opioids in pain management." *Id.; see also* David E. Joranson, *State Medical Board Guidelines for Treatment of Intractable Pain*, AM. PAIN SOC'Y BULL., May/June 1995, at 1, 2 (citing California study reflecting that physicians avoid prescribing controlled substances, including "triplicate" drugs, for patients with intractable pain for fear of discipline by the medical board); COMMITTEE ON CARE AT THE END OF LIFE, INSTITUTE OF MEDICINE, APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE 191, 197 (Marilyn J. Field & Christine K. Cassel eds., 1997) [hereinafter INSTITUTE OF MEDICINE REPORT] (stating that laws designed to prevent diversion of drugs such as triplicate prescriptions and limits on the number of medication dosages prescribed are burdensome and deter legitimate prescribing of opioids to patients at the end of life).

have recognized that there is a constitutional right to adequate pain medication.[23] Efforts to establish this right more firmly can be anticipated.[24]

Justice Stevens, also concurring in the judgments, wrote "separately to make it clear that there is also room for further debate about the limits that the Constitution places on the power of the States to punish the practice" of physician-assisted suicide.[25] Because the Court addressed only the "easy" question, Justice Stevens emphasized that its holding "does not foreclose the possibility that some applications of the statute might well be invalid."[26] Similarly, Justice Souter's concurrence reflected his reservation of the decision on the narrower, more difficult question: "I do not decide for all time that respondents' claim should not be recognized . . . ."[27]

The opinions, both majority and concurring, invited legislative reform. As the majority recognized, "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[28]

Justice Souter's concurring opinion made explicit his preference for legislative action in this area. "The Court should accordingly stay its hand to allow reasonable legislative consideration," and, "the legislative process is to be preferred."[29] Similarly, Justice O'Connor's concurrence demonstrated her concern that state legislatures be given the first opportunity to address the issue: "States are presently undertaking extensive and serious evaluation of physician-assisted suicide and other related issues. In such circumstances, 'the . . . challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the "laboratory" of the States.'"[30]

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23. Other commentators have observed the recognition of the constitutional right to adequate pain medication. *See, e.g.*, Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1236 (1997).

24. *See* discussion *infra* Part IV.

25. *Glucksberg*, 117 S. Ct. at 2304 (Stevens, J., concurring).

26. *Id.* at 2304. Stevens further stated, "a decision upholding a general statutory prohibition of assisted suicide does not mean that every possible application of the statute would be valid." *Id.* at 2305.

27. *Id.* at 2293 (Souter, J., concurring).

28. *Id.* at 2275.

29. *Id.* at 2293 (Souter, J., concurring).

30. *Id.* at 2303 (O'Connor, J., concurring) (quoting Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 292 (1990) (O'Connor, J., concurring)).

Thus, the U.S. Supreme Court has given legislative reform via state political processes the green light.[31] To date, as discussed below, few state legislatures have attempted to address this issue, although commentators have proposed excellent models legislators could use to begin their debate.

II. LEGISLATIVE REFORM AS THE MEANS TO EXPANDING PATIENT CHOICE

To date only one state, Oregon, has passed a law permitting physician-assisted suicide.[32] Implementation of that law, entitled the "Oregon Death with Dignity Act," passed in 1994 through the initiative process, has been obstructed by challenges brought by right-to-life activists.[33] In a lawsuit that turned upside down the equal protection argument advanced in the *Glucksberg* and *Quill* cases, the challengers argued that a law permitting terminally ill patients to choose physician assistance in dying denied the terminally ill equal protection of the laws.[34] The case suffered from fatal threshold infirmities, however, and the Ninth Circuit dismissed the case on the grounds that the plaintiffs lacked standing.[35]

Recognizing that the effort to defeat the Oregon legislation in court was doomed, right-to-life activists refocused their efforts on defeating the measure politically. They succeeded in forcing a repeal measure on the ballot for a vote in November 1997.[36] That effort failed in the November election when sixty percent of Ore-

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31. At least one Justice explicitly has indicated that he would be inclined to intervene with judicial relief if "legislative foot-dragging" occurs. *See Glucksberg*, 117 S. Ct. at 2293 (Souter, J., concurring).

