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COMMENTS

THE LAST BEST PLACE TO DIE: PHYSICIAN- ASSISTED SUICIDE AND MONTANA'S CONSTITUTIONAL RIGHT TO PERSONAL AUTONOMY PRIVACY

Scott A. Fisk

[S]he waits for me, year after year, to so delicately undo an old wound, to empty my breath from its bad prison.¹

I. INTRODUCTION

Under current Montana law, the withholding or withdrawal of life-sustaining treatment at the request of a terminally ill patient is not suicide.² The assistance a physician provides in granting such a request, therefore, is legal so long as legislative-enacted procedures are followed. To allow a terminally ill patient to affirmatively take his or her own life with medication³ prescribed by a physician is different, however, for it involves felonious conduct with roots deeply imbedded in 700 years of Anglo-American common law.⁴ A physician convicted of assisting a patient by prescribing a lethal dose of medication, pursuant to Montana law, may be imprisoned ten years or fined \$50,000, or both.⁵ That is, if the suicide is merely an attempt. A successful

1. ANNE SEXTON, *LIVE OR DIE* 59 (1966).

2. See Montana Rights of the Terminally Ill Act, MONT. CODE ANN. § 50-9-205(1) (1997). "Death resulting from the withholding or withdrawal of life-sustaining treatment in accordance with this chapter does not constitute, for any purpose, a suicide or homicide."

3. The preferred method suggests prescribing a lethal dose of a pain-killing medication. See, e.g., *Washington v. Glucksberg*, 117 S. Ct. 2258, 2262 (1997); OR. REV. STAT. § 127.800-897 (1996).

4. See *Glucksberg*, 117 S. Ct. at 2259.

5. See MONT. CODE ANN. § 45-5-105 (1997). "Aiding or soliciting suicide. (1) A

suicide may result in charges ranging from negligent to deliberate homicide.⁶

Compared with other states, the assisted suicide law in Montana is severe.⁷ With the judicially expanded constitutional right to privacy in Montana, however, the line between withdrawing life-sustaining treatment and administering life-ending treatment is not as indelible as it is in most states. The proscription against same-gender sex, an offense rooted in the same common-law soil as suicide, was found unconstitutional in 1997, under the right of privacy clause of the Montana Constitution.⁸ The Montana Supreme Court, in *Gryczan v. State*,⁹ held that private, same-gender, consensual non-commercial sexual conduct is protected by the state constitution's right of individual, or personal-autonomy, privacy.¹⁰ Chief Justice Turnage, concurring and dissenting in the *Gryczan* decision, predicted that the state supreme court may face an assisted-suicide challenge under the theory espoused by the majority in *Gryczan*. "[T]here is something in the lives of people equally private and more important—the right to life or death."¹¹ By extending Montana's con-

person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide. (2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed \$50,000, or both."

6. See MONT. CODE ANN. § 45-5-105 (1997). Criminal Law Commission Comments state that "if the conduct of the offender made him the agent of the death, the offense is criminal homicide notwithstanding the consent or even the solicitations of the victim," and refers to MONT. CODE ANN. §§ 45-5-102 to -104 (1997) as the appropriate code sections. The code sections are deliberate homicide, § 45-5-102; mitigated deliberate homicide, § 45-5-103; and negligent homicide, § 45-5-104.

7. See Laura Trenaman-Molin, *Physician-Assisted Suicide: Should Texas be Different?*, 33 HOUS. L. REV. 1475, 1492-93 n.134-137 (1997) [hereinafter Trenaman-Molin]. Trenaman-Molin finds that 18 states treat assisted suicide as a felony while only six—Alaska, Arizona, Arkansas, Colorado, Connecticut, and Oregon—characterize assisted suicide as manslaughter. Therefore, Montana may in fact be the only state where deliberate homicide could be pursued by a prosecutor.

8. MONT. CONST. art. II, §10: "The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest."

9. 283 Mont. 433, 942 P.2d 112 (1997).

10. *Id.* at 450-51, 942 P.2d at 123. The Court further addresses the federal constitution-state constitution distinction, finding that "regardless of whether same-gender, consensual sexual conduct is accorded federal constitutional, personal-autonomy privacy protection as a fundamental right or as a right implicit in the concept of ordered liberty, Montana's Constitution, as we have already pointed out, explicitly protects individual or personal-autonomy privacy as a fundamental right by its placement in the Declaration of Rights.

11. *Id.* at 458, 942 P.2d at 127.

stitutional right to privacy into the area of personal autonomy, the courts of this state should, indeed, brace themselves for the physician-assisted suicide challenges that lie ahead. For, as this article demonstrates, a terminally ill Montanan may wish to make such a private choice, and, with the support of a willing physician, challenge the constitutionality of Montana's assisted suicide law—and succeed.

This article discusses an eventual constitutional challenge to the assisted suicide law in Montana. Part II provides a background for the physician-assisted suicide debate. Part III explores the history of suicide as it appears in the recent United States Supreme Court and Ninth Circuit decisions. Part IV looks at the current legal and moral controversy of physician-assisted suicide. Part V examines Montana's constitutional right to privacy. Part VI analyzes the viability of a Montana state constitutional challenge to the current physician-assisted suicide law. Finally, Part VII concludes with the necessary legal and legislative steps if the citizens of Montana wish to direct or deflect this inevitable challenge.

II. BACKGROUND

In 1990, Dr. Jack Kevorkian incited the current national debate over whether a physician may lawfully hasten a terminally ill patient's death when he developed a suicide machine for Janet Adkins.¹² Lying in the back of Dr. Kevorkian's 1968 Volkswagen van, in a campsite parking lot near Grovelands, Michigan, Adkins, suffering the early stages of Alzheimer's disease, pushed a button that caused pentothal to flow intravenously into her arm.¹³ She was unconscious within thirty seconds.¹⁴ Potassium chloride and succinylcholine followed, ending her life within six minutes.¹⁵ After six months and a myriad of media attention, Dr. Kevorkian faced a murder charge, which was dismissed within ten days.¹⁶ His presence in the Michigan state court system since

12. See DEREK HUMPHRY, *FINAL EXIT* 144-45 (1991). Humphry is the founder and executive director of the National Hemlock Society. In a recent public debate, Humphry made clear he is not allied with Kevorkian. "He [Kevorkian] proposed the idea of setting up a suicide clinic. I did not feel a clinic was the proper setting and I said no. He hates me." See Bernie Karsko, *Journalist, Doctor Argue Suicide Issue*, COLUMBUS DISPATCH, March 7, 1998.

13. *Id.* at 144.

14. *Id.*

15. See *id.* at 145. See also *People v. Kevorkian*, 527 N.W.2d 714, 733 (Mich. 1994), for a detailed description of other Dr. Kevorkian suicide machines.

16. See HUMPHRY, *supra* note 12, at 147. See also *A Prosecutor Drops Kevorkian*

then remains as constant as his insistence that his services should not only be legalized, but readily available for all terminally ill patients with few or no restrictions.¹⁷ Thus, whether as an angel of mercy or an agent of death, the remorseless Dr. Kevorkian's role in this debate ever since Adkin's assisted death remains instrumental.¹⁸

An equally defining moment in the debate came in June, of 1997, when the United States Supreme Court, in *Washington v. Glucksberg*,¹⁹ held that a Washington state statute proscribing assisted suicide did not violate the Fourteenth Amendment, "either on its face or as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors."²⁰ Three terminally ill patients, four physicians, and a nonprofit organization brought the original action, which was granted summary judgment in district court,²¹ and affirmed by the Ninth Circuit Court of Appeals.²² The

Charges, N.Y. TIMES, Jan. 12, 1997, at 20. Prosecutor David Gorcyca stated, "[i]t is my judgment that the common-law prohibition against assisted suicide is all but unenforceable." Mr. Gorcyca called upon legislature to arm him with a "clearly enforceable law controlling assisted suicide." See also Annette E. Clark, *Autonomy and Death*, 71 TUL. L. REV. 45, 49 n.9 (1996), for a comprehensive compendium of New York Times headlines arranged in chronological order regarding Dr. Kevorkian.

17. See, e.g., *People ex rel. Oakland County Prosecuting Att'y v. Kevorkian*, 549 N.W.2d 566 (Mich. 1996); *People v. Kevorkian*, 549 N.W.2d 562 (Mich. 1996); *People ex rel. Oakland County Prosecuting Att'y v. Kevorkian*, 534 N.W.2d 172 (Mich. 1995); *Hobbins v. Attorney General*, 518 N.W.2d 487 (Mich. App. 1994); *People v. Kevorkian*, 517 N.W.2d 293 (Mich. App. 1994); *People v. Kevorkian*, No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Dec. 13, 1993).

18. Dr. Kevorkian, a 69-year old retired pathologist, has acknowledged attending forty-five deaths since 1990. Other sources have estimated the number of deaths at seventy. See, e.g., DAILY TELEGRAPH (London), Nov. 2, 1997, at 32. Kevorkian is, indeed, a notorious phenomenon of our times. See James Langton, *Soros Signs Up to 'Dr. Death' Campaign*, THE SUNDAY TELEGRAPH (London), Nov. 4, 1997, at 32, and Ed Bark, *HBO Takes a Chilling Look at 'Dr. Death'*, THE DALLAS MORNING NEWS, Nov. 4, 1997, at 1C, where Dr. Kevorkian admits even his friends, jokingly, refer to him as Dr. Death, and his support for Oregon's assisted suicide legislation is labeled the "Dr. Death campaign." The pervasive influence Kevorkian has made on not only the legal system, but culture as well, should not be overlooked. For example, a Detroit ska-punk band, *Suicide Machines*, only recently dropped, "*Jack Kevorkian and the*," from its name. The band's song, *Break the Glass*, which fits well within the groups "social protest" theme, will be heard in the film *An American Werewolf in Paris*. See Kevin Ransom, *Attempting 'Suicide': Redford's Killer Suicide Machines Enlivens the Ska-punk Fusion Scene*, THE DETROIT NEWS, Sept. 22, 1997, at B3.

19. 117 S. Ct. 2258 (1997).

20. *Id.* at 2275. See also *Washington v. Glucksberg*, 117 S. Ct. 2302 (1997) (O'Connor, Stevens, Ginsburg, and Breyer, JJ., concurring).

21. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994).

22. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996).

unanimous Supreme Court viewed the challenge to the Washington statute²³ as one that would require reversing centuries of legal doctrine and practice, and striking down established policy in almost every state.²⁴

At the state level, however, these legal doctrines, practices, and policies regarding the right of an individual to control his or her final days have undergone dramatic changes in the past two decades. Namely, the withdrawal of life-sustaining treatment for terminally ill patients is now widely recognized as acceptable by statutory provisions in most states.²⁵

Opponents of physician-assisted suicide seem comfortable with such legislation.²⁶ The common ground in the debate, therefore, is that a person has the right to allow death to come *naturally*, and therefore may refuse unwanted treatment that would

23. WASH. REV. CODE § 9A.36.060 (1996) provides that a "person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." A violation is a Class C felony punishable by imprisonment for a maximum of five years and a fine of up to \$10,000. See § 9A.36.060(2), § 9A.20.020(1)(c).

24. See *Glucksberg*, 117 S. Ct. at 2260; see also *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 293 (1990). Justice Scalia's concurrence in *Cruzan* actively points out that suicide under any circumstance is not supported by the Constitution. See also *Passing the Buck Congress Should be Clear About the Meaning of New Laws*, PITTSBURGH POST-GAZETTE, March 18, 1998, where Justice Scalia, in a speech given to a leadership meeting of the American Medical Association, "pithily preached . . . that it is for legislatures, not courts, to adapt the law to contemporary developments." Justice Scalia states that, "[i]n my Constitution, if you want the death penalty, pass a statute. If you don't, pass a statute the other way. If you want a right to abortion or physician-assisted suicide, create it the way most rights are created in a democracy: pass a law."

25. See, e.g., *Compassion in Dying v. Washington*, 79 F.3d 790, 818-19 (9th Cir. 1996). "More than 40 other states have adopted living will statutes that permit competent adults to declare by advance directive that they do not wish to be kept alive by medical treatment in the latter stages of a terminal illness."; Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857 (1992). Kadish writes that "[w]hen Karen Quinlan became comatose in 1975, no state recognized a patient's right to set limits on life-prolonging medical efforts. Now, over 40 states have passed 'living will' statutes giving effect to a person's choice of medical treatment in the event of incompetency." Kadish considers this a "radical departure from what could have been expected of a legislature a decade earlier." *Id.* at 861.