32. *See* OR. REV. STAT. §§ 127.800-127.897 (1996). Washington and California placed aid-in-dying measures before voters in 1991 and 1992, respectively. Voters in each state rejected both measures by the narrow margin of four percent. *See* Davan Maharaj, *Most Would Let Terminally Ill Die*, LOS ANGELES TIMES, March 9, 1993, at 10 (stating that the California doctor-assisted suicide measure lost by a margin of 54% to 46%); *Supporters of Euthanasia Refuse to Give Up*, DETROIT NEWS, November 7, 1991, at 4A (noting that 54% of Washington voters voted "no" on the state's physician-assisted suicide initiative).

33. *See* Lee v. Oregon, 891 F. Supp. 1429, 1434-36 (D. Ore. 1995) (holding that the Oregon Death with Dignity Act eliminates suicide prevention protection for terminally ill persons and thus violates the Equal Protection Clause), *vacated and remanded*, 107 F.3d 1382 (9th Cir.), *cert. denied sub nom.* Lee v. Harcleroad, 118 S. Ct. 328 (1997).

34. *See Lee*, 107 F.3d at 1386.

35. *See id.* at 1390.

36. *See* 6 Health L. Rep. (BNA) 934 (June 12, 1997).

gon voters rejected the repeal.[37] Following these judicial and political losses, opponents of the Oregon Death with Dignity law sought relief from the federal government, urging the Drug Enforcement Agency to take action against Oregon physicians who act in compliance with the law, on the basis that such activity would violate the Controlled Substances Act.[38] Whether this tactic will continue to impede implementation is yet unclear.

Twenty other states have initiative mechanisms,[39] and certainly other states may follow Oregon in enacting reform legislation through the initiative process. The shortcomings of the initiative process, however, are well recognized, and it is particularly ill-suited for addressing complex issues such as those related to end-of-life decisionmaking.[40]

In this complex area, a legislative process that allows for extensive factfinding and continual refinement of proposed provisions throughout the process of development of the legislation would be preferable to the passage of a law by the inflexible procedure necessary with initiative measures. In the legislative process, the concerns raised by the states and interest groups in the federal constitutional litigation could be addressed.[41]

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37. *See* David J. Garrow, *The Oregon Trail*, N.Y. TIMES, Nov. 6, 1997, at A31; Kim Murphy, *Voters in Oregon Soundly Endorse Assisted Suicide*, L.A. TIMES, Nov. 5, 1997, at 1.

38. *See generally* Timothy Egan, *Threat from Washington Has Chilling Effect on Oregon Law Allowing Assisted Suicide*, N.Y. TIMES, Nov. 19, 1997, at A18 (noting that the Administrator of the DEA warned that any physician "who writes a prescription for suicide would be violating the Controlled Substance Act because it is not a legitimate medical purpose for the drugs").

39. *See* Julian N. Eule, *Judicial Review of Direct Democracy*, 99 YALE L.J. 1503, 1509 n.22 (1990) (identifying Alaska, Arizona, Arkansas, California, Colorado, Idaho, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Utah, Washington, and Wyoming as the states that permit citizens to initiate and enact legislation).

40. *See, e.g.*, Judith F. Daar, *Direct Democracy and Bioethical Choices: Voting Life and Death at the Ballot Box*, 28 U. MICH. J.L. REFORM 799, 835 (1995) (summarizing criticisms of the initiative process); David B. Magleby, *Let the Voters Decide? An Assessment of the Initiative and Referendum Process*, 66 U. COLO. L. REV. 13, 18 (1995).

41. Legislative consideration of regulating the practice of physician provision of medication that could be used to bring about a humane death should also bring renewed attention to other forms of medical conduct that bring about death, such as removal of life support and terminal sedation. The physician's effort to bring about a hastened death, whether by provision of prescription medications that patients could take to hasten death, by removal of life-support, or by provision of terminal sedation, is a profound act and often raises legitimate state concerns that should be addressed. Unfortunately, in the context of withdrawal of life-support there are often insufficient protec-

Numerous models have been proposed and provide a useful starting point for development of appropriate legislation. These models generally include measures to ensure accurate diagnosis of terminal status; to ensure mental competency and to rule out depression of a nature that would impede rational decisionmaking; to ensure that the decision is voluntary, rational, deliberative, and enduring; and to ensure that patients have been informed of and offered alternatives such as hospice care.[42]

Legislative reform could provide relief even to the broad universe of patients addressed by the Supreme Court's "easy" question, those who are not terminal but wish to commit suicide,[43] but this seems politically unlikely.[44] Although public opinion strongly favors permitting competent dying patients the right to control the timing and manner of death by having access to prescription medications that could be used to bring about a humane and dignified death,[45] and the U.S. Supreme Court has encouraged resolution of the issue in state legislative procedures,[46] the powerful opposition of the right-to-life lobby, the

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tions, and even those that ostensibly exist are ignored. *See, e.g.*, Kathryn L. Tucker, *Surrogate End of Life Decisionmaking: The Importance of Providing Procedural Due Process, A Case Review*, 72 WASH. L. REV. 859 (1997).

42. *See* Brief of Respondents at 41 & n.29, *Glucksberg* (No. 96-110) (citing Brief Amici Curiae of State Legislators in Support of Respondents); *see also* Heilig et al., *supra* note 6 (presenting guidelines to follow when patients ask for assisted suicide); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119, 122 (1994) (recommending, among other things, that "physician-assisted death be legalized with adequate safeguards to protect vulnerable patients"). These sorts of protections could and probably should be applied to decisions to withdraw life-support and to provide terminal sedation, as the very same concerns about confirming prognosis, ensuring competency and voluntariness, and the request's enduring nature are present. Other commentators have also recognized the need to do so. *See e.g.*, WEBB, *supra* note 1, at 404-05. Such protections, however, do not in fact exist in these other contexts. *See, e.g.*, WASH. REV. CODE §§ 70.122-70.122.920 (1996). Under the Natural Death Act in Washington, a patient may direct withdrawal of life support when terminally ill, yet the diagnosis need not be confirmed by a second opinion. Further, there is no requirement that a physician or mental health provider evaluate the patient's mental competency or rule out depression as a motivating factor. Likewise, there is no waiting period or any requirement that the patient be informed of hospice or other alternatives.

43. *See, e.g.*, Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1 (1996) (proposing legislative reform measures that would permit the option of a physician-assisted death to nonterminal patients).

44. *See* Stewart, *supra* note 2, at 1, 6 (documenting that poll data reflect that citizen support for physician-assisted dying is limited to the terminally ill).

45. *See* Stewart, *supra* note 2, at 6-7.

46. *See supra* notes 28-30 and accompanying text.

Catholic Church, and medical societies may continue to make legislative reform difficult. Thus, a return to the courts for relief may be necessary.[47] As discussed above, the U.S. Supreme Court may find a federal constitutional right in a future case.[48] In addition, patient-rights advocates have the option of seeking relief from state high courts under provisions of state constitutions, as will be discussed in Part III.

III. STATE CONSTITUTIONAL LITIGATION

Many states have constitutions that are either more textually explicit regarding protection of individual liberties than is the Federal Constitution, or have similar text that has been construed by the state's high court as more protective of individual liberties.[49] Thus, for example, state courts have found that restrictions on the use of Medicaid funds for abortions offend state constitutions,[50] notwithstanding that the U.S. Supreme Court has held that there is no federal constitutional right to such funding.[51] Similarly, various state courts have held that consensual homosexual activity is protected under provisions of their own state constitutions,[52] despite the U.S. Supreme Court's holding that there is no federal constitutional protection of such activity.[53]

State courts have often spoken in resounding terms of the greater protection of individual liberties afforded by state consti-

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47. *See supra* note 31.

48. *See supra* notes 15-27 and accompanying text.

49. *See generally* William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 498-502 (1977) (noting various state supreme court decisions that interpret state constitutional provisions more expansively than provisions in the Federal Constitution); Robert F. Williams, *State Constitutional Law: Teaching and Scholarship*, 41 J. LEGAL EDUC. 243 (1991) (describing developments in state constitutional law and calling for increased teaching and study of state constitutional law).

50. *See* Linda M. Vanzi, *Freedom at Home: State Constitutions and Medicaid Funding for Abortions*, 26 N.M. L. REV. 433, 441-53 (1996).