26. For example, the Roman Catholic Church, in its 1980 Declaration on Euthanasia, concluded that "when inevitable death is imminent in spite of the means used, it is permitted in conscience to make the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted." See David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 451 (1997). While opposed to physician-assisted suicide under any circumstance, the American Medical Association allows the cessation or omission of treatment to let a terminally ill patient die. See Council On Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2230 (1992).

prolong life.²⁷ This right, while respecting personal autonomy, rests on a solid common-law foundation.²⁸ Such is not the case for physician-assisted suicide, as the *Glucksberg* Court made clear in its holding. As will be shown here, no body of law recognized by American courts today has ever acknowledged suicide, in any form, as anything more than morally reprehensible. Opponents, therefore, seem legally as well as morally justified in their argument that assisted suicide represents a general disregard for human life.²⁹

Proponents, on the other hand, find the distinction between withholding and administering treatment, both of which ultimately hasten death, as fraught with inconsistency and injustice. In essence, a physician with a patient's consent may withdraw but not insert a needle in order to hasten imminent death. The physician's assistance produces the same result: a terminally ill patient choosing when and how they want to die.³⁰

27. See *Compassion in Dying v. Washington*, 79 F.3d 790, 812 n.60-61 (9th Cir. 1996), where the court cites such dramatic statistics as 87 percent of deaths in America in 1978 resulted from chronic conditions such as heart disease and cancer; 80 to 85 percent of Americans currently die in institutions; and 70 percent of those who die in institutions do so after a decision to hasten their death by withholding or withdrawing medical treatment or technology. See also Robert L. Risely, *Ethical and Legal Issues in the Individual's Right to Die*, 20 OHIO N.U. L. REV. 597, 606 (1994). Risely reports that fifty years ago, most people died at home, and only 20 percent of Americans died in a hospital or health-care facility. Today, however, 80 percent of Americans die in a hospital or other health facility.

28. See *Glucksberg*, 117 S. Ct. at 2270. "Given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption [in *Cruzan*] was entirely consistent with this Nation's history and constitutional traditions."

29. For example, one leading opponent group, the Roman Catholic Bishop's Committee for Pro-Life Activities, characterized recent pro-suicide-assistance legislation as fundamentally rejecting "God's precious gift of life." See Gail Kinsey Hill, *Assisted-Suicide Supporters Offer to Work with Opponents*, PORTLAND OREGONIAN, Nov. 5, 1997, at 1A. See generally Susan R. Martyn & Henry J. Bourguignon, *Physician-Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, 85 CAL. L. REV. 371, 377 (1997); *Washington v. Glucksberg*, 117 S. Ct. 2258, 2271-75 (1997) (addressing state interests in preventing suicide).

30. See, e.g., John Newman, *Live Through This . . . Physician Assisted Suicide*, 21 SETON HALL LEGIS. J. 535 (1997). Newman writes that indeed there are inherent "ironies in the existing law concerning assisted suicide. For example, a person cannot be punished for attempted suicide, yet an assistant may be punished. A person can also have a needle or tube removed from [his or her] arm to facilitate death but cannot have a needle injected into [his or her] arm to achieve the same result. Similarly, it is considered a bodily intrusion to be connected to machines, but it is not a bodily intrusion to take drugs to relieve chronic pain." *Id.* at 565.

III. HISTORICAL PERSPECTIVES

In *Glucksberg*, the United States Supreme Court approached its substantive due process analysis by first searching “our nation’s history, legal traditions and practices,” for a fundamental liberty interest.³¹ As two legal commentators recently noted, “[d]espite *Roe v. Wade* and its progeny, the Court has insisted that there should not be automatic recognition of other, novel fundamental rights.”³² The Court in *Glucksberg*, in overturning the Ninth Circuit’s decision in *Compassion in Dying*,³³ found that “opposition to and condemnation of suicide—and, therefore, of assisting suicide—are consistent and enduring themes of our philosophical, legal and cultural heritages.”³⁴ While recognizing that socio-political attitudes toward suicide have moved in the direction of leniency, the Court maintained that our nation’s laws have always prohibited assisting suicide.³⁵ Of greater importance, the Court acknowledged that dramatic advances in medical technology have, indeed, increased the emphasis on end-of-life decision making.³⁶ Even so, the Court maintained that as a nation, “we have not retreated from this prohibition.”³⁷

The distinction between the two courts’ analyses is worth noting. The Supreme Court’s historical analysis begins with common law jurisprudence, encompassing approximately 700 years. Writing for the Ninth Circuit, Judge Stephen Reinhardt’s

31. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2262 (1997) (Rehnquist, C.J. delivered the opinion of the Court in which O’Connor, Scalia, Kennedy, and Thomas, JJ., joined). This analysis seeks rights that are either implicit in the concept of ordered liberty—such that neither liberty nor justice would exist if they were sacrificed—or those liberties that are deeply rooted in this nation’s history and traditions.

32. Dwight G. Duncan & Peter Lubin, *The Use and Abuse of History in Compassion in Dying*, 20 HARV. J.L. & PUBL. POL’Y 175, 177 (1996) [hereinafter Duncan & Lubin]. See also *Bowers v. Hardwick*, 478 U.S. 186 (1986), where the Court refused to find a fundamental constitutional right to homosexual sodomy. See also *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990), where the Court expressly did not recognize a right to suicide, and provided Justice Scalia the opportunity to pen another of his memorable, quip-filled concurrences. Although he finds himself “agonizing” over the “questions that are presented by the constantly increasing power of science to keep the human body alive for longer than any reasonable person would want to inhabit it,” he laments that “the point at which life becomes ‘worthless,’ and the point at which the means necessary to preserve it become ‘extraordinary’ or ‘inappropriate,’ are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory.” *Id.* at 292-93.

33. *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996).

34. *Glucksberg*, 117 S. Ct. at 2263.

35. *See id.*

36. *See id.* at 2265-67.

37. *Id.* at 2267.

analysis follows the *Roe v. Wade*³⁸ approach, and delves into Greek, Roman, early Christian, and Jewish historical renderings of the subject, encompassing more than 2,000 years.³⁹ In sum, the two courts' understandings of our nation's history, legal traditions, and practices diverge into an irreconcilable dichotomy of interpretations. The following, therefore, synthesizes the two different historical analyses.

A. *Early Actors*

Ancient societies such as the Greeks, Romans, and early Judeo-Christians generally accepted the notion that under certain circumstances it was better to die by one's own hand, with dignity, than to face a certain, far more gruesome or humiliating death. In ancient Greek and Roman societies suicide was punishable, but was often considered commendable.⁴⁰ Although Aristotle and Plato believed an individual has a moral obligation to serve society and viewed suicide with contempt, suicide in Greece was only illegal if it was unauthorized by the state.⁴¹ In the Greek Stoic view, which became popular among the Roman nobility, suicide was justified "because of the loss of preferred indifferents that the sage would suffer if he remained alive."⁴² While the Romans punished some suicides, motive was relevant in determining criminality. Namely, the law was most concerned if the

38. 410 U.S. 113 (1973).

39. Judge Reinhardt has, however, been taken to task for his rendering of the history of suicide. For example, legal scholars Dwight G. Duncan and Peter Lubin accuse Judge Reinhardt of dishonesty, not inspiring confidence, and deploying the "patronizing vocabulary of belittlement." Duncan & Lubin, *supra* note 32, at 180, 188, 202. Their crisp, thorough article should be deemed a mandatory supplement to the court's opinion, if only for the purpose of striking a balance between two distinct interpretations of history.

40. See Thomas J. Marzen et al., "Suicide: A Constitutional Right?"—*Reflections Eleven Years Later*, 35 DUQ. L. REV. 261, 262-63 n.6 (1996) [hereinafter Marzen et al.]. Marzen, it should be noted, was relied on as an authority in both the Ninth Circuit's and the United States Supreme Court's opinions regarding the common-law history of suicide.

41. See Duncan & Lubin, *supra* note 32, at 188-91.

42. Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 DUQ. L. REV. 1, 25 (1985) [hereinafter *Suicide*]. Marzen writes that Stoicism, founded by Zeno of Citium (336-264 B.C.), has found followers in every age, particularly since the Renaissance. "It is essentially a philosophy of freedom as based on rational choice Even if certain death should confront the Stoic, imposing itself against an autonomous will to live, the Stoic must, as Seneca asserts, make death [one's] own in order to be free from it. Thus, rational will, pure and simple, constitutes human dignity and justifies, even glorifies, an act such as self-inflicted death." *Id.* (footnotes omitted).

act was nothing more than a desperate attempt to escape culpability for misdeeds against the government.⁴³ The prohibition against suicide was designed to make sure an accused could not protect his family from disinheritance.⁴⁴ One commentator, Martin Marzen, wrote: “[a]s we have seen, even before the time of Blackstone, there was a tendency to regard suicides rather as victims of mental disorder than as culprits.”⁴⁵

This theme was pivotal in Judge Reinhardt’s historical analysis of antiquity in *Compassion in Dying*: “[t]o live nobly also meant to die nobly and at the right time.”⁴⁶ Therefore, Judge Reinhardt finds significance in such historical occurrences as Socrates willingly drinking the hemlock, the Stoic Cato killing himself to avoid dishonor when Caesar crushed his military aspirations, David’s father Saul dying by falling on his sword when all hope of victory was lost, hundreds of Jews killing themselves at Masada in order to avoid being captured by Roman legions, and countless early Christian martyrs welcoming “death as an escape from the tribulations of a fallen existence and as the doorway to heaven.”⁴⁷

One glaring example of this historical theme of *suicide should not be encouraged, or condoned by law, but is sometimes necessary* is embodied in the Hippocratic Oath. The medical profession has used various forms of the oath for two millennia. The oath has consistently forbidden physicians from supplying a patient with a deadly drug, yet at the same time requires all efforts be made to ease suffering.⁴⁸

43. See *Compassion in Dying v. Washington*, 79 F.3d 790, 807 (9th Cir. 1996); John Newman, *Live Through This . . . Physician Assisted Suicide*, 21 SETON HALL LEGIS. J. 535, 540 n.26 (1997).

44. See Marzen et. al., *supra* note 40, at 262-63 n.6. The law thus ensured that a criminal, prior to conviction, would not dispossess the Emperor of property that would otherwise go to him.

45. *Suicide*, *supra* note 42, at 85.

46. *Compassion in Dying v. Washington*, 79 F.3d 790, 807 (9th Cir. 1996) (emphasis added).

47. *Id.* at 808. See also 1 Samuel 31:4.

48. As three commentators write, “[i]t is well established that Greek and Roman physicians, even those who were Hippocratic, often supplied their patients with the means to commit suicide, despite the injunction against assistance in suicide embodied in the Hippocratic oath.” Rebecca C. Morgan et. al., *The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide*, 57 MO. L. REV. 1, 46 (1992).

B. A Common Stake through the Body

Compared to the ancients, the penalty for suicide under English common law was more severe. Legal historians reason that the common law was influenced not only by Roman law, as distilled by Henry Bracton between 1220 and 1260,⁴⁹ but also quite heavily by Christianity.⁵⁰ Consistent with a Christian view, English common law reflects a change in attitude regarding suicide, namely St. Augustine's "unambiguous voice for the tradition against self-killing."⁵¹ In treating suicide as a form of murder, English common law punished suicide in one of two ways. First, if the motive for suicide was to avoid criminal punishment, akin to Roman law, then the suicidant forfeited *all* lands and chattels to the king, leaving his heirs nothing.⁵² Second, if the suicide resulted from circumstances of despair, an offense largely ignored under Roman law, then the suicidant forfeited chattels, but not land, to the king.⁵³ Regardless of the motive, the suicidant received an ignominious burial at a crossroad with a stake driven through his body, a practice that did not see its last days until the early nineteenth century.⁵⁴

The common law punished assisted suicide as well. If one advised another in committing suicide and was present during its commission, English law charged that person as a principal in the suicide. If one advised a person planning to commit suicide, but was not present during its commission, English law charged that person as an accessory before the fact.⁵⁵

49. See Marzen et. al., *supra* note 40, at 262-63 n.6.

50. See *Compassion in Dying*, 79 F.3d at 808; *Glucksberg*, 117 S. Ct. at 2263-64; see also, Duncan & Lubin, *supra* note 32, at 194-96; Daniel M. Crone, *Historical Attitudes Toward Suicide*, 35 DUQ. L. REV. 7 (1996). "With Augustine's contribution, the Roman Catholic Church articulated its stance against suicide; its condemnation consistently expressed in canonical directives applied to civil life Due to the Church's dominant cultural and ethical influence in Europe, from the time of the late Roman Empire through the period of the Renaissance and Reformation the occurrence of suicide was negligible." *Id.* at 20.

51. See Duncan & Lubin, *supra* note 32, at 194-196. St. Augustine "viewed suicide as a simple violation of one of the Ten Commandments, "Thou shalt not kill." Even so, he condoned martyrdom, which according to Duncan and Lubin was not deemed the same as "self-killing," but nevertheless was interpreted by Judge Reinhardt, in *Compassion in Dying*, as yet another example of authoritative exemptions or leniency toward suicide under certain circumstances.

52. See *Suicide*, *supra* note 42, at 58-61.

53. See *id.*

54. See generally Duncan & Lubin, *supra* note 32, at 202, where the practice of ignominious burial was influenced primarily by superstition, that the spirit of someone who ended his own life would return to haunt the living.

55. See Woolf Brenner, *Undue Influence in the Criminal Law: A Proposed Anal-*

C. *Westward the Course of Suicide Takes Its Way*⁵⁶

Although English common law penalties are seen by the legal community as a moral stiffening against suicide, an element of restraint for those who were “unwilling to endure further bodily pain,”⁵⁷ survived the voyage to the new world. The evolution of the law’s treatment of suicide in American history has been a gradual, progressive move toward leniency. In early America, the practice of ignominious burial and penalizing heirs with forfeiture of estate quickly lost footing, especially since America had no king to demand the return of his land. By 1798, six of the 13 original colonies had abolished all penalties for suicide either by statute or constitution.⁵⁸ The traditional penalties were abolished, according to authorities cited by the Court in *Glucksberg*, not because suicide itself was viewed as a lesser evil or as a human right, but because the penalties punished the family of the suicidant, and failed to reach the real perpetrator of the act.⁵⁹ Nevertheless, although no state adopted the English penalty of forfeiture, the suicide laws of the various states differed; some held suicide was not a crime, others held it was a felony, and still others deemed suicide unlawful, but not a felony. Because American law never adopted the penalty of forfeiture, and the English practice of ignominious burial ceased in 1823, suicide eventually carried no penalty. As time progressed, the American states moved away from treating suicide as a crime because they lacked an effective method of punishment.⁶⁰

Assisting one in suicide, however, has never been legal in this country. When the Fourteenth Amendment was ratified in 1868, for example, nine of the 37 states already had statutes

ysis of the Criminal Offense of “Causing Suicide,” 47 ALB. L. REV. 62, 64-67 (1982).

56. This heading refers to Emanuel Gottlieb Leutze’s *Westward the Course of Empire Takes Its Way*, an 1861 mural study for the west staircase in the U.S. Capitol’s west wing. One of the many works commissioned for the Capital Extension projects during the Civil War era, Leutze’s painting depicts westward expansion and manifest destiny. The allusion of this heading refers to the concept that Anglo-Saxon Americans’ providential mission to expand their civilization and institutions across the breadth of North America, fostered by the U.S. government’s annexation of lands, was somehow justifiable due to the supremacy of its European heritage, which included the common law. Thus, the laws regarding suicide were adopted with little scrutiny state-by-state, territory-by-territory throughout much of the west, including Montana, during the late nineteenth-century.

57. *Compassion in Dying v. Washington*, 79 F.3d 790, 808-09 (9th Cir. 1996) (quoting from Bracton).

58. See *Suicide*, *supra* note 42, at 67.

59. See *Glucksberg*, 117 S. Ct. at 2264-65.

60. See *Suicide*, *supra* note 42, at 85.

that expressly prohibited assisting a suicidant.⁶¹ In one of the more infamous and often-cited cases, *People v. Roberts*,⁶² the defendant was sentenced to life in prison for murder for placing poison within reach of his bedridden wife, who suffered from multiple sclerosis.⁶³ Today, 44 states, the District of Columbia, and two territories either prohibit or condemn assisted suicide.⁶⁴ Six states deem assisted suicide manslaughter, 18 a felony, and the remaining 26 find the act as either a misdemeanor, or expressly disapprove of it in statutes concerning durable powers of attorney and in living wills.⁶⁵

IV. THE CONTEMPORARY CONTROVERSY

The liberty interest raised in today's legal challenges to assisted suicide laws arguably supersedes the foregoing section's historical analysis. This is why advocates of physician-assisted suicide argue that the liberty interest at stake did not exist until very recently and the laws are not synchronized with the society that must abide by them. In his attempt to create what essentially amounts to a new right to meet this new condition, Judge Reinhardt opined:

[w]e are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as "suicide." Certainly, we see little basis for such a classification when deaths that result from patients' decisions to terminate life support systems or to refuse life-sustaining food and water, for example, are not. We believe that there is a strong argument that a decision by a terminally ill patient to

61. In Montana, although early statutes did not mention suicide or assisting suicide, "the territorial legislature adopted an act providing for the punishment of '[a]ll offenses recognized by the common law crimes, and not here enumerated.' On February 14, 1895, as part of a general revision of the laws, this act was replaced by a provision restricting the application of the common law to cases not governed by the code or statute. Five days later, as part of a new penal code, the state legislature enacted: 'Every person who deliberately aids, or advises or encourages another to commit suicide is guilty of a felony.'" See *Suicide*, *supra* note 42, at 192.

62. 178 N.W. 690 (Mich. 1920).

63. *Id.* at 692. Although Roberts placed poison within his wife's reach at her request, after she had already tried and failed to commit suicide by her own hand, the judge reprimanded him: "[i]t is beyond my comprehension how a human being of normal conditions at least, or apparent normal conditions, can commit such a crime as you have in this case It was, indeed, an inhuman and dastardly act."

64. See *Compassion in Dying v. Washington*, 79 F.3d 790, 847 n.10 (9th Cir. 1996) (Beezer, J., dissenting).

65. See *Trenaman-Molin*, *supra* note 7, at 1492-93, n.134; see also *supra* note 6, indicating that Montana may stand alone with its default provision, which allows deliberate homicide charges to be brought against a person who assists in a suicide.

hasten by medical means a death that is *already in process*, should not be classified as suicide.⁶⁶

In essence, modern medical technology has created a new stage of life for a *competent incurable patient*, a *sustained terminal stage*, which one enters not necessarily as a matter of choice and for which history lacks the voice to explain.⁶⁷

A. *The Tragedy of Heroic Technology: The Physician's Dilemma*

Both sides of the physician-assisted suicide controversy seem to agree that improvements in the field of medical science and technology have created a dilemma.⁶⁸ That medical technological improvements often serve to prolong life without regard for improving the quality of life is beyond reproach.⁶⁹ Consequently, in

66. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 824 (9th Cir. 1996) (suggesting that the state's interest in preventing suicide, therefore, may not be implicated in this case) (emphasis added). See also *Glucksberg*, 117 S. Ct. at 2265, where the Court acknowledges that "[b]ecause of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illness."

67. A similar position to this was recently expressed in RONALD DWORKIN, *FREEDOM'S LAW: THE MORAL READING OF THE AMERICAN CONSTITUTION* 130 (1996). Dworkin writes that the "[l]ongstanding practice is an even worse guide to constitutional law when technological change has created entirely new problems or exacerbated old ones." Consequently, when the Supreme Court rules on "whether states can constitutionally forbid someone in that position from taking his own life, or can make it criminal for a doctor to assist him, even if the doctor takes every precaution to be sure that the person has freely decided to commit suicide, the Court will face a very different situation from that in which the common law principles about suicide developed." *Id.* at 139. Dworkin bluntly proclaims, at the close of the chapter, that "[m]aking someone die in a way others approve, but he believes contradicts his own dignity, is a serious, unjustified, unnecessary form of tyranny." *Id.* at 146. Dworkin also writes: "[o]f course the law must protect people who think it would be appalling to be killed, even if they had only painful months or minutes to live anyway. But the law must also protect those with the opposite conviction: that it would be appalling not to be offered an easier, calmer death with the help of doctors they trust." *Id.*

68. "Two decades ago, those who were not and could not swallow and digest food, died . . . Today, various forms of artificial feeding have been developed that are able to keep people metabolically alive for years, even decades." *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 328 (1990) (Brennan, J., dissenting). Justice Brennan is not alone in this observation. A recent article in the *Journal of the American Medical Association* recognized "that the dying process is too often needlessly protracted by medical technology and is consequently marked by incapacitation, intolerable pain, and indignity." American Medical Association Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 *JAMA* 2229 (1992) [hereinafter *Decisions*].

69. "Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues." *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 328 (1990) (Brennan, J., dissenting)

an attempt to fulfill their oath to do everything in their power to treat patients, physicians may be entrapped by the very technology that they wield. A vocal minority of physicians, such as Dr. Guy Benrubi, argue that physicians themselves are culpable in bringing their patients to a state of unbearable agony and must therefore assist these individuals to die in order to exculpate themselves.⁷⁰

The matter is far from resolved within the medical community. The 290,000-member American Medical Association (AMA), for example, refuses to support physician-assisted suicide on the grounds that it is "contrary to the prohibition against using the tools of medicine to cause a patient's death."⁷¹ Even so, the AMA supports what is known as the "double effect" standard: if a physician prescribes medication primarily to *relieve* a patient's pain and suffering, then she is performing a proper medical function although she knows the patient will die because of her actions.⁷² Individually, doctors under certain circumstances support physician-assisted suicide.⁷³ Therefore, when physicians speak for the profession itself, they tend to disfavor physician-assisted suicide; privately, they tend to favor physician-assisted suicide.⁷⁴

B. *The Supreme Court Charts the Course*

The United States Supreme Court recognizes the dilemma modern technology presents as this nation comes to terms with what, exactly, is the right thing to do regarding physician-assisted suicide. "Throughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality,

(quoting *Rasmussen v. Fleming*, 741 P.2d 674, 678 (Ariz. 1987)).

70. See Guy I. Benrubi, *Euthanasia—The Need for Procedural Safeguards*, 326 NEW ENG. J. MED. 197, 197-198 (1992).

71. See *Decisions*, *supra* note 68, at 2233, noting that the AMA also refused to support abortion as a right prior to *Roe v. Wade*.

72. See *Compassion in Dying v. State of Washington*, 79 F.3d 790, 828 n.102 (9th Cir. 1996).

73. A recent survey found that sixty-six percent of responding Oregon-based physicians felt physician-assisted suicide would be ethical in some cases and sixty percent supported its legalization. See Melinda A. Lee et al., *Legalizing Assisted Suicide: Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310, 311 (1996).

74. See *Trenaman-Molin*, *supra* note 7, at 1494 n.146, where the author notes that in a recent survey fifty-three percent of 938 Washington state physicians approve of physician-assisted suicide, while most medical groups formally oppose its legalization. See also *Glucksberg*, 117 S. Ct. at 2309, where similar surveys in Michigan and Oregon found that fifty-six percent and sixty percent, respectively, of responding physicians supported legalizing assisted suicide for terminally ill patients.

and practicality of physician-assisted suicide.⁷⁵ This seems to be the underlying tone in the *Glucksberg* decision; the nation through legislative activity, not the Supreme Court, must determine what is right. Whether an exercise in judicial restraint or new federalism, the *Glucksberg* decision stands not only for the proposition that a fundamental right to suicide, assisted or otherwise, does not exist, but also that such a right, in fact, can be granted by the states. If anything, this is precisely what the *Glucksberg* concurring opinions proposed. Justice Stevens expends tremendous thought in exploring just how such a right may arise under the factual scenarios presented to the Supreme Court. First, in terms of protecting the individual from abuse or coercion, he writes that “[a]n individual adequately informed of the care alternatives thus might make a rational choice for assisted suicide. For such an individual, the State’s interest in preventing potential abuse and mistake is only minimally implicated.”⁷⁶ Next, he addresses the state interest of preserving the traditional integrity of the medical profession.

The fear is that a rule permitting physicians to assist in suicide is inconsistent with the perception that they serve their patients solely as healers. But for some patients, it would be a physician’s refusal to dispense medication to ease their suffering and make their death tolerable and dignified that would be inconsistent with the healing role.⁷⁷

As a final concession, Justice Stevens indicates that physicians already make decisions that hasten the death of terminally ill patients—through termination of life support, withholding of medical treatment, and terminal sedation. “[T]here is in fact significant tension between the traditional view of the physician’s role and the actual practice in a growing number of cases.”⁷⁸ The implication, then, is that the states may choose to

75. *Washington v. Glucksberg*, 117 S. Ct. 2258, 2275 (1997).

76. *Id.* at 2308.