51. *See* Maher v. Roe, 432 U.S. 464 (1977) (holding that the Equal Protection Clause did not require a state participating in the Medicaid program to pay abortion expenses for indigent women, even though it chose to pay childbirth expenses); *see also* Harris v. McRae, 448 U.S. 297 (1980) (holding that the Hyde Amendment's limitations on the use of federal funds to reimburse abortion expenses under Medicaid program did not violate the Fifth Amendment's due process guarantee).

52. *See, e.g.*, Gryczan v. State, 942 P.2d 112 (Mont. 1997) (privacy clause); Commonwealth v. Wasson, 842 S.W.2d 487 (Ky. 1992) (privacy and equal protection clauses).

53. *See* Bowers v. Hardwick, 478 U.S. 186 (1986).

tutions. For example, the California Supreme Court recently noted that "the scope and application of the state constitutional right of privacy is broader and more protective of privacy than the federal constitutional right of privacy as interpreted by the federal courts."[54] It is now well recognized that state courts can and will actively turn to their state constitutions to reach results beyond those mandated by the Federal Constitution.[55]

State court challenges to assisted-suicide prohibitions based on state constitutional provisions protecting individual privacy, liberty, or dignity may offer a route to reform in such states.[56] It is beneficial that the U.S. Supreme Court did not definitively reject recognition of such a right under the Federal Constitution in *Glucksberg* or *Quill*,[57] as it is generally more difficult to persuade a state high court to reach a conclusion squarely at odds with the U.S. Supreme Court's construction of a similar provision in the Federal Constitution.[58]

Recognition by a state high court that the state's constitution protects the choice of a competent dying patient to obtain medications for the purpose of achieving a humane and dignified death would be of obvious national significance. Such a decision would encourage and enable researchers to collect data on how a legalized practice of physician-assisted death actually operates.[59]

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54. American Academy of Pediatrics v. Lungren, 940 P.2d 797, 808 (Cal. 1997) (holding that the California Constitution's privacy clause renders unconstitutional statute requiring parental consent to minor's abortion).

55. *See* Robert F. Williams, *In the Glare of the Supreme Court: Continuing Methodology and Legitimacy Problems in Independent State Constitutional Rights Adjudication*, 72 NOTRE DAME L. REV. 1015, 1017 (1997).

56. Only one such challenge has been decided by a state high court. In that case, the Florida Supreme Court declined to find that the Florida Constitution protected this choice. *See* Krischer v. McIver, 697 So. 2d 97 (Fla. 1997). It is interesting to compare this restrictive interpretation of the Florida Constitution with the much more expansive interpretation by the Montana Supreme Court of that state's similar constitutional provision in a decision addressing state constitutional protection of consensual homosexual activity. *See* Gryczan v. State, 942 P.2d 112 (Mont. 1997). In the Montana case, the high court had to reject the U.S. Supreme Court's analysis when it considered the same issue in *Bowers v. Hardwick*. *See id.* at 121. By contrast, the Florida Supreme Court did not have to overcome the obstacle of a federal constitutional decision to find that the state constitution protected the claimed conduct, since the U.S. Supreme Court had not definitively rejected the claim of constitutional protection for physician-assisted suicide. *See Krischer*, 697 So. 2d at 100.

57. *See supra* notes 11-27 and accompanying text.

58. Scholars have criticized state high court reluctance to analyze analogous state constitutional provisions independently from the U.S. Supreme Court. *See, e.g.*, Williams, *supra* note 55.

59. Such information will shortly be available from Oregon in any event.

This data would help inform the debate regarding legislative reform in other states and in future cases before state or federal courts. Patient-rights advocates expect that this data will refute the speculations of antichoice activists and erode the roadblocks to reform created by unfounded fears in the voting public.[60]

IV. A CONSTITUTIONAL RIGHT TO ADEQUATE PAIN MEDICATION FOR DYING PATIENTS

Hastened death is not the only or the best choice for many dying patients facing severe pain and suffering, and thus advocates of death with dignity also seek to galvanize improvements in the care of the dying and specifically in improving care for pain.[61] The failure of physicians to relieve the pain of dying patients has been extensively documented.[62] An interesting avenue to prompt improved care of pain is the development of challenges to laws that serve to impede or obstruct physicians from prescribing medications of a kind or quantity sufficient to relieve pain. Such challenges were suggested by the concurring opinions in *Glucksberg* and *Quill*,[63] based on the grounds that patients have a federal constitutional right to adequate pain medication and that laws that deter access to such medications abridge that right.