77. *Id.*

78. *Id.* at 2309. Justice Stevens finds that there is “evidence that a significant number of physicians support the practice of hastening death in particular situations.” *Id.* at 2309 n.12. Stevens notes that:

[a] survey published in the *New England Journal of Medicine*, found that 56 percent of responding doctors in Michigan preferred legalizing assisted suicide to an explicit ban. Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303-309 (1996). In a survey of Oregon doctors, 60 percent of the responding doctors supported legalizing assisted suicide for terminally ill patients. See Melinda A. Lee et al., *Legal-*

legitimize and regulate what is, or may become, an accepted reasonable practice by physicians treating terminally ill patients. Therefore, the choice by the states to pass laws regulating the ongoing practice may, quite possibly, stem whatever tide of abuse or coercion that will inevitably occur.⁷⁹

Justices Steven's and O'Connor's opinions leave little doubt that the Court wishes to shift the burden of debate to the states.⁸⁰ The justices, in expanding the text of the majority's opinion, recognize that states are undertaking extensive and serious evaluation of physician-assisted suicide. In such circumstances, "the challenging task of crafting appropriate procedures for safeguarding . . . liberty interests is entrusted to the 'laboratory' of the States . . . in the first instance."⁸¹ The states, therefore, will take the lead role in this purgation of the national

izing Assisted Suicide: Views of Physicians in Oregon, 334 New Eng. J. Med. 310-315 (1996). Another study showed that 12 percent of physicians polled in Washington State reported that they had been asked by their terminally ill patients for prescriptions to hasten death, and that, in the year prior to the study, 24 percent of those physicians had complied with such requests. See Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919-925 (1996); see also David J. Doukas et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. CLIN. ONCOL. 1055 (1995) (reporting that 18 percent of responding Michigan oncologists reported active participation in assisted suicide); Lee Slome et al., *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 5 J. ACQ. IMM. DEF. SYND. 712 (1992) (reporting that 24 percent of responding physicians who treat AIDS patients would likely grant a patient's request for assistance in hastening death).

Id. The point is not that Stevens did his homework, which he did, but that he reveals and acknowledges that the practice is widespread within the medical community and should therefore be consciously addressed not in terms of denial, but rather in terms of safeguards and procedures to ensure that the individuals involved are not subject to the very abuse or coercion that opponents fear.

79. See *Scalia On Target, Congress Not Courts, Should Decide Key Issues*, COLUMBUS DISPATCH, Mar. 16, 1998, at 6A. Justice Scalia, in his speech to the American Medical Association, is quoted as saying, "[i]t is not supposed to be our judgment as to what is the socially desirable answer to all of these questions [death penalty, abortion and physician-assisted suicide]. That's supposed to be the judgment of Congress, and we do our job correctly when we apply what Congress has written as basically and honestly as possible If you have a bad statute, not only should you expect a result to be a very bad result, I would argue that you should criticize the judges as being in violation of their oath if they do not produce a bad result, because it's not supposed to be our call."

80. Justice O'Connor, in her brief concurrence, allies herself with Stevens: "There is no reason to think the democratic process will not strike the proper balance between the interests of terminally ill, mentally competent individuals who would seek to end their suffering and the State's interests in protecting those who might seek to end life mistakenly or under pressure." *Glucksberg*, 117 S. Ct. at 2303.

81. *Id.* (O'Connor, J., concurring) (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 292 (1990)).

psyche, a catharsis that may very well, at last, purify the tragic but inevitable relationship citizens enjoy with death in a time when advances in the science of medicine have all but extinguished traditional notions of personal autonomy for the terminally ill.

C. *The States Take the Lead*

Montana enacted legislation in 1985, permitting a diagnosed terminally ill patient to instruct a physician to withdraw life support. Like most states, the Terminally Ill Act came in response to the public outcry against the indignity of living one's last days, months or even years in a vegetative state.⁸² This wave of state legislative activity occurred after the family of Karen Ann Quinlan was permitted to withdraw life support following a heated court battle culminating with the New Jersey Supreme Court's 1976 landmark decision.⁸³ This liberty interest, the refusal of unwanted medical treatment, was tenuously recognized by the United States Supreme Court in *Cruzan*, its controversial 1990 decision.⁸⁴

82. See Montana Rights of the Terminally Ill Act, MONT. CODE ANN §§ 50-9-101 to 206 (1997).

83. See *In re Quinlan*, 355 A.2d 647 (N.J. 1976). The New Jersey Court held that Quinlan's right of privacy, and thus her right to refuse treatment, could be asserted by her guardian, her father Joseph Quinlan. See *id.* at 664; see also Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857 (1992). Kadish writes that "[w]hen Karen Quinlan became comatose in 1975, no state recognized a patient's right to set limits on life-prolonging medical efforts. Now, over forty states have passed 'living will' statutes giving effect to a person's choice of medical treatment in the event of incompetency." *Id.* at 861. Kadish considers this a "radical departure from what could have been expected of a legislature a decade earlier." *Id.*

84. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). Chief Justice Rehnquist assumed that the constitutional right of a competent person to refuse unwanted medical treatment could be inferred from prior Supreme Court decisions. See *id.* at 278. The Court therefore assumed, but did not decide, that an individual had a right to refuse life-saving treatment, which of course stirred debate concerning a person's right to die. See *id.* The primary focus of the decision was whether a state could, pursuant to its laws, limit a person's ability to exercise the right to refuse unwanted medical treatment. See *id.* at 280-81. The decision, in favor of the State of Missouri, turned on hearsay, what the patient, Nancy Cruzan, had told friends and relatives regarding her desire to have life-sustaining treatment withdrawn. The Court found that a state, as a matter of compelling interest to preserve life, can set forth a series of procedural hurdles for relatives of a victim to overcome in order to end treatment and allow the victim to die naturally. See *id.* As Justice Scalia's concurring opinion indicates, if a person has a constitutionally protected right to refuse life-saving treatment and life-sustaining nutrition, it should be unconstitutional for a state to criminalize whatever steps a person may take in terminating his or her life. See *id.* at 299-300; see also Yale Kamisar, *The "Right to Die": On Draw-*

Proponents of physician-assisted suicide see the current debate and legislative activity as the logical next step to keep in stride with medical technology's inexorable progress. If the right to die with dignity cannot be recognized as a fundamental right existing within the protected zone of personal autonomy, then the right should be statutorily created. Thus, proponents and opponents from all quarters of society have pressured state legislatures and courts across the country to address the constitutional, legal and moral issues surrounding physician-assisted suicide. Indeed, in the past three years alone, legislation that would allow a much refined, limited use of Dr. Kevorkian's methods was introduced, debated and rejected in 27 states.⁸⁵ Truly at the forefront of this issue, at least in terms of supporting the right to physician assisted suicide, is Oregon. In 1994, Oregon voters passed the Death With Dignity Act, becoming the first state to permit a form of physician-assisted suicide.⁸⁶ Maine's

ing (*And Erasing*) Lines, 35 DUQ. L. REV. 481, (1996). Kamisar finds that "[a]lthough the Ninth Circuit found support for its conclusions in *Cruzan v. Director, Mo. Dep't of Health*, [footnote omitted], which is so far the only case on death, dying and the right of privacy decided by the U.S. Supreme Court, the court's reliance on this case is dubious." *Id.* at 483.

85. Currently, thirty-two states have legislatively denied this potential liberty interest by enacting statutes explicitly prohibiting physician-assisted suicide. The state of Michigan, in fact, enacted legislation in 1993 specifically designed to address the challenges to existing laws made by Dr. Kevorkian. See MICH. COMP. LAWS § 752.1027 (1994). Subsection (3) of the statute permits prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort and not to cause death, even if the medication or procedure may hasten or increase the risk of death.

86. OR. REV. STAT. § 127.800-897 (1996). The Act permits a person, who is mentally competent and diagnosed as having less than six months to live, request a lethal prescription from a doctor, wait fifteen days, then take the drugs. On November 5, 1997, these same voters went to the polls and again voted, by a 3-2 ratio, to support the Act. The repeal campaign spent almost \$4 million to persuade voters to get rid of the law. Much of the support came from the Roman Catholic Church and Oregon Right to Life. See, e.g., *Suicide Law Stands*, PORTLAND OREGONIAN, Nov. 5, 1997, at A1. By no means has the Act been free from scrutiny since November. Following the vote, the U.S. Federal Drug Enforcement Administration head, Thomas A. Constantine, spearheaded a U.S. Department of Justice review, arguing that doctors who assist the suicide of a terminally ill patient should lose their prescribing privileges pursuant to the Controlled Substances Act. If enforced, the Oregon law would be rendered useless. See Jim Barnett et. al., *DEA Policy on Suicide Law in Doubt*, PORTLAND OREGONIAN, Jan. 24, 1998. Since the Oregon vote, many proposals to legalize assisted suicide have been and continue to be introduced in the States' legislatures, but none have been enacted. See, e.g., *Glucksberg* 117 S. Ct. at 2266, n.15 (citing Alaska H.B. 371 (1996); Ariz. S.B. 1007 (1996); Cal. A.B. 1080, A.B. 1310 (1995); Colo. H.B. 1185 (1996); Colo. H.B. 1308 (1995); Conn. H.B. 6298 (1995); Ill. H.B. 691, S.B. 948 (1997); Me. H.P. 663 (1997); Me. H.P. 552 (1995); Md. H.B. 474 (1996); Md. H.B. 933 (1995); Mass. H.B. 3173 (1995); Mich. H.B. 6205 (1996);

state legislature recently voted down a bill that would have legalized physician-assisted suicide, following a lengthy statewide public debate that indicated favor for its passage.⁸⁷ As Ninth Circuit Judge Reinhardt wrote, physician-assisted suicide has become "a controversy that may touch more people more profoundly than any other issue the courts will face in the foreseeable future."⁸⁸

V. PRIVACY IN DYING: A FUNDAMENTAL LIBERTY INTEREST?

The right to privacy, first articulated as a common law right in this country by Samuel Warren and future Supreme Court Justice Louis Brandeis in their 1890 article, *The Right to Privacy*,⁸⁹ was premised on the principle that "political, social, and economic changes entail the recognition of new rights" which should include "thoughts, emotions, and sensations [that] demanded legal recognition."⁹⁰ This principle provided the focal point of constitutional challenges to laws in this country that have arguably infringed on rights to privacy that are either fundamental or implicit in the concept of ordered liberty.⁹¹ Until the

Mich. S.B. 556 (1996); Mich. H.B. 4134 (1995); Miss. H.B. 1023 (1996); N.N.N.B. 339 (1995); N.N.S.B. 446 (1995); N.Y.S.B. 5024 (1995); N.Y. A.B. 6333 (1995); Neb. L.B. 406 (1997); Neb. L.B. 1259 (1996); R.I.S. 2985 (1996); Vt. H.B. 109 (1997); Vt. H.B. 335 (1995); Wash. S.B. 5596 (1995); Wis. A.B. 174, S.B. 90 (1995)). Also, in 1906, Ohio became the first state to introduce a bill legalizing assisted suicide. See Antonios P. Tsarouhas, *The Case Against Legal Assisted Suicide*, 20 OHIO N.U. L. REV. 793, 796 (1994).

87. See *Senate Rejects Assisted Suicide*, PORTLAND PRESS HERALD (Me.), Feb. 13, 1998, at 3B; see also Frank Fisher, *Public Gets Chance to Weigh in on Assisted Suicide Bill*, ASSOCIATED PRESS POL. SERV., Jan. 27, 1998, describing the public debate process.

88. *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir. 1996). The Ninth Circuit became the first appellate court in American history to hold that physician-assisted suicide of terminally ill patients is protected as a fundamental liberty by the Constitution under the Fourteenth Amendment's Due Process Clause. See, e.g., *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (holding that New York's Statute prohibiting assisted suicide is unconstitutional under the Fourteenth Amendment's Equal Protection Clause because it lacked a rational basis when applied to the terminally ill, but noting that the prohibition would not be upheld as a fundamental liberty interest under Due Process Clause analysis).

89. 4 HARV. L. REV. 193 (1890).

90. *Id.* at 193, 205. See also *Pavesich v. New England Life Ins. Co.*, 50 S.E. 68 (1905). The Georgia Supreme Court, in *Pavesich*, while acknowledging no precedent for the right to privacy existed, found the right's inchoate existence in other legal rights and observed the changing social, political and economic conditions of society supported its recognition.

91. See generally *Palko v. Connecticut*, 302 U.S. 319 (1937). While the Court, in *Palko*, was not concerned with privacy, it established the fundamental right standard of a "principle of justice so rooted in the traditions and conscience of our people as

1960s, the right primarily had been invoked to prevent unwanted searches or the disclosure of personal information, under the general term "observational" privacy, or the right to be let alone.⁹²

The right to personal autonomy privacy, or personal choice, was first expressed in the United States Supreme Court's 1965 *Griswold v. Connecticut*⁹³ decision. Even so, this privacy right had been developing throughout the course of this century. Within the text of the Due Process Clause of the Fourteenth Amendment,⁹⁴ the rights to marry regardless of race, to procreate, to direct the education and upbringing of one's children, to marital privacy, to use contraception, to bodily integrity, and to abortion have evolved mostly in the latter half of this century.⁹⁵ These themes should not be overlooked. Birth, family, and education are hallmarks of the stages of life that all citizens share, respect, and, indeed, believe are fundamental to the American way of life.

The Supreme Court in *Planned Parenthood v. Casey*,⁹⁶ opined that such decisions involve "intimate and personal choices" and concern "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human

to be ranked fundamental." This standard has been routinely cited in privacy decisions. *Id.* at 325.

92. See, e.g., *Katz v. United States*, 389 U.S. 347, 350-51 (1967).

93. 381 U.S. 479 (1965). Justice Douglas found that the statute forbidding the sale of contraceptive devices impermissibly limited the right of privacy of married persons. The opinion found "that the values of privacy, including freedom from government intrusion with private thoughts, association, and liberty, had long been part of American legal philosophy." JOHN E. NOWAK & RONALD D. ROTUNDA, CONSTITUTIONAL LAW, §14.27 at 799 (5th ed. 1995).

94. Section one of the Fourteenth Amendment states: "No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV.

95. See *Loving v. Virginia*, 388 U.S. 1 (1967) (finding freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (finding marriage and procreation are fundamental); *Myer v. Nebraska*, 262 U.S. 390 (1923) (finding liberty includes "those privileges long recognized at common law as essential to the orderly pursuit of happiness of free men"); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (finding intrusions into the "sacred precincts of marital bedrooms" offend rights "older than the Bill of Rights"); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Rochin v. California*, 342 U.S. 165 (1952); *Roe v. Wade*, 410 U.S. 113 (1973) (stating that at the founding and throughout the nineteenth-century, "a woman enjoyed a substantially broader right to terminate a pregnancy"); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). In addition to the Fourteenth Amendment, the right to privacy may also be expressed, textually, in the Bill of Rights.

96. 505 U.S. 833 (1992).

life.⁹⁷ This language expresses the essence of the Court's definition of personal autonomy. The *Casey* Court cautioned other courts to neither restrict the Due Process clause to only those rights enumerated in the Bill of Rights nor limit the definition of these rights according to the intentions that existed when the Fourteenth Amendment was ratified.⁹⁸ Rather, the courts should engage in "reasoned judgment" when adjudicating substantive due process claims.⁹⁹ The Court emphasized that "[o]ur obligation is to define the liberty of all, not to mandate our own moral code."¹⁰⁰

Proponents of assisted suicide argue that the decision not to endure pain in one's final days is fundamentally personal as well, constituting an essential expression of personal autonomy. Yet, as seen in *Glucksberg*, the final stage of life is noticeably absent from the Court's notion that individuals have a right to define their existence, as if this nation lies in a state of denial, that death to one and all is somehow not inevitable.¹⁰¹ The irony is terrible and curious, for what better defines existence than the certainty of death, and what mystery remains more absolute?

A. *The Mandate for Privacy in Montana*

On June 6, 1972, Montana's current State Constitution was ratified. As Professor Larry M. Elison and Dennis NettikSimmons stated in their 1987 article, *Right of Privacy*,¹⁰² the inclusion of a right to privacy provision, which by then was well established in case law, persisted as a paramount concern among delegates.

There was no disagreement among the delegates concerning Delegate Campbell's assessment of the Bill of Rights Committee's feeling that the times have changed sufficiently that this important right should now be explicitly recognized.

97. *Id.* at 851.

98. *See id.* at 847-48.

99. *Id.* at 849.

100. *Id.* at 850.

101. For an interesting exploration of this subject, see generally EARNEST BECKER, *THE DENIAL OF DEATH* (1973). Chapter one, for example, ends with "[f]or twenty-five hundred years we have hoped and believed that if mankind could reveal itself to itself, could widely come to know its own cherished motives, then somehow it would tilt the balance of things in its own favor." Becker maintains that the ever-present fear of death in the normal biological functioning of our instinct of self-preservation is generally repressed and denied for these very reasons—survival.

102. 48 MONT. L. REV. 1 (1987) [hereinafter Elison & NettikSimmons].

Delegate Campbell attributed this change to an increasingly complex society . . . in which our area of privacy has decreased, decreased, decreased. Delegate Campbell further provided a helpful analogy that one might conclude aptly characterized the sentiments of a vast majority of the delegates: "What this would do—by requiring that this area of privacy be protected unless there is a showing of a compelling state interest, it produces what I call a semipermeable wall of separation between individual and state; just as the wall of separation between church and state is absolute, the wall of separation we are proposing with this section would be semipermeable."¹⁰³

Since ratification, the constitutional right to privacy has provided the Montana State Supreme Court the opportunity to routinely distinguish its holdings from the United States Supreme Court holdings regarding such privacy interests areas as personal information and searches.¹⁰⁴ "We have chosen not to 'march lock-step' with the United States Supreme Court, even when applying nearly identical language. In addition, we have held that Montana's unique constitutional language affords citizens a greater right to privacy."¹⁰⁵ Indeed, unlike the federal constitution, Montana's Constitution, as interpreted by the Montana Supreme Court, explicitly grants all state citizens the fundamental right to individual privacy. In addition to search and personal information protection, this right now includes "personal-autonomy privacy."¹⁰⁶

Legislation regulating the exercise of a privacy right must be justified by a compelling state interest, and narrowly tailored to effectuate only that interest.¹⁰⁷ Even so, the court must still de-

103. *Id.* at 11.

104. This posture, part of what has become known as the new judicial federalism, is by no means limited to Montana, although Montana's constitution perhaps grants broader rights than other states. See Justice William J. Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977). Justice Brennan notes that "[o]f late . . . more and more state courts are construing state constitutional counterparts of provisions of the Bill of Rights as guaranteeing citizens of those states even more protection than the federal provisions, even those identically phrased." *Id.* at 495.

105. *State v. Bullock*, 272 Mont. 361, 384, 901 P.2d 61, 75 (1995). In *Bullock*, the defendants, charged with poaching, had a reasonable expectation of privacy in a section of a private driveway from which an elk carcass was observed, regardless of whether property was located within the curtilage of the defendant's cabin.

106. See *Gryczan v. State*, 283 Mont. 433, 451, 942 P.2d 112, 123 (1997). Prior to *Gryczan*, the right to privacy was invoked primarily in response to searches and personal records.

107. See *State v. Siegal*, 281 Mont. 250, 263, 934 P.2d 176, 184 (1997) (citing *State v. Pastos*, 269 Mont. 43, 47, 887 P.2d 199, 202 (1994)).

termine whether an activity is covered by the right to privacy. For this purpose the court has employed the *Katz* test, which requires that (1) a person have an actual expectation of privacy; and (2) the expectation must be one society is willing to recognize as reasonable.¹⁰⁸

The Montana Supreme Court's analysis, in a myriad of right to privacy challenges, follows a simple formula: that while an expectation of privacy may exist, it is not absolute. For example, while an arrestee may establish a legitimate expectation of privacy that society is willing to recognize, such an expectation can be trumped by the state's:

legitimate and compelling interest in protecting, to the extent possible, the safety of the arrestee and other person in and about the station house from weapons, dangerous instrumentalities, and hazardous substances which might be concealed on or in the personal property and possession of the arrestee.¹⁰⁹

Following the reasoning set forth in *State v. Pastos*,¹¹⁰ for example, a defendant's backpack was within the legitimate zone of privacy, pursuant to the *Katz* test, up until the time he was arrested. The State's compelling interest outweighed the individual's privacy interests once the defendant entered the police station. In other words, police cannot simply walk up to a citizen without cause and demand to see the contents of the citizen's possessions. Nor can the State, in certain instances, use technological heat-measuring devices, review employer or church files, obtain medical records, or, now, criminally sanction certain kinds of consensual sexual conduct.¹¹¹

B. A Fundamental Step Past *Bowers*

For Montanans, 1997 may well be remembered as the year the range of protection afforded by Montana's constitutional right to privacy took a significant leap forward beyond the scope

108. See *Katz v. United States*, 389 U.S. 347, 361 (1967).

109. *State v. Pastos*, 269 Mont. 43, 51, 887 P.2d 199, 204 (1994).

110. 269 Mont. 43, 887 P.2d 199 (1994).

111. See *State v. Siegal*, 281 Mont. 250, 934 P.2d 176 (1997); see also *State v. Burns*, 253 Mont. 37, 830 P.2d 1318 (1992). In *Burns*, the Supreme Court decided that right to privacy of personnel records kept by employer, a church, outweighed the interests of the State in reviewing the files to identify incidents or potential witnesses in a case involving a defendant charged with deviate sexual conduct. See also *State v. Nelson*, 283 Mont. 231, 941 P.2d 441 (1997) (holding driver's right to privacy under state constitution extended to his medical records); *Gryczan v. State*, 283 Mont. 433, 942 P.2d 112 (1997).

of searches and documents.¹¹² Justice Nelson, writing the *Gryczan* majority opinion, illumed the sexual conduct privacy right with stark precision, leaving virtually no room for future legislative inversions.

The right of consenting adults, regardless of gender, to engage in private, non-commercial sexual conduct strikes at the very core of Montana's constitutional right of individual privacy; and, absent an interest more compelling than a legislative distaste of what is perceived to be offensive and immoral sexual practices on the part of homosexuals, state regulation, much less criminalization, of this most intimate social relationship will not withstand constitutional scrutiny.¹¹³

This decision clearly distinguished the right of privacy under the Montana Constitution from the same right afforded by the United States Constitution. For example, the United States Supreme Court has held that laws forbidding the use of contraceptive devices violated the right of marital privacy.¹¹⁴ Even so, in *Bowers v. Hardwick*,¹¹⁵ the Court determined that the United States Constitution does not convey a fundamental privacy right upon consenting homosexuals to engage in sodomy, free from the prying eyes of the government. Justice Blackmun's dissent in *Bowers*, however, articulated that the privacy right at stake did not concern homosexual sodomy, rather the right to be let alone, a right which the Supreme Court has historically advanced to

112. See *Gryczan v. State*, 283 Mont. 433, 942 P.2d 112 (1997); see also *State v. Bullock*, 272 Mont. 361, 901 P.2d 61 (1995). This decision, involving privacy as it relates to searches, was similarly dramatic, as it departed from standard United States Supreme Court analysis of "curtilage." See *id.* at 384, 901 P.2d at 75-76.

113. *Gryczan*, 283 Mont. at 455, 942 P.2d at 125-126. Justice Nelson elaborates on this right by writing that "it is hard to imagine any activity that adults would consider more fundamental, more private and, thus, more deserving of protection from governmental interference than non-commercial, consensual adult sexual activity." *Id.* at 451, 942 P.2d at 123.