Vulnerable laws would include those that discourage physicians from prescribing controlled substances. It is well documented that laws requiring that prescriptions for controlled substances be written in triplicate and laws strictly limiting the number of

60. Speculative parades of horribles are often employed by those opposing reform. For example, in *United States v. Virginia*, 116 S. Ct. 2264 (1996), Virginia argued that "admission of women would downgrade [Virginia Military Institute's] ... adversarial system and, with it, even the school." *Id.* at 2280. Justice Ginsberg, writing for a majority in holding that Virginia's categorical denial of women's admission into VMI violated the Equal Protection Clause, recognized that Virginia's argument was "a judgment hardly proved, a prediction hardly different from other 'self-fulfilling prophec[ies]' once routinely used to deny rights or opportunities." *Id.* at 2280 (citation omitted).

61. The *Quill* and *Glucksberg* cases discussed *supra* Part I have been widely credited with focusing efforts to improve the care of the dying. *See, e.g.*, INSTITUTE OF MEDICINE REPORT, *supra* note 22, at 206 ("Deficiencies in care of the dying were recognized well before the recent assisted suicide ... court challenges. Nonetheless, much of the recent attention to deficiencies in end-of-life care arose only when the issue of assisted suicide came before the Supreme Court.").

62. *See supra* note 21. A thoughtful critique of the bioethics community's failure to condemn this is presented in Ben A. Rich, *A Legacy of Silence: Bioethics and the Culture of Pain*, 18 J. MED. & HUMAN. 233 (1997).

63. *See supra* notes 15-23 and accompanying text.

dosage units per prescription, for example, have the effect of deterring physicians from prescribing controlled substances.[64]

Cases challenging such laws could be brought on federal constitutional grounds, asserting that, to the extent the laws serve to deter physicians from prescribing controlled substances in kind and quantity sufficient to relieve the pain of a dying patient, they abridge the constitutional rights of such patients.

V. DISCIPLINARY ACTION AND MEDICAL MALPRACTICE LITIGATION: HOLDING PHYSICIANS RESPONSIBLE FOR FAILING TO ADEQUATELY TREAT THE PAIN OF DYING PATIENTS

An area ripe for examination by those committed to prompting improvements in the care of the dying is the possibility of motivating physicians to take more seriously the pain management of their dying patients by subjecting physicians who fail to do so to disciplinary proceedings or malpractice actions. As noted above, a disturbing number of dying patients suffer unrelieved pain in the terminal phase of their illness. This percentage is much larger than it should be because with utilization of pain management techniques, including the provision of sufficient medication, pain can be alleviated in all but a small fraction of cases.[65]

Currently, physicians fear that prescribing controlled substances will invite regulatory oversight, and, in fact, medical disciplinary boards are active in policing prescribing practices.[66] This is one reason for the endemic problem of insufficient provision of strong pain relievers.[67] However, physicians who fail to adequately treat and medicate suffering patients do not currently perceive that their actions may be subject to review by medical disciplinary boards. Moreover, inadequate pain treatment can potentially expose a physician to civil negligence liability, although this risk too is underappreciated. This imbalance between perceived and potential risk must be corrected.

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64. *See supra* note 22 (listing studies documenting this effect).

65. *See supra* note 15.

66. *See, e.g.*, Arthur Allen, *First Do No Harm*, WASH. POST, July 27, 1997, Magazine, at 10 (detailing case involving disciplinary action taken against Dr. William Hurwitz for perceived excessive prescribing of controlled substances to patients with chronic intractable pain); Jacob Sullum, *No Relief in Sight*, REASON, Jan. 1997, at 22 (discussing disciplinary action against Dr. Hurwitz).

67. *See supra* notes 22, 62, 64 and accompanying text.