114. See *Griswold v. Connecticut*, 381 U.S. 479 (1965).

115. 478 U.S. 186 (1986). *Hardwick* brought suit to challenge the constitutionality of the Georgia state statute, which criminalized sodomy for all citizens, unlike Montana's statute challenged in *Gryczan*. The five-to-four decision held that Georgia's sodomy statute did not violate the fundamental rights of homosexuals. Contrary to obvious suspicions, *Hardwick* was in his bedroom engaged *only* in oral genital sex when he was disrupted by a police officer, who had come to his house purportedly to serve him a summons for a traffic violation and was let in by *Hardwick's* roommate. "Though he was never formally charged, *Hardwick* brought a civil rights action challenging the law, and the lower court agreed with his claim that it violated the constitutional right of privacy." Rhonda Copelon, *A Crime Not Fit to be Named: Sex, Lies, and the Constitution*, THE POLITICS OF LAW, A PROGRESSIVE CRITIQUE 180 (David Kairys ed., 1990).

keep pace with contemporary conditions.¹¹⁶

It is this fundamental right to be let alone that has driven recent decisions interpreting Montana's constitutional right to privacy.¹¹⁷ Justice Nelson made this clear in *Gryczan* when he wrote, "[r]egardless of whether Bowers was correctly decided, we have long held that Montana's Constitution affords citizens broader protection of their right to privacy than does the federal constitution."¹¹⁸

The lack of a compelling state interest in preserving the sodomy statute, in light of the fundamental right identified in *Gryczan*, was deftly overcome on two grounds. Both have significance for physician-assisted suicide. First, public health goals, namely AIDs prevention, lacked a foundation of reliable information supporting such a finding.¹¹⁹ Second, the state's interest in protecting morals was not sufficiently compelling to warrant governmental intrusion. "Regardless that majoritarian morality may be expressed in the public-policy pronouncements of the legislature, it remains the obligation of the courts—and of this Court in particular—to scrupulously support, protect and defend those rights and liberties guaranteed to all persons under our Constitution."¹²⁰

C. Personal Autonomy in Montana

Although the Montana Supreme Court in *Gryczan* acknowledges personal-autonomy privacy is a fundamental right under Montana's constitution, the Court does not explicitly define the

116. See, e.g., *Olmstead v. United States*, 277 U.S. 438 (1928). "We have likewise held that general limitations on the powers of government, like those embodied in the due process clauses of the Fifth and Fourteenth Amendments, do not forbid the United States or the States from meeting modern conditions by regulations which 'a century ago, or even half a century ago, probably would have been rejected as arbitrary and oppressive.'" *Id.* at 472 (citing *Village of Euclid v. Ambler Realty Co.*, 272 U.S. 365, 387 (1926)).

117. See *Elison & NettikSimmons*, *supra* note 102, at 12-13 (stating that "[f]rom the [constitutional convention] debates it is clear that the right was intended to protect citizens from illegal private and from legislation and governmental practices that interfered with their autonomy to make decisions in matters that are generally considered private"); see also *Welsh v. Pritchard*, 125 Mont. 517, 523, 241 P.2d 816, 819 (1952). The Montana Supreme Court in *Welsh* stated that "[t]he right of privacy is embraced within the absolute rights of personal security and personal liberty . . . [t]he basis of the right of privacy is the right to be let alone and it is a part of the right to liberty and pursuit of happiness." *Id.*

118. *Gryczan*, 283 Mont. at 448, 942 P.2d at 121.

119. *Id.* at 452-53, 942 P.2d at 123-24.

120. *Id.* at 454-55, 942 P.2d at 125.

concept.¹²¹ As discussed earlier, the United States Supreme Court has, through the course of landmark privacy decisions, offered such personal-autonomy definitions as "intimate and personal choices" that concern "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."¹²² If the Montana Court wished to adopt the meaning of personal autonomy found in United States Supreme Court privacy jurisprudence, it does not expressly say so. With the emphasis the *Gryczan* court places on distinguishing state constitutional privacy from its federal counterpart, such a lock-step interpretation seems dubious at best. In other words, this peculiar oversight demonstrates a flaw in the *Gryczan* decision.

The following, therefore, elaborates on the foundation implicit in *Gryczan* upon which a Montana court may build a working definition of personal autonomy in light of current legal thought—beyond the scope of United States Supreme Court decisions—and within the context of Montana's traditions.

1. *Perspectives on Personal Autonomy*

Joel Feinberg, a professor of philosophy at the University of Arizona, describes personal autonomy as the "realm of inviolable sanctuary most of us sense in our own beings."¹²³ He describes that this lofty notion of self-determination derives from the Greek roots of "self," and "law" or "rule," literally meaning "the having or making of one's own laws."¹²⁴ Legal scholar and professor of law, David A.J. Richards, who has written extensively in the area of autonomy and human rights, finds that personal autonomy "begins with the conception that persons have a range of capacities that enables them to develop."¹²⁵ This range of capacities is quite broad according to Richards, who sees the concept emerging from the shadows of the age of enlightenment, and illumed by the writings of philosopher Immanuel Kant.

121. See *Elison & NettikSimmons*, *supra* note 102, at 13, n.83 (examining the Montana Supreme Court's reluctance to address this area of privacy in such cases as *Yanzick v. School Dist. No. 23*, 196 Mont. 375, 641 P.2d 431 (1982) and *Storch v. Board of Directors*, 169 Mont. 176, 545 P.2d 644 (1976)).

122. See *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992).

123. JOEL FEINBERG, *HARM TO SELF, THE MORAL LIMITS OF THE CRIMINAL LAW* 27 (1986) [hereinafter FEINBERG]. *HARM TO SELF* is the third volume in a four-volume work, *THE MORAL LIMITS OF THE CRIMINAL LAW*. Feinberg has written widely on such topics as legal paternalism, pornography, and obscenity.

124. *Id.*

125. DAVID A.J. RICHARDS, *SEX, DRUGS, DEATH AND THE LAW* 8 (1982) [hereinafter RICHARDS].

The complex human capacities that constitute autonomy include language, self-consciousness, memory, logical relations, empirical reasoning about beliefs and their validity (human intelligence), and the capacity to use normative principles, including, *inter alia*, principles of rational choice, to decide which among several ends may be most effectively and coherently realized. These capacities permit persons to make independent decisions regarding their lives: which of their first-order desires will be developed and which disowned, which capacities cultivated and which left fallow, with what or with whom in their life histories they will or will not identify, what they will define and pursue as basic goals, and what they will strive towards as an aspiration.¹²⁶

Narrowing the scope to end of life decisions, Feinberg finds that “the most basic autonomy-right is the right to decide how one is to live one’s life, in particular how to make the critical life-decisions.”¹²⁷ Feinberg sees personal autonomy as more than allowing or refusing what is done to one’s body. Such autonomy may be violated by:

withholding of the physical treatment I request (when due allowance has been made for the personal autonomy of the parties of whom the request is made). For to say that I am sovereign over my bodily territory is to say that I, and I alone, decide (so long as I am capable of deciding) what goes on there. My authority is a discretionary competence, an authority to choose and make decisions.¹²⁸

Arguably, this view includes physician-assisted suicide as a personal-autonomy choice.¹²⁹

As stated above, the meaning of personal autonomy privacy was not expressly provided in *Gryczan*. Therefore, a Montana court could, conceivably, include the privacy of the dying process within the scope of personal autonomy. In other words, if the Montana Supreme Court was willing to grant greater privacy

126. *Id.*

127. FEINBERG, *supra* note 123, at 54.

128. *Id.* at 53.

129. See, e.g., Rachel D. Kleinberg & Toshiro M. Mochizuki, *The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases*, 32 HARV. C.R.-C.L. L. REV. 197, 205 (1997) (asserting that “individual autonomy demands protection of one’s liberty interest in determining the time and manner of one’s death”); RICHARDS, *supra* note 125, at 9 (stating that “the idea of ‘human rights’ respects this capacity of persons for rational autonomy — their capacity to be, in Kant’s memorable phrase, free and rational sovereigns in the kingdom of ends”).

regarding sexual relations than the United States Supreme Court, then the Montana Court quite logically could apply the same set of personal-autonomy privacy principles to a *Glucksberg*-like physician-assisted suicide challenge and, likewise, grant greater privacy.

2. *The Last Best Place to Die: Montana's Uncommon Tolerance for Personal Choice*

In Montana, the right to privacy, in the personal autonomy sense, seems intricately woven into the fabric of this state's cultural heritage. The right to decide how one is to live one's life is revealed in the historical as well as literary narratives that describe the Montana experience. As historian K. Ross Toole explains, Montana's growth as a territory and a state, "in one sense, has been a series of traumas Optimism has alternated almost monotonously with despair."¹³⁰ Toole characterizes the human experience in Montana as "men battling both the wilderness and each other. And the combat was ruthless."¹³¹ The unique sense of respect for personal choice that evolved under such adversity is explained by Toole's observation:

[b]ecause Montanans are so few and the land is so large (each person having about one-quarter of a square mile to himself on the average), the Montanan is unusually mobile, unusually informed about what his neighbors are doing, and, in spite of close personal relationships, uncommonly tolerant.¹³²

This uncommon tolerance lies at the heart of the express right to privacy in Montana. As First Judicial District Judge Jeffrey M. Sherlock wrote, in his *Gryczan* summary judgment order:

Montanans generally mind their own business and do not wish to restrict other people in their freedoms unless the exercise of those freedoms interferes with other members of society. This is a rule most of us learn in kindergarten and does not need to be supported by reference to fancy law review articles, exalted philosophers, or the hard to understand writing of some federal or state court.¹³³

130. K. ROSS TOOLE, MONTANA, AN UNCOMMON LAND 9 (1959). Toole also writes that "Montanans often speak of being proud of their heritage. Perhaps no state in the West produces so many historical pageants, is more eager in support of historical societies, or is more given to celebrations and the erection of monuments in commemoration of some past event." *Id.* at 243.

131. *Id.* at 9.

132. *Id.* at 257.

133. Order on Motions for Summary Judgment at 11, *Gryczan v. State*, No.

In essence, Montana history and literature capture and define the personal choices that often have nothing to do with anyone else but the lone individual deciding his or her own fate.¹³⁴ One Montana literary prolocutor, William Kittredge,¹³⁵ writes:

We live in stories. What we are is stories. We do things because of what is called character, and our character is formed by the stories we learn to live in. Late in the night we listen to our own breathing in the dark, and rework our stories. We do it again the next morning, and all day long, before the looking glass of ourselves, reinventing reasons for our lives. Other than such storytelling there is no reason to things.¹³⁶

The life that an individual chooses in Montana, according to Kittredge, is the individual's own story of his or her own sense of what is right. This sense of personal choice often appears as an individual's confrontation with inevitable mortality. Notably, such contemporary Montana stories as Kittredge's *We Are Not In This Together*,¹³⁷ David Quammen's *Walking Out*,¹³⁸ Richard

BDV-93-1869 (D. Mont. filed Feb. 16, 1996).

134. The concept here of deriving some sense of personal autonomy from Montana's historical and literary narratives can be loosely attributed to recent writings concerning the Law and Literature movement. In particular, see John Fischer, *Reading Literature/Reading Law: Is There a Literary Jurisprudence*, 72 TEX. L. REV. 135, 138 (1993) (stating that "[t]he Law and Literature movement is thus fundamentally a form of jurisprudence, one that provides insight into the nature of law without invoking the formal vocabulary of traditional legal philosophy"). See also Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2414-15 (1988). Delgado writes that "stories build consensus, a common culture of shared understandings, and deeper, more vital ethics. Counterstories, which challenge the received wisdom, do that as well. They open new windows into reality, showing us that there are possibilities for life other than the ones we live. They enrich imagination and teach that by combining elements from the story and current reality, we may construct a new world richer than either alone." *Id.*

135. William Kittredge co-edited *THE LAST BEST PLACE, A MONTANA ANTHOLOGY* (1988), a collection of writings including the Native American experience, Lewis and Clark journal entries, stories from pioneers and farmers, and modern fiction.

136. William Kittredge, *The Politics of Storytelling*, NORTHERN LIGHT, A SELECTION OF NEW WRITING FROM THE AMERICAN WEST 42 (1994).

137. "Halverson for the first time in all this surprised himself absolutely by drawing the knife along the tender flesh inside his left forearm, careful to avoid the veins as they stood out, just softly tracing and watching the painless slide of the blade and the immediate welling streak of blood, holding himself so he did not force the blade deeper, pulling away just as he reached the wrist." WILLIAM KITTREDGE, *We Are Not in this Together*, WRITERS OF THE PURPLE SAGE, AN ANTHOLOGY OF RECENT WESTERN WRITING 243, 262 (1984).

138. "He thought of his mother's face and her voice as she was told that her son was lost in the woods in Montana with a damaged hand that would never be right, and with his father, who had been shot and was unconscious and dying." DAVID

Ford's *Winterkill*,¹³⁹ and Norman Maclean's *A River Runs Through It*,¹⁴⁰ depict the individual's private confrontation with this ultimate uncertainty. Such a confrontation is a private affair, governed by the laws of one's own design, or one's own personal autonomy as suggested by Feinberg. In the context of Montana tradition, therefore, shaping one's own story when facing death speaks to personal dignity and integrity, about how a person chooses to be remembered by the choices he or she made during the course of his or her life. The Montana Supreme Court should, given the opportunity, recognize the choices that arise from these "stories" as existing within the zone of privacy that the Montana State Constitution provides.

This historical-literary backdrop, therefore, should inform the substance of personal autonomy in future Montana jurisprudence, including decisions on the individual's end of life choices. Arguably, it already has, in light of the current expansion of the right to privacy by the Montana Supreme Court in making the Montana Constitution unique among all other states.¹⁴¹

VI. MONTANA'S LABORATORY OF PRIVACY: THE SUICIDE TEST

A. A Constitutional Challenge

Conceivably, the *Katz* test, when applied to assisted-suicide, may be met following the same rationale used in *Gryczan*. An actual expectation of privacy regarding the choice of a terminally-ill person, who wishes to put an end to his or her suffering as certain death looms, arguably falls within the realm of expectations Montanans recognize as reasonable.¹⁴² Choices arising from

QUAMMEN, *Walking Out*, WRITERS OF THE PURPLE SAGE, AN ANTHOLOGY OF RECENT WESTERN WRITING 97, 122 (1984).

139. "Troy looked back at the little deer for a moment, and stared as if he did not know what to say about it. And sitting on the wet sand, in the foggy night, he all at once looked scary to me, as though it was him who had washed up there and was finished." RICHARD FORD, *Winterkill*, ROCK SPRINGS 166 (First Vintage Contemporaries Ed. 1988). "But here's a man cut in three pieces in front of me. What can you do? You can't do very much. I squatted down and touched his good hand. And it was like ice. His eyes were open and roaming all up in the sky . . . And I said to him, 'It's all right, bud, you're in Montana.'" *Id.* at 176 (excerpted from *Optimists*).

140. "My mother turned and went to her bedroom where, in a house full of men and rods and rifles, she had faced most of her great problems alone. She was never to ask me a question about the man she loved most and understood the least." NORMAN MACLEAN, *A RIVER RUNS THROUGH IT AND OTHER STORIES* 102 (The University of Chicago Press 1976).

141. See *State v. Burns*, 253 Mont. 37, 41, 830 P.2d 1318, 1320 (1992), where the Court states that Montana has the strongest privacy provision in the United States.

142. See *State v. Dolan*, 283 Mont. 245, 256, 940 P.2d 436, 442-443 (1997),

the patient-physician relationship conceivably fall within the choice of "intimate social relationship[s]" that Justice Nelson addresses in *Gryczan*.¹⁴³ Likewise, the decision to choose a painless death over a prolonged painful one gives rise to a subjective expectation that such a choice will not be subject to such intrusive governmental regulation as criminal sanctions.¹⁴⁴

While segments of society do not morally approve of such a choice, that is not to say society is unwilling to recognize that adults have a reasonable expectation that these choices are personal and private. After all, the citizens of Montana recognize the right of the terminally ill to permit physicians to withdraw life-sustaining treatment.

The [Terminally Ill] Act permits an individual to execute a declaration that instructs a physician to withhold or withdraw life-sustaining treatment in the event the individual is in a terminal condition and is unable to participate in medical treatment decisions The Act . . . is limited to treatment that is merely life-prolonging, and to patients whose terminal condition is incurable and irreversible, whose death will soon occur, and who are unable to participate in a treatment decision.¹⁴⁵

Following the Act's rationale, the right to permit the administering of lethal medication by physicians potentially could be recognized as well.¹⁴⁶ A plaintiff patient would only have to convince a court that the two choices, essentially, are the same. Again, in the words of Justice Turnage, "there is something in the lives of people equally private and more important—the right to life or

where the Montana Supreme Court held that medical records fall within the zone of privacy protected by Montana's Constitution and voiced the opinion of the state legislature pursuant to MONT. CODE ANN. 50-16-502(1) (1997), that "health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interest in privacy and health care or other interests." *Id.*

143. See *Gryczan*, 283 Mont. at 455, 942 P.2d at 125-26.

144. See *id.* at 450, 942 P.2d at 122.

145. See Montana Rights of the Terminally Ill Act, MONT. CODE ANN. §§ 50-9-101-206 (1997), chapter commissioner's comments. The Act was originally approved by the Montana state legislature in 1985.

146. Washington State's act, nearly identical in scope as Montana's, states that "adult persons have the fundamental right . . . to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition." WASH. REV. CODE ANN. § 70.122-010 (1996). The only state supreme court to address this issue up to now has been the Michigan Supreme Court. The Court held that there was no right to, or liberty interest in, assisted suicide protected by the Fourteenth Amendment. See *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994). Unlike Montana, Michigan does not have a state constitutional right to privacy.

death.¹⁴⁷ If so, and the *Katz* test is met, then only a compelling state interest expressed in narrowly-tailored legislation may abridge this right.

1. *The Compelling State Interest: Prevention Without a Cure*

The Court, in *Compassion in Dying*, identified six elements comprising the compelling state interests in preventing physician-assisted suicide: (1) preserving life; (2) preventing suicide; (3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; (4) protecting family members and loved ones; (5) protecting the integrity of the medical profession; and (6) avoiding future movement toward euthanasia and other abuses.¹⁴⁸

Under the Montana Constitution, a fundamental right requires a strict-scrutiny analysis.¹⁴⁹ Therefore, if the right to physician-assisted suicide for terminally ill patients was deemed fundamental, and is consistent with Montana's right to personal autonomy privacy, a state statute that limits that interest must "be narrowly tailored to effectuate *only that compelling interest*."¹⁵⁰ Plainly, this is not the case under Montana law today. The aiding or soliciting suicide statute pertains only to instances where the suicide fails.¹⁵¹ If the suicide is successful, a physician can be charged under one of the homicide statutes, depending on the factual circumstances, none of which provide any mention of such specific application.¹⁵²

As previously discussed, *sustained terminal* patients would not exist but for modern medical technology. End-of-life decisions for such patients, therefore, transcend the broad, sweeping common law notions of suicide and its social consequences that served as a foundation for Montana's assisted-suicide statute. Indeed, as the Ninth Circuit suggested in *Compassion In Dying*, "deaths resulting from terminally ill patients taking medication prescribed by their doctors" might not fall under the traditional

147. *Gryczan v. State*, 283 Mont. 433, 458, 942 P.2d 112, 127 (1997).

148. See *Compassion in Dying v. Washington*, 79 F.3d 790, 816-832 (9th Cir. 1996). The Supreme Court in *Glucksberg* followed the lower court's examination of these six state interests. 117 S. Ct. at 2272. The Court found that the requirement that Washington's assisted-suicide ban be rationally related to legitimate government interests as "unquestionably met." *Id.* at 2271.

149. See *Gryczan*, 283 Mont. at 449, 942 P.2d at 122.

150. *Gryczan*, 283 Mont. at 450, 942 P.2d at 122, (emphasis added).

151. See MONT. CODE ANN § 45-5-105(1) (1997).

152. See MONT. CODE ANN § 45-5-102-104 (1997).

notion of suicide, and thus the state's interest in preventing suicide would not be implicated.¹⁵³ A person faced with terminal illness would not invoke the compelling state interest of *preserving life or preventing one's taking of his or her own life*. Justice Stevens, in his *Glucksberg* concurrence, offers a compelling statement.

Although there is no absolute right to physician-assisted suicide, *Cruzan* makes it clear that some individuals who no longer have the option of deciding whether to live or to die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die.¹⁵⁴

One's life, ultimately, is the highest valued possession one has. Therefore, the compelling state interest must be very great in proportion to the privacy right in which it propounds to have an interest. In preserving six months of a life that a patient no longer wishes to live, the state abuses the very interest it claims to protect.¹⁵⁵ Ronald Dworkin questioned the nature of such a state interest when he wrote:

Nevertheless, in spite of the crucial part that the idea of a legitimate state interest in preserving all human life now plays in constitutional law, there has been remarkably little attention, either in Supreme Court opinions or in the legal litera-

153. 79 F.3d 790, 824 (1996).

154. *Washington v. Glucksberg*, 117 S. Ct. 2302, 2307 (Stevens, J., concurring). Worth noting is that some state courts have, in fact, found that it is not irrational to prefer imminent death to an uncertain one, in the context of the death penalty. See, e.g., *People v. Guzman*, 755 P.2d 917 (Cal. 1988). In *Guzman*, the California Supreme Court found that the choice made by a defendant who chooses the death penalty over life without parole should be honored as "an informed choice" by a "sound mind." *Id.* at 947. See also *Autry v. McKaskle*, 727 F.2d 358, 363 (5th Cir. 1984) (finding that "[t]he idea that a deliberate decision of one under sentence of death to abandon possible additional legal avenues of attack on that sentence cannot be a rational decision, regardless of its motive, suggests that the preservation of one's own life at whatever cost is the *summum bonum*, a proposition with respect to which the greatest philosophers and theologians have not agreed and with respect to which the United States Constitution by its terms does not speak").

155. As one commentator wrote, "to a pain-racked, terminally ill individual eagerly awaiting death to relieve suffering, the state is indeed forcing its will on the individual. The threat of state sanctions forces an individual, against his or her will, to endure the final days of pain and indignity." Robert L. Kline, *Give Me Liberty and Give Me Death: Assisted Suicide as a Fundamental Liberty Interest*, 6 B.U. PUB. INT. L.J. 527 (1997).

ture, to the question of what that supposed interest is or why it is legitimate for a state to pursue it Of course government is properly concerned with the welfare and well-being of its citizens, and it has the right, for that reason to try to prevent them from being killed or put at risk of death from disease or accident. But the state's obvious and general concern with its citizens' well-being does not give it a reason to preserve someone's life when his or her welfare would be better served by being permitted to die in dignity.¹⁵⁶

In *Glucksberg*, four doctors asserted the rights of terminally ill, competent adult patients who wished to hasten their deaths with the help of their physicians so that they might die peacefully and with dignity. The district court described one of the patients as follows:

Jane Roe is a 69-year-old retired pediatrician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. Although she tried and benefitted temporarily from various treatments including chemotherapy and radiation, she is now in the terminal phase of her disease. In November 1993, her doctor referred her to hospice care. Only patients with a life expectancy of less than six months are eligible for such care. Jane Roe has been almost completely bedridden since June of 1993 and experiences constant pain, which becomes especially sharp and severe when she moves. The only medical treatment available to her at this time is medication, which cannot fully alleviate her pain. In addition, she suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.¹⁵⁷

It is hard to imagine a state's interest regarding the preservation of life or the prevention of suicide so utterly compelling that it could interfere with a patient, under similar circumstances, who requests nothing more than a prescription for a lethal quantity of sleeping pills.

A leading opponent of assisted suicide is not the medical community, nor an elected body of representatives, but the right-to-life movement, which, in concurrence with English common law tradition, wishes to drive a wooden stake through the body of the assisted suicide movement. The right-to-life argument

156. RONALD DWORKIN, FREEDOM'S LAW: THE MORAL READING OF THE AMERICAN CONSTITUTION 130, 138 (1996).

157. *Compassion in Dying v. Washington*, 79 F.3d 790, 794 (9th Cir. 1996). See *id.* at 794-95 for similar description of the other two patient-plaintiffs.

focuses on a *this is no different than abortion* approach. Namely, if physician-assisted suicide is legalized, the sanctity of life will be abused and it will become a norm to put people out of their misery in a cold, calculated fashion. Terminally ill patients will be wrongly convinced and coerced into ending their lives.

The counter to these legitimate social-moral policy arguments is that a woman's right to terminate her pregnancy *is still deemed a fundamental right* enjoying constitutional protection. In this sense, proponents of physician-assisted suicide seek the legal and legislative community to see the two rights as the same. The only pain which terminally ill patients suffer is the pain of being alive. The only sanctity of life that can be measured for such patients, therefore, is the sanctity of their own dying. As one commentator reflected, "[b]y comparison the impact of a constitutional right to physician-aided suicide for the terminally ill is much less controversial than a constitutional right to abortion when considering the interests of third parties There is no harm to third parties if these individuals were to hasten their deaths by a few months only to avoid the pain and suffering of a terminal illness."¹⁵⁸

The personal, autonomous choice of an individual, based on his or her own subjective sense of dignity, therefore, falls within the zone of privacy established by the *Gryczan* court. Again, Justice Turnage's words ring true, for what could be more private and more important than the right to life or death; and, in certain circumstances, what interest could be more compelling than that of the person who, as a matter of necessity, must choose one over the other?

B. Legislative Action: Manifest Necessity

Unlike *Gryczan*, a successful recognition of physician-assisted suicide as a privacy right within the zone of Montana's constitutional protection requires more than striking a bad law from the books. Clearly, as all sides to the debate concede, a set of safeguards and procedures must be established in order to quell the compelling state interests. Prompted by the United States Supreme Court's decision in *Glucksberg*, some form of legislative action addressing the issue is necessary in establishing the

158. Matthew Graham Zagrodzky, *Constitutional Law—The Development of Liberty and the Right to Physician-Assisted Suicide—Compassion in Dying v. Washington*, 38 S. TEX. L. REV. 353, 362-63 (1997).

boundaries of what Montanans deem as appropriate in establishing this fundamental right to privacy for the terminally ill.