One effective way to prompt physicians to improve pain management for dying patients is to hold accountable those who fail to do so adequately. Medical disciplinary boards will likely soon play an important role in this process.[68] Boards should begin pursuing cases of inadequate pain management as zealously as they do cases of perceived excessive prescription. Outside efforts to speed disciplinary boards in this direction can be anticipated.

Medical malpractice actions provide a second vehicle for prompting improved pain management for the dying. A growing number of states have passed statutes designed to encourage physicians to prescribe controlled substances in kind and quantity sufficient to relieve patients' pain.[69] In some states, medical regulatory boards have also promulgated pain management guidelines.[70] In states with this kind of legislation or regulatory guidance, it should be possible to prevail on a medical negligence claim, because these provisions will assist in establishing the standard of care to which the provider should be held.[71]

CONCLUSION

The U.S. Supreme Court, in the first cases to present the question, declined to answer the narrow question posed by physicians and dying patients asserting a constitutional right to choose a humane and dignified death with physician assistance in the form of provision of medications the patient could self-administer. All of the Justices expressed the hope that the issue would be resolved through the political process, on a state-by-

68. The recent landmark report issued by the Institute of Medicine concluded that it would be appropriate for medical boards to discipline physicians who fail to apply proven methods of pain control. *See* INSTITUTE OF MEDICINE REPORT, *supra* note 22, at 197.

69. *See, e.g.*, CAL. BUS. & PROF. CODE § 2241.5 (West Supp. 1998); FLA. STAT. ch. 458.326 (West Supp. 1998); NEV. REV. STAT. ANN. § 630.3066 (Michie 1996); N.D. CENT. CODE § 19-03.3-02 (1997).

70. *See* Sullum, *supra* note 66, at 10 (discussing reform of medical board guidelines in states of Texas and California).

71. *See* Shapiro, *supra* note 22, at 362 (finding that "[s]ome state statutes expressly accommodate the admissibility of practice guidelines as evidence of the standard of care," citing Vermont and Maine, in particular). Even without the aid of such provisions, success may be obtainable. For example, in a 1991 North Carolina case involving inadequate treatment for pain against a nurse and a long-term care facility, a jury awarded the deceased patient's estate and the patient's survivors $15 million, half of which was for punitive damages. The case was later settled for an unreported amount while it was on appeal. *See* Estate of Henry James v. Hillhaven Corp., Super Ct. Div. 89CVS 64 (Hertford Cty., N.C. Nov. 20, 1990), *cited in* Shapiro, *supra* note 22, at 361.

state basis.[72] The Court's invitation to state legislatures to take on this issue should now be used by advocates of expanding patient choice as they urge legislators and voters to take responsibility for this matter.

A majority of the Court expressed the view that federal constitutional protection for choosing physician assistance in dying might be recognized in a future case.[73] A case presenting the plight of competent, terminally ill patients whose pain cannot be relieved even with state-of-the-art pain-management techniques is most likely to succeed.

Similarly, litigation designed to make the option of a humane, physician-assisted death available to competent dying patients may be brought to state high courts under state constitutional provisions protecting individual liberty, privacy, or dignity. These state provisions are often more textually explicit regarding the protection of individual liberty than are those of the Federal Constitution. State high courts are obligated to independently examine a claim to state constitutional protection and are not, and must not be, bound to interpret the state constitution in the same manner that the federal high court has interpreted a counterpart provision in the Federal Constitution.

Several Supreme Court Justices revealed their view that patients have, in effect, a constitutional right to receive adequate pain medication.[74] Laws that serve to obstruct access to such medication should not survive judicial scrutiny. Cases challenging such laws based on a claim of federal constitutional protection of a right to adequate pain medication can be anticipated.

Medical providers who care for the terminally ill and fail to provide pain medication in type and quantity sufficient to relieve pain, in cases where this is possible, are at risk for professional discipline and medical malpractice actions. At the same time, fear that prescribing strong pain medication to relieve the pain of terminally ill patients will invite disciplinary action must be eradicated. Efforts to correct the imbalance of perceived and actual risk in this area can be anticipated.

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72. *See supra* notes 28-30 and accompanying text.
73. *See supra* notes 12-27 and accompanying text.
74. *See supra* notes 15-23 and accompanying text.