One model the state legislature could follow is Montana's Rights of the Terminally Ill Act. The Act's safeguard procedures ensure the withdrawal of life-sustaining treatment results only after a well-reasoned, well-documented decision:

- (1) the individual must be of sound mind; (2) at least 18 years-old; (3) have a diagnosed incurable condition; (4) will in the opinion of an attending physician die without the administration of life-sustaining treatment; and (5) the declaration may be revoked at any time.¹⁵⁹

A "terminal condition," as required under the Montana Act, requires that so little life remains, extinguishing rather than prolonging it has been deemed acceptable.¹⁶⁰ This can be compared with Oregon's Death With Dignity Act, which requires:

- (1) the person must be at least 18 years-old; (2) the request for life-ending medication must be voluntary; (3) a 15-day waiting period between a patient's first request for a lethal prescription and the time the pills can be obtained from a pharmacist; (4) before the prescription can be written, two doctors reasonably determine the patient has less than six months to live; (5) the patient must be fully informed of feasible alternatives; and (6) no medication to end a patient's life may be prescribed until it is determined that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.¹⁶¹

One element of the *preserving life* state interest, often raised by opponents, is that terminally ill patients may be subject to undue influence or pressure from family members or health care professionals. This problem, as commentators suggest, can be resolved by the "strength of the regulations and safeguards instituted by the State."¹⁶² Essentially, if a physician-assisted sui-

159. See MONT. CODE ANN §§ 50-9-103 to -104 (1997).

160. MONT. CODE ANN § 50-9-102(14) (1997). "Terminal condition" means an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time. Also, under (7) of the same section, "life-sustaining treatment means any medical procedure or intervention that, when administered to a qualified patient, serves only to prolong the dying process."

161. OR. REV. STAT. § 127.800-897 (1996).

162. Rachel D. Kleinberg & Toshiro M. Mochizuki, *The Final Freedom: Maintaining Autonomy and Valuing Life in Physician-Assisted Suicide Cases*, 32 HARV. C.R.-C.L. L. REV. 197, 213 (1997).

cide act, similar to Montana's Terminally Ill Act, was adopted, the procedural safeguards would alleviate potential abuse. If state legislators can pass an act that ensures the individual's right in choosing to have life-sustaining treatment withdrawn, surely similar safeguards can be drafted into a physician-assisted suicide act.

Narrowly tailored drafting would also address the related state interest of ensuring that other factors, such as depression, were not controlling the person's choice, a problem which seemed particularly troubling to the Supreme Court in *Glucksberg*.¹⁶³ Because of physician-assisted suicide's close alliance with the Terminally Ill Act, both in terms of substance and the potential form it could take in effectively addressing the compelling state interest of preserving life and preventing suicides, the issue, ultimately, turns on the role of the physician.¹⁶⁴

1. *The Integrity of Physicians*

The American Medical Association officially opposes physician-assisted suicide. "The AMA," as one commentator wrote, "views such acts as antithetical to a doctor's fundamental role as a healer and guardian of life Even the Hippocratic Oath seems to be explicitly opposed to physician-assisted suicide. It states: 'I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.'"¹⁶⁵ As the dissent in *Compassion in Dying* stated, "[p]hysician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."¹⁶⁶

Even so, another theme of the oath is for the physician to perform anything within his or her means to prevent suffering. Mixed in with these codes of conduct is the bald fact that by

163. See 117 S. Ct. at 2272-73.

164. Because suicide is no longer a punishable offense, terminally ill patients can take their own lives, and many do. But, as the Court in *Compassion in Dying* pointed out, "[b]y prohibiting physician assistance, it bars what for many terminally ill patients is the only palatable, and only practical, way to end their lives. Physically frail, confined to wheelchairs or beds, many terminally ill patients do not have the means or ability to kill themselves in the multitude of ways that healthy individuals can. Often, for example, they cannot even secure the medication or devices they would need to carry out their wishes." *Compassion in Dying v. Washington*, 79 F.3d 790, 832 (9th Cir. 1996).

165. Peter G. Daniels, *An Illinois Physician-Assisted Suicide Act: A Merciful End to a Terminally Ill Criminal Tradition*, 28 LOY. U. CHI. L.J. 763, 773-74 (1997).

166. *Compassion in Dying*, 79 F.3d at 855 (Beezer, J., dissenting).

withdrawing life-sustaining equipment from a terminally ill patient, a physician is, essentially, respecting a request for death with dignity. Some commentators have, in fact, argued that the well-established and accepted practice of the withdrawal of life support is subject to more abuse than proposed assisted-suicide legislation and challenges.

Indeed, I venture to say that a law that sanctions the "taking of human life" indirectly or negatively rather than directly or positively contains much more potential for abuse. Because of the repugnance surrounding active euthanasia—because it is what might be called "straightforward" or "out in the open" euthanasia—I think it may be forcefully argued that it is less likely to be abused than other less readily identifiable forms of euthanasia. Many a Down's syndrome baby has been "allowed to die" by not removing an intestinal blockage or otherwise performing relatively simple surgery. Very few would have died if death were by lethal injection—if parents and physician could not deny what they were doing—if they had to accept the responsibility (or should one say "guilt") of "killing" rather than "letting die."¹⁶⁷

Recent studies indicate that the opinion regarding assisted suicide among physicians is mixed, possibly favorable.¹⁶⁸ Again,

167. Yale Kamisar, *When is there a Constitutional "Right to Die"? When is there No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203, 1216-17 (1991); see also *Compassion in Dying*, 79 F.3d at 828 n.102 (discussing the "double effect," which occurs when physicians knowingly give terminally-ill patients medication, with informed consent, that relieves pain but may also hasten death).

168. See Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89-93 (1994). A survey conducted among 1355 randomly selected physicians in the state of Washington illustrates the polarization on the issue of physician-assisted death. Thirty-nine percent of physicians agreed that physician-assisted suicide is never ethically justified, while fifty percent disagreed with that statement. On the question of legalization, just over fifty percent thought physician-assisted suicide and euthanasia should be legal under some circumstances, but not all of those in favor of legalizing physician-assisted suicide and euthanasia would be willing to participate themselves. The majority who favored legalization of physician-assisted suicide and euthanasia also expressed strong support for safeguards such as requiring an independent witness to the patient's request, an established relationship between physician and patient, two physicians who agree on the proposed course, a waiting period between the request and the assistance, and the exhaustion of available alternatives such as pain control and hospice care before resort is made to assisted death. See also Melinda Lee et al., *Legalizing Assisted Suicide: Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310 (1996). A recently study of Oregon physicians found that sixty percent of those who responded believed that physician assisted suicide should be legal. See also Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J.

narrowly tailored legislation could relieve physicians from the dilemma by including provisions that exclude physicians who do not wish to participate. The ethical challenge faced by the medical profession, which gives rise to a state compelling interest, can be compared to the one the profession faced prior to the legalization of abortion. After all, few physicians offer abortion services. If anything, legislative enactment that provides willing physicians with a legitimate, overt method to provide terminally ill patients the means to choose the time and place of their own death, will enhance the integrity of a state's medical profession far more than perpetuating an environment of covertness and coverups.

VII. THE FINAL ACT: A MANDATE FOR ACTION

Clearly, the mandate sent down from the United States Supreme Court in *Glucksberg* was physician assisted-suicide should be a state-law issue, and if meddled with at the federal level would lead to prolonged partisan debate and judicial congestion from district courts on up through the appellate system. Therefore, the decision by the Ninth Circuit in *Compassion In Dying*, although reversed, retains the value of its substantive due process analysis. By no means are states, such as Montana, prevented from recognizing or adopting the exact same liberty interest identified by the Ninth Circuit.

Consequently, if Chief Justice Turnage is correct, that a challenge to Montana's assisted suicide law under the right to privacy is inevitable—which, given the climate for judicial activism in the area of privacy, is quite plausible—the state legislature should prepare by taking action long before legal actions arise. The legislature should draft and pass a counterpart to its Terminally Ill Act that is compatible with state constitutional concerns raised thus far.¹⁶⁹ A motivating factor in taking action is that a profound controversy must be brought into the realm of reasonable deliberation. In Oregon, for example, undue influence

MED. 303, 303 (1996) (finding the "most Michigan physicians prefer either the legalization of physician-assisted suicide or no law at all; fewer than one fifth prefer a complete ban on the practice").

169. A model act does exist. See Rebecca C. Morgan & D. Dixon Sutherland, *Last Rights? Confronting Physician-Assisted Suicide in Law and Legal Liturgies on Physician-Assisted Suicide*, 26 STETSON L. REV. 481, 522-28 (1996) [hereinafter Morgan & Sutherland]. See also William J. Tarnow, *Recognizing a Fundamental Liberty Interest Protecting the Right to Die: An Analysis of Statutes Which Criminalize or Legalize Physician-Assisted Suicide*, 4 ELDER L.J. 407, 449-457 (1996), where the Oregon Death with Dignity Act in its entirety is included in the appendix.

on the state from beyond its borders from both sides of the issue, including the Vatican and Dr. Kevorkian, resulted in a lengthy and costly process.¹⁷⁰

Ultimately, physician-assisted suicide should be a Montana issue, decided by its voters as expressed by their elected representatives. Of course, the legislature could decide to pass legislation carefully tailored to prevent assisted suicide. If so, a new law potentially could withstand a constitutional privacy challenge by clearly delineating the compelling state interests that simply are not expressed under current state law. Indeed, had the state legislature taken action in addressing the issue of same-sex conduct, the *Gryczan* challenge may have yielded a different result. It was the legislature's *failure to act* in clear accordance with state constitutional privacy concerns that prompted the Montana Supreme Court to resolve the matter.¹⁷¹

Furthermore, Montana's governor, prompted by a coalition of concerned citizens or an organization such as Missoula Demonstration Project: The Quality of Life's End,¹⁷² could appoint a commission to draft a proposed physician-assisted suicide act, as well as conduct public opinion polls and hold town-hall meetings across the state, providing guidance for the next session of the state legislature, which will meet early in 1999.¹⁷³ Alternatively,

170. The battle in Oregon began in 1994, when work on its Death with Dignity Act was begun by its state legislature, and was only recently resolved, at least for the time being. The repeal campaign spent almost \$4 million to persuade voters to get rid of the law. Much of the support came from the Roman Catholic Church and Oregon Right to Life.

171. See *Gryczan*, 283 Mont. at 454-55, 942 P.2d at 125. "Regardless that majoritarian morality may be expressed in the public-policy pronouncements of the legislature, it remains the obligation of the courts—and of this Court in particular—to scrupulously support, protect and defend those rights and liberties guaranteed to all persons under our Constitution."

172. The organization, founded by Missoula physician Ira Byock, is devoted to researching life's end, enhancing it and developing Missoula as a model for the rest of the nation. Byock's book, *DYING WELL, PEACE AND POSSIBILITIES AT THE END OF LIFE* (1997), provides an instructive and intimate look at improved hospice care and its potential for helping society come to terms with the process of dying. For example, chapter one is devoted to Byock's experience with dealing with the process of his own father's death. Byock, it should be noted, opposes physician-assisted suicide because the debate has "diverted our attention from the more logical, humane, and lasting solutions to the crisis." *Id.* at 245.

173. Such commissions have been formed elsewhere to examine the issues surrounding assisted suicide and propose legislation. See *Glucksberg* 117 S. Ct. at 2267; Morgan & Sutherland, *supra* note 169, at 513. Commissions generally include professors of law and philosophy, religious leaders, terminally-ill patient advocates, attorneys who represent such patients, physicians and hospitals, as well as concerned citizens.

the commission could reach the conclusion that such an act would not reflect the will of the people of this state. The commission could examine alternative, viable choices for terminally ill patients, such as increased funding for hospice care. Regardless of the outcome, it would be an affirmative step forward.

As *Gryczan* proved, perhaps once and for all, if the elected representatives of this state remain reluctant to act, the judiciary will gladly serve as in instrument of progressive change when the privacy of Montana citizens is at stake. In other words, the current justices of Montana's Supreme Court simply are better politicians than any given state legislature of recent memory. Regardless, the imperative for action is imminent. The lesson to be learned from Dr. Kevorkian, Oregon, and the *Glucksberg* decision is that the issue of physician-assisted suicide cannot be denied any more than death itself. For, if Montana truly is the last best place, it truly must be the last best place for all citizens, even for the terminally ill, whose sense of personal autonomy remains very much alive.

